FROM THE EDITORS, Mary Rorty & Mark Sheldon

FROM THE CHAIR, John Lizza

ARTICLES

Bette Crigger
“Some Thoughts about Updating the AMA Code of Medical Ethics”

Jason T. Eberl
“Ambiguities and Inconsistencies among the Opinions of the AMA Code of Medical Ethics”

Michael Davis
“Some Thoughts on Revising the AMA’s Code of Ethics”

Tod Chambers
“The Usefulness and Uselessness of Code”

Anonymous
“Patient”

Jennifer Radden
“Classifying Dysthymia”

Claire Pouncey
“Nosologic Validity and the Intuitively Accessible View of Natural Kinds”

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FELICIA NIMUE ACKERMAN
“The Other Two Sides”

ANITA HO
“Epistemic and Ethical Implications of Expert Authority in Medicine”

TOD CHAMBERS
“The Case for Applied Philosophy”

SARAH HEIDT
“Response to Chambers”

BOOK REVIEW

Cynthia Cohen: *Renewing the Stuff of Life: Stem Cells, Ethics, and Public Policy*
REVIEWED BY BONNIE STEINBOCK

ANNOUNCEMENT
FROM THE EDITORS

This is a very large and rich volume of the Newsletter on Philosophy and Medicine. Included are the Committee on Philosophy and Medicine’s programs from both the Central and Eastern Division meetings, as well as some interesting additional articles, and a short story.

The two Division meetings, interestingly enough, both focus on large revision projects currently underway. The American Medical Association (AMA) is currently updating its Code of Medical Ethics. The Committee on Philosophy and Medicine saw the Division meeting in Chicago as an opportunity to invite commentary on the Code since the AMA is headquartered in the Windy City. Bette-Jane Crigger, Director of Ethics Policy and Secretary to the Council on Ethical and Judicial Affairs, provides a description of the objectives of the current project, as well as the history behind the Code. Jason T. Eberl, in his comments, focuses on examples of ambiguities and inconsistencies in the current Code as a way of showing how formidable the task will be for those who are engaged in the revision. He chooses certain current sections, areas in which he works, to demonstrate the difficulty in the existing Code and the difficulty that lies ahead. Michael Davis points to even more fundamental issues, the very meaning of the term “ethics” and the multiple senses in which the term is used in the current Code, and in light of this ambiguity he proposes a revision that goes forward with language that has great clarity in relation to this very fundamental concept. Finally, Tod Chambers provides some general thoughts about the functions of codes, suggesting that the nature and purpose of professional codes ought to be kept in mind as the revision goes forward. Kevin McDonnell chaired the session.

The two papers that were presented at the Eastern Division session focus on the other large revision project, the American Psychiatric Association’s (APA) Diagnostic and Statistical Manuals (DSMs) of Mental Disorder. The first, “Classifying Dysthymia,” by Jennifer Radden, is an analysis that points to problems involved in the attempt to develop taxonomies, problems that Radden finds evident in the APA’s DSM, and the World Health Organization’s International Classification of Diseases. She illustrates this with a consideration of the concept of Dysthymia, asking whether, in the future revised diagnostic manual, it ought to continue to be viewed as a mental disorder at all. Following Radden is a paper by Claire Pouncey, “Nosologic Validity and the Intuitively Accessible View of Natural Kinds.” Pouncey writes, “As inherently philosophical as psychiatry is, it describes its own philosophy badly.” The result, the author claims, is that critics attack a “straw man.” The author develops the perspective that a more meaningful criticism would have to take.

“The Other Two Sides,” a short story by Felicia Nimue Ackerman, is included in this volume of the Newsletter, reprinted from What Philosophy Can Tell You About Your Cat. It seems to be a story, among other things, about relationships where communication is complicated by both the availability of language and its absence, particularly when that communication involves determining the wishes of a loved one regarding ultimate life choices.

The occasion for the discussion between Tod Chambers and Sarah Heidt appears to be an assessment of the activity of “philosophical counseling,” where professional philosophers actually engage in working with clients on matters of basic life choices and ethical dilemmas. However, the deeper focus of their remarks appears to be what to make of and how to think about the use of “cases” in relation to claims to objectivity that any professional group might make to validate what they have to offer to the public.

Finally, included in this issue of the Newsletter, is a paper by Anita Ho and book review by Bonnie Steinbock. Ho, in “Epistemic and Ethical Implications of Expert Authority in Medicine,” explores the issue of expert authority in relation to the possibility of such expert authority becoming the basis for oppression. The point that Ho wants to make is that the legitimacy of such expert authority depends fundamentally on how dissent in opposition to such authority is regarded and dealt with. Steinbock considers Cynthia Cohen’s Renewing the Stuff of Life: Stem Cells, Ethics, and Public Policy, finding particularly interesting Cohen’s discussion of former President Bush’s stem cell policy.

As always, we are looking for papers, presentations, works in progress, stories, poems, and anything else that you would like us to consider. Please submit your work!

Thank you,

Mary V. Rorty (mvr2j@stanford.edu)
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FROM THE CHAIR

In response to recent controversy over the neurological criterion for determining death, the Committee on Philosophy and Medicine organized a session on “Is ‘brain death’ death?” for the 2009 Pacific Division Meeting in Vancouver. Our panel consisted of three physicians, Drs. D. Alan Shewmon (UCLA), Robert Truog (Harvard), and Ari Joffe (University of Alberta), and the philosophers Bernard Gert (Dartmouth) and Don Marquis (Kansas). I moderated and provided some commentary on
an exciting discussion at a critical juncture of philosophy and medicine.

The Pacific Division meeting in Vancouver featured a number of papers of interest to our constituency, in addition to the session sponsored by the Committee. Participants and other sympathetic attendees were invited to a reception sponsored by the Committee and the Newsletter, in hopes of facilitating dialogue among people with shared interests and soliciting submissions to the Newsletter.

The Committee sponsored sessions at the recent Eastern and Central Division Meetings. At the 2008 Eastern Meeting in Philadelphia, Kenneth Richman organized and moderated a fascinating discussion on “Ethical and Conceptual Issues in the Classification and Treatment of Mental Illness.” Talks were given by Dominic Murphy (California Institute of Technology), Claire Pouncey (Temple University), and Jennifer Radden (University of Massachusetts–Boston). At the 2009 Central Division Meeting in Chicago, the Midwestern members of our committee organized a session on ethics codes. Bette Crigger of the American Medical Association (AMA) gave a presentation on the work she is doing to revise the AMA code of ethics. A round table discussion followed with prepared comments by Mike Davis (IIT), Tod Chambers (Northwestern), and Jason Eberl (IUPUI). Kevin McDonnell chaired the session.

As we look towards the future, it is good to see that health care has a prominent place on the agenda of the Obama administration. Hopefully, we will see some real progress in addressing the problems of the uninsured and justice in the distribution of health care. These problems, however, require an honest dealing with the cost of health care and recognition that we cannot have it all. There is nothing like an economic recession to make us aware of the need to set limits. The time may be particularly ripe for the leaders of our country to explain this to the American people.

John P. Lizza
Kutztown University of Pennsylvania

ARTICLES

Some Thoughts about Updating the AMA Code of Medical Ethics
Bette Crigger
The American Medical Association

Every 50 years or so the American Medical Association undertakes to “update” the AMA’s Code of Medical Ethics. The Council on Ethical and Judicial Affairs, the institutional “keeper” of the Code, has just embarked on a comprehensive, critical review of the Code’s current incarnation with an eye to identifying outdated content, discrepancies in guidance, issues not yet addressed that require development of new ethics policy, and opportunities to combine and streamline guidance on closely related matters currently found in multiple opinions. For a linguistic anthropologist who’s been involved in medical ethics for a while now, overseeing that project has got to qualify as a dream job.

Where did the Code come from?
In thinking about what it means to update the AMA Code it helps to have some familiarity with both the document’s own history and the policymaking process of the AMA as an organization. The American Medical Association and the Code of Medical Ethics came into being at one and the same time. At the meeting that launched the AMA in 1947, members of the newly formed organization unanimously adopted the first national code of ethics for professional medicine, a set of twelve “articles” addressing the mutual duties of physicians and patients, physicians’ duties to one another and the profession, and the mutual responsibilities of physicians and the public. The underpinnings of that first Code continue to inform its current content. (The passionately interested can find a PDF copy of the original Code at http://www.ama-assn.org/ama/upload/mm/369/1847code.pdf.)

Today, development and interpretation of AMA ethics policy is the responsibility of the Council on Ethical and Judicial Affairs (CEJA), a nine-member body of seven practicing physicians, a resident or fellow, and a medical student. CEJA’s physician members are nominated by the AMA’s incoming president and affirmed by the House of Delegates (HOD), the larger policy-making body of the organization. Resident/fellow and student members are appointed by their respective bodies within the AMA. Council composition is diverse, ranging across a variety of specialties—among current members, neurosurgery, pulmonology, general internal medicine, emergency medicine, psychiatry, general surgery, and oncology. With the exception of the resident and student members, who serve three-year terms, each CEJA member serves for seven years, with the senior most rotating off each year as the newest joins the council. For lack of a better term, call that a situation of “dynamic continuity.”

CEJA issues ethics policy in the form of reports that provide ethical analysis of a given topic accompanied by recommendations for what action physicians should (or should not) take. Those recommendations ultimately form the substantive content of the Code of Medical Ethics. CEJA has the authority to issue ethics policy on its own initiative, without consulting the HOD, but the council has only exercised that authority on the rarest of occasions, preferring to seek adoption or affirmation of ethics policy through the parliamentary process of testimony and deliberation in the House. The House may only “adopt,” “refer,” or “not adopt” reports and recommendations put forward by CEJA; it cannot require that CEJA make specific substantive revisions or direct CEJA’s ethical conclusions. That said, the HOD reference committee that heard testimony may ask CEJA to clarify a report’s analysis and/or recommendations.

CEJA develops both discretionary reports, when it identifies a need for ethics policy on a particular topic, and mandated reports. Mandated reports come to the council in the form of resolutions adopted by the HOD that directly ask for CEJA to examine an ethical issue and provide guidance or that raise ethical questions which the AMA’s Board of Trustees direct CEJA to address. In developing a mandated report, CEJA must balance the need to be responsive to the House and clearly address the specific concern(s) raised in the resolution and the importance, at times at least, of setting particular questions in their broader ethical context. CEJA may also determine that the question itself must be clarified or further refined if the council’s report is to provide cogent guidance for practicing physicians.

Practicing physicians are in fact the intended audience for the Code. Residents, fellows, medical students, and medical educators form a second key audience. Beyond that, state medical societies and licensing boards look to the Code for guidance and some have adopted it in whole or in part (explicitly or by implication). The Code is also frequently cited in legal cases and court decisions. Finally, it provides a resource for scholars in medical ethics and health policy.
Why update the Code?

As the foregoing might suggest, the Code is an “organic” body of guidance that is continuously evolving through accretion and attrition as new opinions are incorporated and older ones superseded, amended, or “sunsetted.” The nature of the issues CEJA is asked or chooses to address in some measure reflect the times in which those questions are raised, as may the guidance the council offers in response. In part also, guidance can reflect the “dynamic continuity” of CEJA itself as the resources of the council change with respect to members’ specialties, the degree of formal training or experience in ethics they bring to council deliberations, and their individual philosophical and political perspectives and commitments.

The Code is also a complex document, now encompassing the nine core Principles of Medical Ethics (established by the HOD and more than two hundred CEJA opinions on specific ethical issues organized in ten broadly topical chapters. Chapters vary considerably in the range of topics they encompass. For example, the chapter containing opinions on “social policy issues” encompasses more than sixty separate opinions offering guidance on abortion, genetic testing, surrogate decision making, capital punishment, subject selection for clinical trials, in vitro fertilization, organ transplantation, physician aid in dying, quarantine, and radio frequency ID devices in humans, among others—while the chapter on interprofessional relations addresses physicians’ relationships with other health care professionals in eight opinions. Points of guidance on closely related issues can occur in different opinions in different chapters. In essence, the only way to know fully what guidance the Code offers on an issue is to read through the entire document. Another result of how the Code has evolved is that inconsistencies or discrepancies in guidance that have crept in over time can be invisible to all but a very close reading. (The current Code is available online at http://www.ama-assn.org/ama1/pub/upload/mm/Code_of_Med_Eth/about.html.)

Finally, the opinions constituting the Code vary considerably in the breadth and specificity of the guidance they provide. This variation reflects CEJA’s considered ethical judgment with respect to the issue, including the extent to which the council found it important to consider “externalities” at play at the time a given opinion was promulgated. Opinions can also vary with respect to clarity of expression and the format in which they present their guidance, no doubt an artifact of council (and staff) composition at the time of the writing.

How should the Code be updated?

The overarching goal of CEJA’s project to update and modernize the Code is to ensure that its ethical guidance is easy to find, cogent, easy to read, and easy to use. The first task was to reorganize content into a more “intuitive” chapter structure that clusters guidance on closely related issues (Table 1).

The second task is to carry out a comprehensive critical review to identify outdated content, discrepancies in guidance, issue “gaps” that CEJA should address in new policy, and opportunities to combine and streamline guidance from multiple opinions into a single statement. As project staff and consultants have carried out the initial round of substantive review, we’ve also found opportunities to refine the chapter structure originally proposed. In addition, we’ve come to appreciate more fully the degree to which we may find ourselves revisiting earlier chapters as the work progresses in an iterative process of critique and refinement.

The third task is to develop a uniform, overarching format for opinions. The current working proposal is to adopt a three-part structure: a “preamble” that briefly identifies key ethical values, principles, professional commitments, and issues at stake; a “transition” that identifies the specific context in which the guidance applies; and a set of succinctly framed points of conduct that put the key values, principles, and commitments into practice. Almost certainly, this initial proposal for organizing the content within opinions will be refined through several iterations as the work progresses. Along with standardizing the form of opinions—to the degree to which that is appropriate—revisions will focus on ensuring that terminology is consistent across opinions and accessible to readers who aren’t philosophers or medical ethicists as such.

We know relatively little about how physicians actually use the Code in practice, but we recognize that no code of ethics can ever be perfectly self-interpreting. One goal for the modernization project, then, is to provide more in the way of information that will enable users to interpret the Code in novel situations. Most current opinions say very little, explicitly, about the ethical reasoning that informs their guidance. By briefly identifying key ethical values, principles, and commitments at the head of opinions we hope to make those underpinnings transparent to readers and enhance its behavioral guidance. Incorporating the core ethical rationale for the guidance contained in any given opinion may also have particular practical value for those who cite the Code in legal contexts, as well as for scholars in other disciplines.

As the project moves forward staff and consultants will surely discover new challenges and gain further insight into how the Code’s ethical guidance can be presented most helpfully and compellingly to the practicing physicians it is meant to serve.

Acknowledgements

Many thanks to Kevin McDonnell and the Central Division of the APA for the invitation to participate in a panel discussion on codes of ethics at the division’s February meeting. I owe special thanks to my fellow panelists Tod Chambers, Michael Davis, and Jason Eberl, who shared many insightful and thought-provoking comments, as did our audience. I’m sure they’ll recognize that my reflections have already begun to evolve since our conversation, in no small measure as a result of their contributions. The incoherencies remain ever my own.
Ambiguities and Inconsistencies among the Opinions of the AMA Code of Medical Ethics

Jason T. Eberl
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Introduction
These comments will focus upon various individual opinions presented by the AMA Council on Ethical and Judicial Affairs (CEJA) in the current Code of Medical Ethics.¹ Having reviewed a number of entries in the current “Opinions on Social Policy Issues,” I have encountered both ambiguity and inconsistency in the ways certain key conceptual terms are invoked and applied to specific issues. CEJA has explicitly recognized the existence of such problems based on the Code’s long evolutionary history, which is a primary reason why it is undergoing its first wholesale revision in over thirty years.² Of course, many of these opinions are based upon more in-depth reports published by CEJA in which some of the ambiguities may be clarified; nevertheless, proceeding from the assumption that most medical practitioners and students will utilize only the Code itself as their primary resource, and may not avail themselves of the relevant background and commentary on each opinion, when available, it is important to minimize any ambiguities in the document at hand. The selected opinions upon which I will comment, relevant to my own areas of research focus and expertise, fall within the categories of reproduction and end-of-life care. In raising these issues, I do not presume to offer my own opinion as to how the Council should revise the Code to resolve the stated ambiguities and inconsistencies.

Opinion 2.141 Frozen Pre-Embryos
My first comment focuses on terminology as the opinion consistently uses the term “pre-embryo,” which is a non-scientific, politically motivated term that begs the question regarding an unimplanted embryo’s biological and ontological status as a human organism, as admitted by embryonic stem cell research and cloning proponent Lee Silver.³ A more accurate term would be “pre-implantation embryo” or “embryo prior to implantation.”

Inconsistency, or at least ambiguity, then follows when the opinion makes reference to “the interests of a frozen pre-embryo.” Clearly, a frozen embryo, given the ontological assumptions present in the opinion, can have no interests. One could refer here to the future interests held by a child who may be born as a result of a frozen embryo being thawed and implanted, which would preclude causing harm to the embryo that could result in mental or physical disabilities accruing to the born child; if so, then it would be helpful if the nature of the relevant interests were specified.

A serious internal inconsistency occurs when the opinion asserts, “research on pre-embryos should be permitted as long as the pre-embryos are not destined for transfer to a woman for implantation and [my emphasis] as long as the research is conducted in accordance with the Council’s guidelines for fetal research.” Notice the use of the conjunctive “and,” signifying that, even if embryos are not destined for uterine implantation, any use of them in research—such as the derivation of embryonic stem cells supported in Opinion 2.146—must follow the guidelines for fetal research given in Opinion 2.10. The latter opinion, however, includes the following guidelines [emphases are mine]:

- In fetal research projects, the investigator should demonstrate the same care and concern for the fetus as a physician providing fetal care or treatment in a non-research setting.
- In fetal research involving a fetus in utero, primarily for the accumulation of scientific knowledge: …
  - (b) The risk to the fetus imposed by the research should be the least possible.
  - (c) The purpose of research is the production of data and knowledge which are scientifically significant and which cannot otherwise be obtained.
  - (d) In this area of research, it is especially important to emphasize that care and concern for the fetus should be demonstrated.

If, as implied in Opinion 2.141, we can replace “fetal research involving a fetus in utero” with “embryonic research involving an embryo ex utero,” it becomes difficult, if not impossible, to justify stem cell research that inherently involves disaggregating an embryo.

Opinion 2.21 Euthanasia
It would be more accurate to define “euthanasia” in the opening sentence as “the administration of a lethal agent by another person to a patient for the purpose of ending the patient’s life in order to relieve the patient’s intolerable and incurable suffering” [added text italicized]. This would correctly identify both the proximate and remote ends that are intended by those who engage in this practice. This addition would also allow the opinion to preempt the argument that euthanasia—as currently defined—could be justified by appeal to the ethical principle of double-effect. Since one of the principle’s criteria is that a morally impermissible effect cannot be intended as the means by which a morally permissible end is brought about, it would not justify ending a patient’s life as a means of relieving suffering.

Opinion 2.035 Futile Care
The opinion states, “Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patient.” “Benefiting,” however, is an ambiguous term, particularly in this context. For example, in the debates concerning the case of Terri Schiavo, who lived in a persistent vegetative state (PVS) for fifteen years, it was argued that continued artificial nutrition and hydration (ANH) was futile insofar as it did not benefit Ms. Schiavo since she had no reasonable possibility of ever regaining consciousness. Contrary to this claim, it was argued that artificial nutrition and hydration did benefit Ms. Schiavo insofar as it effectively fulfilled the purpose of such treatment, which is not to facilitate the recovery of consciousness, but to provide the necessary alimentation to sustain biological life.⁴ Hence, further clarification regarding the form of benefit a treatment ought to provide—whether a proximate benefit of maintaining biological life or a remote benefit of facilitating recovery—would be warranted in justifying judgments of futility.

Opinion 2.157 Organ Donation after Cardiac Death (DCD)³
The opinion states, “Hospital policies should specify important details of the DCD process, such as the required time delay before death can be pronounced after cardiac arrest.” Such a specification, however, seems to be a paradigmatic instance where a general, informed opinion from the AMA would be warranted. Based on Aristotle’s formal requirement of justice...
to “treat like cases alike,” sound medical and ethical judgment regarding the appropriate delay between pronouncement of cardiac death and the exploitation of vital organs should inform individual hospital policies; otherwise, the risk is run that a patient who satisfies the “dead donor rule” at one hospital—because an appropriate time has elapsed per that hospital’s particular protocol—would not satisfy this foundational criterion for the ethical exploitation of vital organs at another hospital, even one that is in the same locale. Of course, the difficulty lies in establishing an appropriate time delay. The original Pittsburgh protocol requires only two minutes of asystole for death to be declared. The Institute of Medicine, in its study of DCD protocols, calls for a five-minute waiting period before procurement begins. Five minutes, however, may be “too short a period to cause sufficient ischemic damage to the brain to ensure that patients would meet brain death criteria. Probably ten to fifteen minutes would be required.” But waiting so long after the heart has stopped beating to procure vital organs is problematic because damage to the organs from warm ischemia may render them unsuitable for transplant; unless available pre-mortem interventions to preserve the organs are used.

On this point, the opinion states, “pre-mortem interventions aimed at organ preservation...that are likely to hasten death must not be used.” This judgment, however, does not take account of the potential applicability of the principle of double-effect, which may allow for, in this case, the use of interventions for the morally permissible intention of preserving organs even if they entail a known, but unintended, side-effect of hastening death. The Institute of Medicine concludes that justifying the pre-mortem use of such drugs “is a heavy burden for the principle of double effect, and there is no consensus about whether the principle can bear it.”

Robert Veatch, on the other hand, argues that such an action can be justified by the double-effect principle. The patient’s death is not directly intended as the end, nor is her death the means by which the directly intended end—the preservation of viable organs—is brought about. Furthermore, it is arguable that the positive effect of procuring viable organs for transplant, which will likely save numerous lives, outweighs the negative effect of the patient’s death being hastened. Of course, the inherent fundamental value of the donor’s life is incommensurable with the sum total of any number of other lives. Hence, it is always wrong to act from a direct intention to end the donor’s life. In DCD, however, a decision is previously made to withhold or withdraw life-sustaining treatment based on the futility of providing such treatment or in compliance with a patient’s advance directive. The donor’s death, caused by her underlying illness or injury, is imminent and risking the side-effect of hastening her death through the use of interventions aimed at preserving organs for transplant is not equivalent to negating the value of the donor’s life.

Of course, given the nature of this type of case, and legitimate concerns regarding the intentions of those who may employ such interventions—intending perhaps both to hasten death and to preserve organs—the current judgment may be valid; however, the risk of potential bad intentions on the part of physicians is accepted in the paradigmatic end-of-life case in which the double-effect principle justifies the use of palliative medication, which may hasten death while achieving the intended end of alleviating a patient’s suffering, as affirmed by CEJA.

**Opinion 2.20 Withholding or Withdrawing Life-Sustaining Medical Treatment**
The opinion refers to the frequent necessity of surrogate decision-makers and identifies the patient’s family as the proper default decision-maker when no proxy is designated in an advance directive. The opinion defines “family” as including “persons with whom the patient is closely associated.” The term “closely associated,” though, is ambiguous. In practice, depending on various state laws, it may happen that the individual who is most closely associated with the patient does not fall under a legal definition of being a family member. A prime example would be a homosexual patient’s committed partner in states where same-sex unions or marriages, and the legal rights and protections that follow therefrom, are not recognized. In such cases, in which being “closely associated” to a patient may be defined in terms of blood rather than actual relationship, a patient’s estranged sibling may end up having the legal say-so as the default surrogate decision-maker over someone who is clearly in a superior position to know the patient’s relevant wishes. Granted that such cases may be rare and circumvented through the use of advance directives; however, given the relatively low percentage of individuals who write advance directives or otherwise designate a surrogate decision-maker—about 20 percent of Americans as of 2004—requiring such of committed homosexual couples in order to ensure that the optimal surrogate is legally empowered to fulfill this function may be an unjust burden.

On the subject of advance directives, the opinion later states, “In making a substituted judgment, decision makers may consider the patient’s advance directive (if any).” First, the concept of “substituted judgment” is roundly criticized by Tom Beauchamp and James Childress. It either runs the risk of being used inappropriately—by virtue of the surrogate decision-maker basing her decision upon what she would want for the patient, as opposed to what the patient would want for himself—or, if used appropriately, it collapses into the alternative “pure autonomy” standard in which a patient’s prior autonomous judgments—either made explicitly or derivable from the patient’s previous lifestyle choices—are the basis upon which a decision is rendered. Second, this statement raises the question of why a stronger assertion is not made to respect a patient’s advance directive, if one exists, as opposed to the current “may consider” language, which allows for various other criteria to enter into a surrogate’s substituted judgment—and thereby raises precisely the concern voiced by Beauchamp and Childress.

**Conclusion**
The above comments represent only a sampling of various ambiguities and inconsistencies one may find within and among the AMA Code’s various opinions; the existence of these issues is not an indictment of CEJA per se, but rather is a reflection of the ever-changing nature of medical practice and technological advancements that generate new or evolved ethical problems. Hence, CEJA’s current task of revising the Code in toto is both formidable and laudable. A more streamlined, intuitively organized, and cross-referenced Code will surely be of immense help to medical practitioners, students, and ethicists as they contend with the various issues upon which CEJA has developed an informed judgment.

**Endnotes**
1. An online version of the Code with links to each opinion as well as available background reports from CEJA can be found at http://www.ama-assn.org/ama1/pub/upload/mm/Code_of_Med_Eth/amacode_home.html.
2. See CEJA Report 5-1-08, “Modernizing the AMA Code of Medical Ethics.”
4. For examples of these arguments, see the collection edited by Christopher Tollefson, Artificial Nutrition and Hydration:
Some Thoughts on Revising the AMA's Code of Ethics

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There are many good reasons for the AMA to have a code of ethics for physicians, to revise it every few years, and to undertake the major reorganization now under consideration. But I shall say nothing more about those reasons here, having said so much elsewhere that saying something new would make better use of the ten minutes allotted to my introductory remarks. I shall therefore suggest two small changes to make the Code more “user friendly.”

The first change concerns the term “ethics.” The Code seems to have three senses of “ethics.” The Preface uses one—“a statement of the values to which physicians commit themselves individually and collectively.” This is what I call the special-standards sense of ethics (the sense I prefer in discussions of professional ethics). This is, however, not the sense that the Opinions give “ethics.” Opinion 1.01 gives two other senses. The first is ethics-as-morality—“moral principles and practices.” The second is a derivative of ethics-as-morality—special standards “involving” morality. Both these uses of “ethics” at least suggest that morality somehow settles medical ethics—or at least that medical ethics cannot be about matters that ordinary morality leaves open. Yet, what is plain is that ordinary morality seems to have left open many questions the Opinions settle. For example, Opinion 4.01 says:

Charging a separate and distinct fee for the incidental, administrative, non-medical service the physician performs in securing the admission of a patient to a hospital is unethical. Physicians should derive their income from medical services rendered, in keeping with the traditions of the American Medical Association.

While there does not seem to be a moral rule or principle to justify this “tradition” rather than the alternative (allowing physicians to charge such referral fees), it is not hard to see why physicians might have adopted this standard. Most physicians would find it unseemly to charge for such non-medical services. The patient might not be worse off overall. Insurance companies might, for example, recover the costs of referral fees by reducing other fees. But, without the Opinion, the market might press physicians into this unseemly selling of hospital admission. The Opinion solves a problem of coordination: the market might otherwise have solved in a way physicians would not like (though everyone else might be indifferent). In other words, Opinion 4.01 is (from the perspective of morality) a convention (much as are many points of honor or rules of the road).

The observation that many provisions of the AMA Code of Ethics (and, indeed, of most professional codes) are mere conventions has led some thoughtful people, especially philosophers, to distinguish “true ethics” (by which they mean standards deriving from morality) from convention (“etiquette,” “petty morals,” or “mere custom”). The chief problem with this distinction is that physicians generally don’t make it. They treat violations of conventions such as 4.01 much as they do violation of some rule that clearly has a connection with morality (such as Principle II’s requirement of honesty in all professional interactions).

The distinction between “true ethics” and convention is not descriptive but prescriptive. The reason for the prescription seems to be a problem of theory, an inability or unwillingness to admit that conventions can create moral obligations. Yet, the AMA Code itself includes a plausible theory of moral obligation that seems to do the job. Its Preface says that physicians “commit” themselves to these standards. Since the commitments are morally permissible, the moral authority of conventions like Opinion 4.01 can rest on that commitment. Their moral authority is no harder to understand than the moral authority of a (morally permissible) promise, which also can turn a morally indifferent act into a morally obliging one.

Opinion 1.01 thus seems to introduce into the Code a confusion easily removed. I recommend rewriting 1.01 in some such way as this:

The term “ethical” is used in opinions of the Council on Ethical and Judicial Affairs to refer to any standard (1) interpreting a Principle of Medical Ethics or (2) otherwise designed to serve, in a morally permissible way, the professional ideals to which physicians are committed.

That’s my first suggestion. My second is to offer those using the Code more help in interpreting it than they now receive. The Opinions are doubtless a great help in interpreting the Principles because, being much more specific, they settle many questions that might otherwise be open. Nonetheless, the Code will always be an incomplete guide for at least two reasons.
The first is that the advance of medicine is constantly creating problems the authors of existing Opinions did not conceive or at least did not know how to resolve. So, for example, physicians concerned with preserving “life” have, for the last forty years, needed new guidance about what a physician should consider a patient’s “life”—as technology made it possible to keep the brain alive even though the heart had stopped, then to keep the body alive long after the heart and brain had stopped, and then to keep various parts of the body alive independent of the rest. In the end, the Code, with a few overlooked phrases (such as in 2.06 Capital Punishment), has had to give up preserving “life” as an end of medicine.  

Second, even without advances in medicine, there will always be overlooked issues suddenly noticed or issues that come to have a different look because society has changed. For example, advances in medicine do not seem to explain why physicians no longer think it appropriate to lie to patients when the truth would hurt.

Because the Code can never be a complete guide, that is, a moral algorithm, physicians should be encouraged to approach the Code as a document requiring careful interpretation, some of which may extend the Code’s application to cases the authors never considered. Physicians should also be given help with interpretation. Here, the recent Software Engineering Code of Ethics and Professional Practice provides a useful model. Its Preamble includes such aid. I nonetheless have two improvements to suggest over that model.

First, I recommend putting the AMA version of the aid to interpretation in the Opinions rather than, as the SE Code does, in the Preamble. Aid to interpretation comes alive only when one has a problem it might help to solve. Readers should not have to slog through such aid before reaching the standards that, often, clearly solve the problem in hand. The Principles must be read through. There is no other way to see which provision is relevant (though the addition of keyword titles might help with that). The Opinions, in contrast, have a table of contents allowing the reader to find the relevant provision without reading through the entire document. A provision aiding in interpretation would be easy to find there.

Second, I’d recommend something shorter than the SE Code’s several paragraphs, something like:

1.03 This Code is not a moral algorithm, a substitute for deliberation, an ordinary regulation designed for external enforcement, or a mere restatement of common sense, but a guide to conscientious physicians concerned to conduct themselves according to the special standards of their profession. This Code consists of a Preface, Principles, and Opinions. The Preface and the Principle’s Preamble explain the purpose of the Code. The Principles provide a general guide to all questions of medical ethics, a framework for thinking through any problem. The Opinions are intended to provide more detailed guidance, especially in areas of practice where experience has taught the profession that certain responses are better than others. The Opinions, indeed, the entire Code, are designed to help physicians act in morally permissible ways that all other physicians would want them to act, even if that would meant having to do the same. The entire Code should be read with that design in mind.

That is all I have time to say now.

Endnotes


2. This also seems to be the sense in which the term appears in the Preamble to the Principles (“not laws, but standards of conduct which define the essentials of honorable behavior for the physician”).


The Usefulness and Uselessness of Code

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In a chapter on professional codes for a book on methods in medical ethics, Edmund Pellegrino notes that until recently ethics codes were “the only ‘method’ of ethical argumentation” (2001, 70). When he uses the word method, Pellegrino puts scare quotes around it for, later in this chapter, he states that, “strictly speaking, the use of professional codes in moral discourse and argumentation does not fit precisely under the rubric of ‘methodology’ as that term is used to define other modes of argumentation presented in this book” (72). Instead, Pellegrino observes, and I think correctly so, that professional codes are “taken to be prima facie self-justifying obligations” (72), a series of statements that everyone within the profession simply accepts as a natural expression of their understanding of professional obligation. As Michael Davis points out, “Ideally, a code of professional ethics should consist of those standards everyone in the profession, at her rational best, wants everyone else in the profession to follow even if that means having to follow them too” (Davis 2007, 180).

Pellegrino, however, argues that codes do have a ‘method’ (maintaining those scare quotes throughout his chapter) but that method is a rhetorical one, that is, codes are groups of assertions that are justified by their appeal to an external authority. Codes cannot stand on their own but must instead sit on the shoulders of another form of authority. For the remainder of his chapter, Pellegrino tries to find some way in which codes could be justified: through deontology, utilitarianism, social construction. There are problems with Pellegrino’s formulation, for if the moral proclamations found in codes are by their nature self-evident then why would they need any form of external authority, including, ironically, Ross’s type of prima facie principles? But it seems that Pellegrino cannot abide by any sentiment that it might be prima facie turtles all the way down. For if things are self-evident (even if only for people at their reasonable best) then no one would feel any need to have them justified, but if they are self-evident then why does one
even need to make the code? I suspect the reason is more a matter of Durkheimian solidarity than any Kantian need for moral obligations.

The code is a type of speech genre that is in many ways the exact opposite of the genre of the aphorism. While aphorisms are often used to provide new perspectives (at times, to challenge conservative ways of thinking), codes exist primarily to support traditional values, continuity, essential moral directives, to reinforce continuity between generations of professionals. They do not exist to challenge our perspective but to ritually reinforce our membership in a particular moral community. When Robert Veatch attacked the Hippocratic tradition in *A Theory of Medical Ethics*, he supported his critique by noting how unhelpful the Hippocratic code of ethics was in resolving ethics cases. I would argue, however, that no code, by its very nature, can really provide any type of robust assistance in resolving moral problems, whether it be grounded in the teachings of Hippocrates or Maimonides or anyone else, for that matter.

So let me make my concerns more concrete. I would like to see how the AMA *Code* will help me with a case that was raised by a fourth-year medical student during his subinternship. He reported that while he was working in the ER a woman came to the hospital because she was having trouble seeing out of one eye. She had just moved to Chicago, had no friends or family, and she had no primary care physician. She also had an important interview for a potential job the next day, so she came to the ER that night. In the end there was nothing seriously wrong with her eye, but as she left the hospital she gave the medical student a note:

“As you know I have just moved to Chicago and don’t know many people. I find you very attractive and if you are interested please give me a call. I will understand completely if you do not.”

The medical student admitted that he did find her attractive but he was unsure if he could contact her.

So if I turned to the AMA *Code* for assistance I find the following in opinion 8.14.

**Opinion 8.14 SEXUAL MISCONDUCT IN THE PRACTICE OF MEDICINE**

Sexual contact that occurs concurrent with the patient-physician relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician’s objective judgment concerning the patient’s health care, and ultimately may be detrimental to the patient’s well-being.

If a physician has reason to believe that non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact. At a minimum, a physician’s ethical duties include terminating the physician-patient relationship before initiating a dating, romantic, or sexual relationship with a patient.

Sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship. (I, II, IV)¹

Now I admit that if I were to write an opinion for the *Code* that I imagine I would come up with something very similar. But once again this represents what I believe are primarily elements that I would imagine “all rational physicians” would be willing to advocate. But I think that this provides very little assistance when it comes to actual cases and this is because the genre of the code cannot provide the kind of assistance for a method as casuistry or deontology or consequentialism.

**Endnotes**


**Works Cited**


**Patient**

*A contribution to our “Therapy” series, another perspective to add to the two in previous issues. Further contributions welcome!*

A gem with countless facets reflecting the light from outside and revealing the core within each word and reaction a refraction at times revealing at times obscuring trusting the core will be revealed again

—Anonymous

**Classifying Dysthymia**

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Analytic philosophers have frequently (and fruitfully) directed their attention to the broader concepts framing psychiatric classification, particularly the overarching category of mental disorder or disease. In contrast, the following discussion is focused on one diagnostic category, that of Dysthymic Disorder. In pointing to anomalies and conceptual difficulties in classifying the persistently dispirited moods, attitudes, and feelings making up what is known as Dysthymia, I hope to as well illustrate some more general problems encountered by taxonomies such as the American Psychiatric Association’s Diagnostic and Statistical Manuals (DSMs) of Mental Disorder, and the World Health Organization’s International Classification of Diseases (APA 1994, ICD 1992).

**Section 1: Definitions**

Within today’s psychiatry, the condition known as Dysthymia is defined as “a chronically depressed mood that occurs for most of the day or more days for at least two years.” The general diagnostic feature of Dysthymic Disorder relates to its status as an *unrelieved or chronic mood state* that is accompanied by at least two of the symptoms of poor appetite or overeating,
in onset, course, duration, persistence, and severity. Major Depressive Disorder, while different from briefer Depressive Episodes, is a condition that has an *episodic* clinical course. (It is characterized by one or several “Major Depressive Episodes” occurring in the absence of any mania or hypomania.) Indeed, along with its greater severity, this episodic course is presented as a *defining feature*. Major Depressive Episode may be diagnosed when a depressed mood has been present for a period of at least two weeks (APA 1994, 343).

Dysthymia might thus be seen to be a disorder that is chronic rather than episodic. Chronicity here is complicated, however. There is its actual longevity, measured in weeks, months, and years; a chronic disorder or disease is long-lasting in comparison to an acute one. But, chronic conditions exhibit very different profiles. Sometimes a complex “course” is identified through the onset and changing progress or career of a disorder. When ascribed to this kind of condition, chronicity often connotes disease, understood categorically. (On that conception, an underlying disease process produces symptoms, and diseases are distinguishable both from normal conditions and from other diseases by sharp phenotypic margins.) Diseases have a course, maladaptive traits, seemingly may not; each is “chronic,” and in these rather different ways. Dysthymia is *chronic* in the first sense only—it is not acute—and is a long-term, but relatively unchanging, condition.

**Section 2: History of the concept**

Dysthymia comes to us from the Greek *thumos*, or *thymos* (meaning variously “spiritedness,” “spirit,” and (in Plato) “passion”), and indicates a deficiency of that quality. As such, it is linked to the subjective states or dispositions long associated with the diseases of the black bile, in particular, the eponymous melancholy or melancholia. Medical and literary translators have rendered the subjective qualities associated with this condition as “dejection,” “dispiritedness,” “sadness,” “depression,” “listlessness,” and “despondency.” Dysthymia reminds us, then, of the long Western history of identifying temperamental variation—both normal and disordered—in terms of mood and feeling, and of the emphasis on the particular states of sadness and dispiritedness captured in medical lore about the effects of melancholy. By way of background to the discussion that follows, these two legacies each deserve separate attention.

**Melancholy as Temperament as well as Disorder**

Personalities and clusters of traits can be identified through the typologies and trait analyses applied to normal individual variation. These typologies of normal variation have entered Western medicine because of its reliance on, and framing within, humoral and astrological lore. Through literature and art, they are also an integral part of our Western cultural legacy and, as such, have arguably formed the way we understand personality and individuality. It is in light of this recognition of normal or natural temperamental differences that we must view Dysthymic Disorder, which so evidently captures the maladaptive extreme of what was long recognized as a normal personality type—*homo melancholicus*, the melancholy man.

Aristotelian writing about melancholy and the effects of the black bile provides a clear distinction between the melancholy temperament (as a sad, sour, but normal character type), and as a disorder. This writing (likely by one of his followers, rather than by Aristotle himself), notes that: “…those who have a small share of [the melancholy] temperament are normal, but those who have much are unlike the majority.”

These ideas persist throughout medieval, and early modern, writing about melancholy. As products of natural and unnatural humoral arrangements, normal melancholy and pathological melancholy differ at most as variations on a unitary condition. So, for example, the disease of melancholy was brought about when the black bile became heated or “adjusted”; then, smoke-like vapors interfered with brain functioning, and disturbances of imagination occurred that in turn brought apprehensive and dispirited feelings.

**Chronic and Episodic Disorders of the Black Bile**

Robert Burton in his *Anatomy of Melancholy* (1621) insisted that melancholy states were universal, the lot of humankind. Melancholy is nothing less than “the Character of Mortality,” and from Melancholy Dispositions “no man living is free.” Burton distinguishes Melancholy Dispositions from melancholy the “Habit” however. Melancholy Dispositions make us “dull, sad, sour, lumpish, ill-disposed, solitary, any way moved or displeased.” As a Habit, in contrast, melancholy is “a chronic or continue disease, a settled humour,” he says, “…not errant, but fixed.” And in some people, melancholy the Disposition becomes a Habit. Burton’s “sad,” “sour,” “lumpish” dispositions, when habituated, constituted a chronic (“fixed”), not episodic (“errant”) condition. As a Habit, or chronic condition, these ways of apprehending the world would affect behavior, mood, and attitude.

We may acknowledge this vivid legacy as evidence of an actual clinical condition, familiar to countless physicians since Hippocratic times, and as recognizable as dysentery or gall stones. Or we may point to disorders of temperament as aspects of the frame within which our present-day ways of seeing and understanding have by accidents of history and circumstance been “constructed.” Either way, these are powerful ideas that form an inescapable backdrop to any present-day discussion of where Dysthymia should be fitted into today’s nosological schemes.

**Section 3**

Dysthymia, we have seen, is a disorder involving mood or affect. Its characteristic subjectivity is sad and dispirited. It is a chronic condition. It is also taken to differ from naturally sad and sour temperaments. And, finally, it is not merely a normal (or normative) response to life stresses. Each of these aspects of the disorder, together with their implied distinctions, has consequences for how it is to be located within a broader taxonomy, and I will comment on them in turn.

*(a) Dysthymia as a disorder of mood or affect* The classification of one group of conditions under this broad category finds its origins in Kraepelin’s influential separation between *dementia praecox* (closely capturing today’s schizophrenic disorder) on the one hand, and Manic Depressive Insanity, on the other. Kraepelin believed a difference of prognosis separated these two sorts of condition, and that belief formed his ostensible classificatory rationale. The various conditions making up Manic Depressive Insanity were all thought to have a more promising outcome than Dementia Praecox. (Twentieth-century studies have failed to confirm
these findings.) But also underlying Kraepelin’s broad division, it has been shown, was his acceptance of the binary division between cognitive and affective states found in, and a legacy of, earlier faculty psychology (Radden 1996). That this distinction, and the separation of disorders of mood or affect on which it rests, are misleadingly bifurcated, has been widely recognized. Cognitivist philosophical analyses of emotion, for example, point to the beliefs (cognitive states) involved in emotions, such as those that distinguish one emotion from another. (Cognitivist theories like this also underlie today’s cognitivist-behavioral therapeutics.)

That affections also involve cognitive states, and many disorders are apparently mixtures, was not lost on early classifiers such as Kraepelin. Again, then, we must consider classificatory rationale. If, although with cognitive as well as affective features, this group of disorders nonetheless were characterized by a relatively greater preponderance of affective symptoms, then the division between affective and other disorders may be warranted. However, such an analysis is in tension with the categorical conception of disease—itself originating in Kraepelian nosology—embodying taxonomic orthodoxy today. There, separate mental disorders are depicted as distinct, diagnostic categories with clear phenotypic margins, differing in kind from one another. Constrained as mixtures of affective and cognitive deficiencies, such disorders seem to jeopardize the sharp boundaries separating disorders of affect from other, non-affective conditions (such as schizophrenia).

In philosophical discussions of affective states it is customary to distinguish emotions, defined according to the particular (intentional) objects they are said to be about or over, from moods, which lack such sharp cognitive specification. Moods are accounted for in terms of feelings and, as that suggests, they are less easy to differentiate from one another. To the extent that the symptoms of some affective disorders possess this non-cognitive or less sharply cognitive aspect, there may be some classificatory warrant for the separation of this set of conditions (Major Depressive Disorder, Bipolar Disorder etc.) as affective or mood disorders.

(d) Dysthymia as Chronic

Disorders such as schizophrenia and depression are commonly distinguished from other conditions using the contrast between “states” and the “traits.” Personality Disorders, part of orthodox classifications since DSM’s third edition (1980), are construed as long term, unchanging patterns of behavior that are maladaptive. Since their inclusion in DSM-III they have been accorded a separate axis from the other major mental disorders, separated within their own frame of reference that is orthogonal to others; they are with the so-called Axis II disorders. The ostensible rationale for this decision in DSM-III was to ensure that this group of disorders would not be overlooked. The implicit and more plausible rationale, however, which captures their distinctness, is their status as chronic, in the sense both of long-lived, and of unchanging, traits. In contrast to disorders that can more readily be seen to involve a disease process running an identifiable course through time, personality disorders remain obdurately invariant. Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself, exhibited in a wide range of social and personal contexts: they constitute Personality Disorders only when they are “inflexible and maladaptive and cause significant functional impairment or subjective distress” (APA 1994, 630).

The omission of Dysthymia from within the group of personality disorders is what is noteworthy here. Due to the depressed mood that seems to explain and frame its primary symptoms, Dysthymia occurs with other Affective conditions in today’s classifications. Yet, it is recognized to be a long-term pattern of response without any evident “course.” It is a trait (or a collection or cluster of traits), not a “state.” Moreover, the current arrangement replaces earlier ones where something at least very like this disorder was so recognized, as “Depressive Personality Disorder,” or “Neurotic Depression.” Writing at the mid-point between the publication of the third edition of the DSM (1980) and the fourth edition (1994), of which he was to be an editor, Allen Frances recognized this, and urged (unsuccessfully) that Dysthymia (as well as Cyclothymic Disorder) be classified not with Affective Disorders, but with other, trait-based personality disorders (Frances 1986, 175).

We can agree that because of its trait-like aspects, Dysthymic Disorder might better be grouped with other Axis II disorders. Yet, I now want to show this would perhaps take it out of the frying pan into the fire.

The conceptual difficulties that arise with the inclusion of maladaptive personality traits in the broader taxonomy—that is, in counting personality disorders as mental disorders of any kind—are legion, and have been the subject of candid and relentless acknowledgement throughout the last three decades (DSM-IV 1994 and DSM-IV-TR 2000). Empirical studies have long cast doubt on the applicability of the categorical model to personality disorders, and alternative, dimensional systems, employed to understand normal personality variation, have been endorsed for them: whatever its applicability to other psychiatric disorders, a categorical model is inappropriate for maladaptive personality (Tyre and Alexander 1979; Livesley et. al. 1998).

As disorders involving traits rather than states, personality disorders require a dimensional analysis.

Even disorders with a more evident clinical course have been subject to concerns about the inapplicability of the categorical model, granted. It is now questioned whether conditions such as hypertension and osteoarthritis, rather than infectious disease and tumors, may provide more accurate models for all psychiatric illnesses (see Kendler and Gardner 1998; Cloninger 1999). But their chronic unchanging nature makes traits especially inhospitable to the kind of categorical...
analyses traditionally given Axis I disorders such as schizophrenia and depression. The assignment of Dysthymic Disorder to a category whose model at best fits conditions exhibiting a changing clinical course, is particularly anomalous.

(d) **Dysthymia as Disorder not Natural Temperament**

Trait-like disorders such as Dysthymia, which are appropriately seen as dysfunctional or maladaptive, must be differentiated from normal temperamental variation, and this imposes another sort of challenge for the classifier.

This one is a challenge familiar from much previous writing about melancholy. In humoral medicine, the same humors that might culminate in a severe disease condition gave rise to normal temperamental variations as well. The melancholy man was not ill in any way. His was a fixed tendency to respond more gloomily and sourly than would, for example, the sanguine or choleric man.

Typologies of this kind and trait-based accounts of personality may have less currency today, either in folk psychology and lore, or in more formal analyses. Yet, arguably, the category of a temperamentally depressive or melancholic personality is one we still recognize and want to avoid confusing with any kind of disorder. Individual differences between people will include mildly depressive or melancholic temperaments. Just as the suffering from which, as Burton says, “no man living is free” is different from melancholy (or “depression”) understood as a disorder, so normal melancholy or dour temperaments are different from disorders of temperament. The person whose sad and sour disposition is a natural personality trait may be without disorder; only when those traits reach dysfunctional or distressing proportions is it customary to attribute Dysthymia.

Dysthymia is far from alone in raising these difficulties for the classifier at the margins between disorder and normalcy. But personality disorders, particularly, present this problem. The same factors that occur in studies of normal personality are only distinguishable from those in personality disorders with respect to intensity and maladaptiveness (Livesley et al. 1998). By the end of the twentieth century there is widespread and even official American Psychiatric Association acknowledgement that personality disorders may represent “maladaptive variants of personality traits that merge imperceptibly into normalcy and into one another” (APA 2000; 689, emphasis added).

The chronic unhappiness of outlook that afflicts the person with Dysthymia may differ only in magnitude and maladaptiveness from these more normal sad and sour dispositions, then, and even that may not be any difference immediately observable in the clinical setting. Indeed, the penumbra around mood disorders more generally understood, including Major Depressive Disorder, make for fuzziness and a shading from the frankly pathological to the normal (what we might expect) and normative (what is not only predictable but appropriate and fitting).

The apparently fuzzy margins here have led to challenges over the arbitrariness of the categories, and the unwarranted “pathologizing” or “medicalization” of states and traits that are normal. One such recent critique is that of Horwitz and Wakefield (2007).

(e) **Dysthymia as Disorder, not Normal or Normative Reaction**

In a sustained effort to distinguish the clinical mood disorders from what they call normal sadness, Horwitz and Wakefield have assigned the de-contextualized, “descriptivist” approach adopted by the DSMs since 1980 as the cause of this state of affairs (Horwitz and Wakefield 2007). Symptoms, they say, such as “depressed mood, loss of interest in usual activities, insomnia, lessened appetite, inability to concentrate, and so on might naturally occur... in the absence of any disorder after any of a wide range of negative events...” Yet, such reactions, “even when quite intense due to the severity of the experience, are surely part of normal human nature” (Horwitz and Wakefield 2007, 9).

Their particular concern, then, are the depressive “symptoms” brought about by difficult and painful life experiences that they judge normal responses to untoward experiences. As they put it, the descriptive “symptom-based” definition of depression to be found in DSM-III and DSM-IV “does not exclude... nongrief responses. Because of the symptom-based nature of the criteria, any sadness response involving enough of the specified symptoms... will be misclassified as disorder, along with genuine psychiatric disturbances” (Horwitz and Wakefield 2007, 9).

A point not emphasized in Horwitz and Wakefield’s otherwise extensive analysis is that, from a moral perspective, the category of non-pathological suffering of these kinds is a significantly heterogeneous one. It includes responses to experiences and states of affairs both avoidable and unavoidable. Some are the results of human nature and the human condition. (No matter what their situation, humans have pride and suffer from slights; they form close attachments, so suffer when loved ones suffer, grieve when they die, and so on.) Other responses derive from seemingly contingent and preventable forms of oppression and misfortune.

For the most part Horwitz and Wakefield also limit their focus to the kinds of suffering that mimic episodes of clinical depression, not the more long-term traits associated with Dysthymia. Yet, the distinction between disorder and normal or normative reaction can also be applied to the chronic dispiritedness of Dysthymia. Medical anthropologist Arthur Kleinman decades ago decried the medicalization of social problems in parts of the world where severe economic, political, and health constraints create, as he said “endemic feelings of hopelessness and helplessness, where demoralization and despair are responses to real conditions of chronic deprivation and persistent loss, where powerlessness is not a cognitive distortion but an accurate mapping of one’s place in an oppressive social system...” (Kleinman 1987, 452).

Horwitz and Wakefield have put forward a three-part criterion for distinguishing states of depressive disorder from what they regard as normal responses to stress. They are responses to some form of loss (very broadly defined to cover a range of setbacks); their intensity is appropriate to that loss, and they disappear with the disappearance of the loss (Horwitz and Wakefield 2007, 28).

The last of these—the notion of a separate “sustaining” (Gert and Culver) or “environmental maintaining” (Wakefield) cause, the presence of which betokens not genuine disorder but a normal—and perhaps normative—response to stress, deserves further attention (Gert and Culver 2004; Wakefield 1992). Such a cause is one whose effect will not outlast its continuing stimulus. Only when the suffering originally caused by trauma outlives the trauma (most notably in forms of Post Traumatic Stress Disorder), according to this view, is there true disorder.

The sustaining cause analysis has much plausibility. When habituated response to stress ceases with the cessation of the stressor, the sustaining cause analysis seems to be confirmed: here were no ordinary, or at least no lasting, states of disorder. Moreover, recurrent stresses will surely sometimes cause lasting pathological depressive states or dispositions, again proving themselves to be more than mere sustaining causes. The sustaining cause model will often allow us to separate
pathological from normal and normative depressive states and traits.

But other examples involving external stressors apparently belie the model of sustaining causation. Applied to our task of demarcating normal cases of a habituated sadness and dispiritedness resulting from external stressors, this criterion will be insufficient, our intuitions about the effect of life experiences on character suggest. Even normal and normative responses, once habituated, sometimes outlive their stressors to result in a lasting, but non-pathological, alteration in the temperament of the sufferer. They might transform her from a sunny to a sourer person, for example, or from a light-hearted to a graver one. Here, the initiating cause is not a mere sustaining cause because its effects outlive it. The change is permanent, or at least obdurately long-lasting. The resulting effect is not pathology or disorder; it is normal temperamental or character change.

How common is this alternative pattern? No “data” is available on such cases. Arguably, though, literature provides examples of permanent, personal alteration of this kind. So does life. People who have witnessed or participated in great human evil can seem so changed—transformed to a more “melancholy” emotional style. Holocaust survivors speak this way about themselves, and/or give evidence of such transformation. Those who have come to sincerely repent great and irreparable harm they have wrought sometimes do, also. And so sometimes do those whose belief in human or divine goodness has been permanently extinguished. It may even be that experience with severe mental disorder itself sometimes leaves a residue of normal, long-term effects on character of this kind. Speaking of earlier episodes of melancholia in the lives of John Bunyan and Leo Tolstoy, Williams James remarks that “the iron of melancholy left a permanent imprint,” and here, I think, he does not imply that the illness lingered so much as that it was profound enough to permanently change the character of these two men toward a sadder, sourer outlook (James 1961, 143).

The difference noted earlier between normal and normative responses becomes evident in such examples. Perhaps extreme and life-changing experiences of this kind are too rare for us to speak with any confidence of the resulting character effects as expectable (i.e., as normal). But we certainly regard them as normative—they are fitting and appropriate in light of the experience or experiences undergone. When sufficiently profound, certain experiences ought to permanently mark the person, and show in that person’s outlook and responses, it seems generally believed. In our culture at least, this is a social norm. And the person unaffected by such experiences will be deemed shallow, or callow, or morally wanting.

The melancholy or depressive type of character or personality without disorder may not always reflect innate temperamental differences, then. As well as innate disposition, life experiences can produce such character types. Thus, corresponding to the temporary suffering that is recognized to be a normal or normative response to certain sorts of external stressor is permanent personality transformation—also the result of such stressors—that is equally “normal” and, more importantly, is normative.

Can Dysthymic Disorder be separated from such effects? That these permanent changes in personality might engender a degree of social dysfunction and personal suffering is obvious. Yet, it seems to me we would not always regard the presence of either as a reason to classify such changes as pathological. Given the appropriateness of the effect to the enormity of its cause—they are exactly what should be experienced, when that “should” reflects a moral assessment.

### Conclusion

As we look toward a revised diagnostic classification for psychiatry, I propose that we pay close attention to where—if it is to be retained as a category of mental disorder at all—Dysthymia should be placed. In particular, several aspects of its present classification must be reconsidered: its status as a trait-based disorder, calling for a dimensional rather than a categorical analysis; its separation from naturally sad and sour temperaments; and its status in contrast to normal and normative responses to life experiences.

### References


### Nosologic Validity and the Intuitively Accessible View of Natural Kinds

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As inherently philosophical as psychiatry is, it describes its own philosophy badly. However, this is not apparent in the debates about the validity of the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM), in which DSM’s proponents and critics argue in philosophical terms, yet often talk at cross purposes. This paper introduces a conceptual
caricature that I call the “Intuitively Accessible View of natural kinds,” an oversimplified conception that grounds both psychiatry’s articulation of its own philosophy, and many criticisms of the DSM. I show that critiquing the validity of DSM on the grounds that it does not identify natural kinds is a straw man, and does not reveal anything about what nosologic validity is, or whether the DSM achieves it.

The DSM and the secondary psychiatric literature about classification often use philosophical technical terminology without defining terms clearly or developing the positions the terms are meant to capture. To complicate things further, most of the philosophy behind both the DSM and criticisms of it remains tacit. However, it is worth trying to understand these assumptions so that we can recognize and dismiss them. Given these ambiguities, my arguments and reconstructions are transcendental: I argue from what different authors say to what they must have assumed in order to make such claims. Some of my reconstructions have been assembled from the quips of different authors rather than from explication of a single author’s position. This strategy is limited but necessary, and it provides some insight about where DSM authors and critics go wrong in trying to conceptualize valid classification as a classification of natural kinds.

I attempt to make plausible both realist and empiricist views of natural kinds not because I believe they are helpful for understanding psychiatric nosology, but because they help to understand the grounds on which psychiatric nosology is criticized and determined to be unfounded, false, or invalid. The positions I present here are not ones that I take seriously, but they are ones that others, especially persons involved in developing psychiatric nosology, do take seriously. It is for this reason that ground clearing is necessary: part of the reason that our current nosology receives so much criticism is that its authors describe it in misleading philosophical terms. My own position is that the epistemological commitments suggested by the DSM introduction do not amount to a coherent, directive philosophical position, the refutation of which has unambiguous implications for the validity of psychiatric nosology. Rather, the DSM expresses epistemological desiderata. The DSM’s description of its project is philosophically misleading, but philosophically minded critics need to look beyond the DSM’s language to its substance. The rhetoric of natural kinds distracts many worthy commentators from this task.

The Intuitively Accessible View of Natural Kinds

The validity of psychiatric nosology commonly is understood to be a function of whether the classification names natural kinds. For example, in the paper that allegedly inspired the empiricism of DSM-III, Carl Hempel argues that a classification of mental disorders should name natural kinds (Hempel 1994). Philosophers Joseph Margolis agrees that “[DSM is motivated by an] underlying anticipation of an improved approximation to a scientific taxonomy—one that corresponds to natural-kind mental disorders” (Margolis 1994, 108). And philosopher-psychiatrist Lawrie Reznek similarly argues that only a classification of natural kind diseases is scientifically legitimate (Reznek 1987). Although it is not always made this explicit, there is general agreement that a nosology is valid only if it names natural kind mental disorders.

The traditional views of natural kinds are familiar. The first is the Platonic, realist view, in which natural kinds are conceived as real entities that exist in the world independent of human theories. The second is the Lockean, empiricist view, in which natural kinds are ideas that we construct from our sensory perceptions of the world. More recently, Putnam and others have posited a new theory of kinds, which strives to reconcile the certainty of Platonic realism with the methodological integrity we derive from empirical investigation (Putnam 1975a, 1975b). Many philosophers, including myself, now reject both the classical realist and Enlightenment empiricist interpretations of natural kinds in favor of a theory of reference in which kind predicates are contingent but still fix reference.

This contemporary view of natural kinds is all but ignored in discussions of the validity of psychiatric nosology. Although the DSM actually progresses in something like the manner Putnam describes, its description of its own project contributes to misunderstandings about how natural kinds establish validity. There is a set of persuasive criticisms of the DSM which presupposes that the DSM strives to identify natural kind mental disorders. Here, I argue that despite their rhetoric about natural kind mental disorders, many of these “standard” criticisms express worries about the epistemology presumed by the intuitive, traditional view of natural kinds. Since the concept of natural kinds contributes the unifying theme for these myriad concerns, I begin my discussion by making plausible the oversimplified—but intuitively accessible—view of natural kinds that appears to inspire both the DSM introduction and the standard DSM criticisms. I emphasize strongly that this characterization has instrumental value only and does not provide a positive argument of my own. I use this characterization to supply the suppressed premises required to make sense of the DSM criticisms presented later in this talk. I call it the “Intuitively Accessible View” of natural kinds because it is what I take most psychiatrists to understand of natural kinds. My purpose here is not to endorse such a view, but to provide it as a heuristic exercise that will make apparent the sources of error in several of the common DSM criticisms. With this qualification in mind, I ask you to bear with me while I present the Intuitively Accessible View of natural kinds.

Natural kinds are “real” in that we think they exist in the world whether or not we happen to recognize them. We think that they are there to be discovered; and that where there is one feature in common there are likely to be more. We think of natural kinds as the appropriate candidates for scientific investigation. This view is reflected in Reznek’s definition of natural kinds:

Objects belong to a natural kind if and only if (1) they have the same cluster properties, (2) the possession of the cluster is explained in the same way (by the same laws of nature), and (3) natural boundaries exist between them and members of neighboring kinds. (Reznek 1987, 42)

Reznek endorses our view of kinds defined by clustered properties of their members, which are united by an explanatory organizing principle. In order to be explanatory, however, natural kinds must be constant across time. As such, they can appear in scientific laws and generalizations. Boyd defines a natural kind as “a type of property, process, state, event, or object studied by science, mentioned in scientific laws, and assumed to be a causal feature of the world” (Boyd, Gasper, & Trout 1995). Hempel’s discussion of natural kinds agrees that “to be scientifically useful a [natural kind] concept must lend itself to the formulation of general laws or theoretical principles which reflect uniformities in the subject matter under study and which thus provide a basis for explanation, prediction, and generally scientific understanding” (Hempel 1994, 323-24). Hempel tells us that we need to be confident about the constancy of kinds in order to believe that our current scientific laws genuinely explain past events and predict future events. If this were not so, as Goodman’s new riddle of induction so aptly demonstrates, there would be no point to science at all (Goodman 1955).
The third element of Reznek's definition of natural kinds is that natural boundaries distinguish one kind from another. The assumption that the purpose of classification is to "cut nature at the joints" is nearly ubiquitous in the literature about psychiatric nosology. Although Hacking dismisses this assumption as "Plato's unseemly metaphor" (Hacking 1993, 291), the phrase does capture the intuition that natural kinds have the sort of discrete boundaries that we expect to find in scientific classifications. People do assume that there are qualitative similarities and differences to be discovered in the world, and that these similarities and differences can be captured in scientific classifications.

This certainty about the boundaries of kinds is classically captured in the assumption of essentialism, the view that natural kinds are defined according to necessary and sufficient properties of their component members. As Buck and Hull describe the longstanding assumption in biology,

Traditional taxonomic theory and practice have treated each taxon as in principle definable by a single set of properties of organisms which qualifies some organisms for membership and excludes all others. Possession of these properties was held to provide both necessary and sufficient conditions for membership. (Buck & Hull 1966, 106, original emphasis)

Buck and Hull reject this view as outdated and unsophisticated. However, their description captures the intuition that when we have the necessary and sufficient conditions that make something a kind K, we can be confident that we are excluding items with features that are not unique to K's, and including members with the features that are required to make something a K. Thus we get clean boundaries for natural kinds.

Scientific or "natural" kinds, then, are defined by organizing principles. They are intentional rather than extensional classes, and the organizing principles provide criteria for membership in that class. An extensionally defined class can be established ostensively, by stipulating members in word or gesture. Other than the fact of that membership, they need not have any features in common; if they do, it is purely accidental.

To illustrate, let's extensionally define class A as being comprised of my hat, violets, and vision. These items are members of class A because I say so, not because they share an underlying connection or similarity—obvious or hidden—that links them. Class A is a real class, but it is not an especially useful one for scientific purposes. Because I constructed class A by enumeration, we do not learn anything about my hat by identifying it as a member; nor can we learn anything about a shared property "A-ness" by studying class A's members. This is another way of saying that the identification of class A is not principled in any way, but merely involves an arbitrary assignment of items to that class. The classes formed by this process are genuine classes, but they are not especially interesting ones.

In contrast, we identify members of an intentionally defined class by stipulating the conditions for membership in it, rather than by indicating the members directly. An intentional classification groups members not by stipulating each one individually, but by specifying ordering principles that define the class. The members of an intensional class, then, are the things that fulfill the ordering criteria. Let's intentionally define class B as the set of things that are on my desk. The members of the class include six books, a telephone, and a cup of coffee. In this case, I could pick out the members of the set ostensively, by gesturing to them or naming them, and thus we could think of B as an extensional set. However, I also could pick out the members of the set according to their shared property of being-on-my-desk, thereby defining an intensional set.

The shared defining feature(s) of intensional classes are what make them kinds, types, or taxa. If we know the ordering principles that define them, and if we discover an item that fits the definition, then we can identify the item as a token of the given type. As a result, knowing of my coffee's membership in Class B is informative in a way that knowing of my hat's membership in Class A is not: if I know that class B is the set of things that are on my desk, and if I learn that my coffee is a member of class B, I learn something about my coffee (e.g., where to look for it when I misplace it). Although there may be hidden similarities among members of an extensionally defined set, we cannot assume that there are.

Of course, this does not establish that kinds actually exist, or that there is any clear basis for identifying and discriminating them if they do. However, the imprecision of this objection is instructive: note the equivocation about whether our concern in this discussion is ontological or epistemological. We can ask both sorts of questions. On an ontological note we might ask: "Is there really some 'set B' that exists in the world, and is my coffee really a part of it?" On an epistemological note, as we go through the world looking for similarities among its objects, we might ask: "If I observe similarities among objects, does that really make them a class? If I fail to observe similarities that truly are there, does that make classes real but unrecognized?" On the ontological side, it seems strange to think that classes of objects are real if they are unrecognized. On the epistemological side, it seems equally strange to suppose that what makes them real is simply our identification of them. These questions are tacit in the literature on psychiatric nosologic validity, and they affect our understanding of mental disorders as natural kinds.

To be a scientific kind, a class must be not only intensional, but also must be natural rather than contingent, artificial, or artifactual. Identifying tokens of intensional types does not entail that we learn something that is necessarily true about them: just because my coffee happens to be on my desk doesn't mean that it belongs there, or that it ought to be there for any teleological reason. The class of "things that are on my desk" is an artifactual rather than a natural kind.

According to the Intuitive View, what makes a class "real" (in the as yet unspecified way that we want mental disorders to be "real") depends on a notion that the class does not exist by accident, or as an artifact of our own concepts or investigations. According to this view, our set B is not a natural kind, not only because I invented the class "things on my desk," but also because it is purely contingent that my six books, telephone, lamp, and coffee happen to be there. There is no property intrinsic to my desk that makes it a holder of books and cups; and there is nothing inherent about my books or cup that would make me expect to find them on my desk. The ordering principle "things on my desk" provides no meaningful knowledge of the world. An artificial kind imposes order on the world by stipulation, rather than revealing order in the world by discovering the ordering principles that determine class membership.

Reznek's three criteria for natural kinds—clustering objects (1) according to necessary and sufficient defining properties, that are (2) explainable by organizing principles and (3) have natural boundaries between levels of a hierarchical classification—capture an Intuitively Accessible, if outdated, view of natural kinds. As Reznek puts it, what makes kinds "real," and classifications "true," according to this view, is that "Natural classifications, as opposed to what we might call 'artificial' ones, are thought to reflect an independent order" (Reznek 1987, 34). Or, as psychologist Paul Meehl applies the same criteria to the identification of mental disorders,
The purpose of taxometrics is to help the investigator identify and sort those categories of individuals that are in some sense “really in nature,” that would be there whether or not clinical psychologists had bothered to take notice of them or were clever enough to detect them. (Meehl & Golden 1982, 127)

When science identifies a natural kind, it discovers order that exists in the world apart from what we happen to think about it. Natural kinds are real kinds, in the sense that they provide an ontology, and appear in scientific laws. Their organizing principles are discovered in the world rather than invented. As such, they have clear boundaries, which are established by necessary and sufficient conditions. The work they do is to eliminate contingency and maximize certainty. This view of natural kinds is not precise, accurate, or philosophically defensible. However, it is a tenable view of commonly held intuitions of what it is to be a natural kind, and what it means for them to be “real.”

Top-down Classification
We can use the Intuitive View of natural kinds to make sense of some of the criticisms of DSM. When the DSM specifies that “the order in which diagnostic classes are listed represents, to some extent, a hierarchy in which a disorder high in the hierarchy may have features found in disorders lower in the hierarchy, but not the reverse” (American Psychiatric Association 1980, 8-9), it suggests that the DSM conceives of mental disorders as discrete taxa with precise definitional criteria, which are themselves grouped into higher categories. The DSM also explicitly attempts to define “mental disorder,” and suggests that the purpose of doing so is “to guide decisions regarding which conditions on the boundary between normality and pathology should be included in DSM” (DSM-IV, xxxi). This suggests that the process of classifying mental disorders proceeds “top-down,” by beginning with an intentional definition of the class of all mental disorders, and subsequently identifying members as they are found to conform to those operating principles. As Robert Kendell describes top-down classification of diseases,

A logician would have started by defining what he meant by disease as a whole and then produced individual diseases by sub-dividing the territory whose boundaries he had thus defined. (Kendell 1975, 307)

With respect to the DSM, a top-down process of this sort would require that classification begin with the necessary and sufficient conditions that define the class of mental disorders generally, and would proceed by subsequently picking out the broad types of “mental disorder”: e.g., anxiety disorders, sleep disorders, substance abuse disorders, etc. The next step would be to identify the lower order taxa—the individual mental disorders—according to the intensional definitions of the next category higher. This seems to be what Wakefield has in mind when he says that:

Every psychodiagnostic manual is based on some set of principles by which conditions are accepted or rejected as mental disorders. These principles in effect constitute the manual’s definition of mental disorder. Often...this definition is left implicit. Nonetheless, a manual will be coherent and conceptually valid (i.e., valid in discriminating disorder from nondisorder) only if its construction is guided by an adequate definition of disorder. In addition to determining which conditions are identified as disorders, such a definition provides a framework for constructing diagnostic criteria for specific disorders. (Wakefield 1993, 160)

The advantage of such a top-down process is that it would provide the certainty we expect from the Intuitive View of natural kinds: we could be certain that our taxa and categories have clear demarcations and, thus, that they pick out “real” classes. We would have necessary and sufficient conditions to pick out definitive classes, and it would therefore be fairly obvious whether a given individual was or was not a member of a class. If the DSM were derived from a top-down classification process, then, it would draw the world with joints—it would present mental disorders as natural kinds according to the Intuitive View described above.

The disadvantage of the top-down process is that it could identify kinds that do not actually represent the natural world—they could be artificial. A top-down approach to classification depends on pre-established intensional definitions, which must derive from scientific and metaphysical theory, in the sense suggested by the earlier criticisms. Metaphysics and values, along with scientific theory, could shape the content of the intensional definitions; metaphysics would have to contribute the necessity and sufficiency required for essentialist definitions. Without theory, there can be no ordering principles; and without ordering principles, there can be no kinds. One epistemological problem that follows from the Intuitive View of natural kinds together with hierarchical structure, then, is that a classification may name kinds, but it may not be very well grounded in the natural world.

The Criticisms: Mental Disorders as Artificial Kinds
The DSM does not say explicitly that it takes mental disorders to be natural kinds, or that the diagnostic criteria are organizing principles for those kinds. However, many criticisms of the DSM seem to interpret this assumption as psychiatry’s claim that the mental disorders it describes are natural kinds.

The following examples from the critical literature all presuppose the Intuitively Accessible View of natural kinds, and accordingly criticize the DSM for failing to establish natural kind mental disorders. I present them here not because they should be taken seriously, but because they are taken seriously.

Some critics accuse the DSM of being an extensional class, which lacks any satisfactory organizing principles for including a condition as a mental disorder. Millon, for instance, argues that the DSM is not valid because it fails to provide a definition of “mental disorder” in terms of necessary and sufficient conditions (Millon 1991). In this charge, Millon presupposes both the intuitive view of natural kinds, and a top-down classification process. The criticism amounts to a charge that since the DSM does not adequately define “mental disorder” it lacks the organizing principles of an intensional class. Similarly, Blashfield argues that the DSM fails to provide definitions of the individual mental disorders that establish discrete boundaries between them (Blashfield 1984). That is, Blashfield’s criticism constitutes a charge that the DSM is extensional because it fails to provide organizing principles for each lower-order mental disorder class.

Some critics believe that the DSM does provide intensional classes, but charge that the operating principles that define mental disorders are metaphysical, contingent, evaluative, or artificial. These arguments take several forms. Some authors accuse the DSM of using organizing principles derived from a priori, metaphysical considerations (Blashfield 1984); others charge that the organizing principles are ad hoc rather than scientific and systematic (Wakefield 1992b, 384).

Some authors accuse the DSM of being based in consensus rather than science. These criticisms amount to charges that the organizing principles that define mental disorders are artificial, political, or evaluative rather than natural. Part of the charge
is true: the DSM makes no effort to disguise its conventional basis. Altogether, over one thousand people are credited with producing the DSM-IV (American Psychiatric Association 1994b, xxiii). The American Psychiatric Association strived for explicit group deliberation and agreement in order to maximize the objectivity of the process, and to prevent the DSM from reflecting the idiosyncratic views of prominent or charismatic participants.

However, some critics interpret the fact of this consensus methodology to mean that the DSM is purely a matter of decision rather than discovery (Farber 1993, 118; Faust & Miner 1986). Furthermore, such critics often attribute these decisions to personal or sociopolitical values. In one of his earlier discussions of psychiatry, Ian Hacking argued that Multiple Personality Disorder is an artificial kind because it is grounded in the self-interest of the psychiatrists who study it:

“[M]ultiple personality disorder” had completely disappeared from the second edition of the DSM but has a slot in the third, and was enlarged in the revised third edition, much to the delight of those psychiatrists sardonically called “multipliers” by their opponents, who in turn were dismayed. The multipliers have acknowledged many times in print that the entrance of multiple personality disorder into the official taxonomy enormously strengthened their case and dramatically increased their caseload. . . .Physics and psychiatry may both have structures of taxonomic kinds, but do not the kinds of physics arise from the science and not from committee vote and lobbying? (Hacking 1993, 303)

Other critics join Hacking in assuming that DSM should be based in “fact” rather than mere social convention. Marcie Kaplan argues that some mental disorders simply reinforce social expectations of how women should act. Because values rather than scientifically sound organizing principles direct the DSM conventions, she says of DSM-III’s Histrionic and Dependent personality disorders:

not only are women being punished (by being diagnosed) for acting out of line (not acting like women) and not only are traditional roles driving women crazy, but also male-centered assumptions... are causing clinicians to see normal females as abnormal. (Kaplan 1983, 791)

In other words, Marcie Kaplan argues that gender biases are built right into the diagnostic criteria for certain disorders, and even into the DSM definition of “mental disorder.” Similarly, Paula Caplan argues that the political, unscientific DSM process allows sexist values to be imposed on diagnostic categories, and ultimately on the women diagnosed (Caplan 1995). Both of these authors are arguing that the conventional DSM process permits evaluative and idiosyncratic preferences, rather than scientific evidence, to affect the identification and definitions of mental disorders, thus making them artificial rather than natural kinds.

We have seen in this section of my discussion some illustrations of how the Intuitive View of natural kinds tacitly grounds criticisms of psychiatric nosology. Although the authors I cited do not explicitly require that the DSM name natural kinds, or provide intensional classes, their criticisms suggest that they do hold this particular view of what a valid classification of mental disorders would be.

**Top-down and Bottom-up Classification**

There are other examples of DSM critiques that both abide by and ascribe to DSM what we have called the Intuitive View of natural kinds. Thus far, the critiques have been levied as ontological questions: to be a kind, the intension of a mental disorder class must determine the extension, using intensional definitions to specify class members at each level of the hierarchy. The question thus far has been whether DSM mental disorders are, in fact, kinds. But there are also attendant epistemological questions. These questions, too, arise because the DSM’s self-description as “hierarchical” suggests that the process of constructing the nosology is unidirectional. The DSM critics discussed thus far assume that the structure of the classification implies what in the last section I called “top down.”

In contrast, however, it is not clear that the DSM does, in fact, derive from a top-down, deductive process. The DSM describes its process as empirical: beginning with DSM-II, it adopts an explicitly “atheoretical” strategy, in the sense that it “tried to avoid terms which carry with them implications regarding either the nature of a disorder or its causes” (DSM-II, viii). DSM-III elaborates that its atheoretical approach is “descriptive” in that the definitions of the disorders generally consist of descriptions of the clinical features of the disorders. These features are described at the lowest order of inference necessary to describe the characteristic features of the disorder” (DSM-III, 7). Thus, we see that the DSM process may actually be the sort of “bottom up” method that Ruse describes for biological classification:

First, organisms are grouped together into classes [taxa] which are assumed to be incapable of significant subdivision; then, these classes are in turn grouped so that the members of a number of classes at the lowest level also form a class at the next higher level. This process is repeated until, at the highest level, all organisms are grouped into a very few large classes. (Ruse 1969, 97)

A bottom-up process of psychiatric classification, then, would start with the observation of individual persons, in order to identify the patterns of characteristics by which they can be grouped. Based on these definitional criteria, we could then posit higher order categories and, eventually, a highest order category of all mental disorders. This process would have the advantage of actually being grounded in the empirical world in a way that classes identified by a top-down process are not. It seems to provide a stronger basis for claiming that those classes are “natural.”

The compromise is that we would have little confidence that they are kinds. Recall that extensionally defined classes may or may not have intensions that can act as organizing principles. Some extensionally defined classes will have no intension at all; others may have an intension that remains to be discovered. In short, the bottom-up classification process presents us with insurmountable epistemic limitations—we can’t know whether or not the kinds we identify refer to kinds in the world. As one group of authors describes this problem with respect to psychiatric nosology:

There is simply no reason to suppose that features of clinical psychopathology which catch our attention and are the source of great human distress are also features upon which a science of psychopathology should directly focus when searching for regularities and natural kinds. (Poland, Von Eckardt, & Spaullding 1994, 254)

Thus, the bottom-up process seems to forfeit the certainty of kinds that would give us confidence in the results of our empirical investigations. After the publication of DSM-III, Faust and Miner (somewhat misguided) challenged what they call its “strict empiricism” on the grounds that a classification based
in pure observation first, is impossible, and second, cannot yield knowledge “based on objective data” (Faust & Minner 1986). Their primary concern seems to be that all observation is theory-laden, and that psychiatry should not fool itself into believing that any observations of human behavior can be “ atheoretical.” But they also say that “[I]f theories only summarize descriptions they are virtually useless. A theory that does only this is more like a filing system which knows and can discover only that which is already discovered and known.”

This empiricist problem is not unique to psychiatry, of course. This last quotation merely applies Locke’s distinction between real and nominal essences (Locke 1975) to psychiatric nosology. The nominal essence of a substance is the collection of observable properties by which we define that substance, and these properties are, at best, the ones we contingently discover and, at worst, unrelated to the real nature of that substance—its real essence—by which it ought to be defined. As long as we ground the classificatory enterprise in our observations of the world, the classes or species of objects that we identify are contingent on what we happen to observe about them. Consequently, we cannot know if our empirically generated, bottom-up classifications reflect kinds that exist in nature, or if nature contains kinds or has “joints” at all. The epistemic gap between the kinds that exist in nature, defined by essences that are real but unknowable to us, and the kinds that we identify based on our observations of descriptive properties, defined by nominal essences, is therefore unbridgeable. Even if our nominal essences actually capture real essences, we have no way of knowing that they do.

Immediately, we can see that the Intuitive View of natural kinds, together with the assumption that the classification process must be top-down or bottom-up, entails a contradiction. On the one hand, if classification proceeds according to a top-down process, then intentional organizing principles can be used to identify extensions. But if we use intentional organizing principles to pick out the extensions of classes, then they precede empirical study, they may be influenced by metaphysics or values, and hence, the resulting classes are not natural. On the other hand, if classification proceeds according to a bottom-up process, then extensions determine intensions. In this case, we have little basis for confidence in the homogeneity of the conditions we identify, and less confidence that the resulting classes we identify are kinds. The dilemma is this: as long as we hold the Intuitive View of natural kinds, and as long as we suppose that they are identified according to one of the unidirectional methods, then there will always be a compromise between certainty and empirical grounding. Neither classification process yields natural kinds that meet the criteria of the Intuitive View.

We would expect DSM critics who attribute to it a top-down or a bottom-up process to challenge it for identifying natural kind mental disorders at all. However, this is not what happens. Instead, DSM critics endorse the Intuitive View of natural kinds, attribute to the DSM either a toptop-down or a bottom-up classification process, and then challenge it for failing to follow the alternative process. I suggest that many of these problems can be addressed by (1) disregarding the DSM’s characterization of its own philosophy, (2) rejecting the Intuitive View of natural kinds, and (3) understanding the classification process as iterative rather than unidimensional.

References
**The Other Two Sides**

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“Look at it this way,” Julie said, “at least no one’s going to say it’s her own fault.”

“Nah, they’ll say it’s ours. People resemble their pets.” Nick rubbed his puffy red eyes, which did not resemble Gabriella’s golden ones, then turned Gabriella over and began rubbing her belly. “So, naturally, pudgy couch-potato reprobes who brought their diabetes on themselves are going to have a diabetic cat,” he continued, his fingers knuckle-deep in the shimmering silver fur. “ Lucky I’m the pudgy reprobate and you’re the diabetic.”

“Yes, it’s certainly lucky for you,” Julie was tempted to reply, but she knew what he meant. Didn’t she often assure people that she was an innocent Type 1 diabetic whose pancreas had failed when she was twelve, rather than an overeating inactive Type 2 diabetic whom they were allowed and even encouraged to blame? This let her criticize their criticism while at the same time escaping it, Nick pointed out when in a bad mood, but he hardly seemed to be thinking along those lines now. “So what are we going to do?” he was saying.

“I’m going to finish rubbing her head,” Julie’s fingers were making tiny circles where Gabriella’s chin and ears met, “and you’re going to finish rubbing her belly—don’t forget the part near her legs; you know how she loves that—and then, since it’s nearly eight, we’re going to give her a shot.”

“She’s not going to love that,” Nick said.

“Dr. Horton said the needles are so thin she’ll scarcely feel them.”

“You scarcely feel yours?”

“Well, we’ll give her other things to love. Like this.” Julie pressed her nose against Gabriella’s, then stroked both ears, reveling in Gabriella’s varied and wonderful fur. Short sleek solid silver on the ears and nose, but so soft and long everywhere else, with black markings that continually surprised you. No matter how much time you had spent looking at Gabriella, you always saw something in the pattern that you hadn’t noticed before.

“She’s a cat,” Nick said.

“She is? Are you sure? Let’s see—Gabriella, are you a cat?” Julie looked down into the golden eyes and ran a finger along Gabriella’s chin. Gabriella let out a chirp and started purring. Julie looked up. “Yes,” she said, “she’s definitely a cat. So?”

“So she’s not going to realize the shot’s for her own good, and she’s not going to have intellectual thrills to make up for all the sickness in her future. Physical pleasures are all she’s got.”

“And you think diabetics can’t have physical pleasures? Maybe you’ve forgotten last night?” Julie’s right hand momentarily abandoned Gabriella to pat Nick in a strategic place, making his face turn slightly pink. Married for six years and absent from Mass for almost twice that, he still retained whatever in his Catholic background made him flush at the mention of sex. Julie, non-religious all her life, found that endearing. This was one man who would always be faithful; she had never had a moment’s worry on that score.

“But she’s uh, neutered,” Nick was saying.

“Not all physical pleasures are sexy. How about this?” Once again, Julie rubbed the place where Gabriella’s chin and ears met, and this time Gabriella’s eyes closed and her purring intensified, her mouth stretching into what Julie liked to think was a smile. “I’d better get the shot ready now,” she added, reluctantly lifting her hands from Gabriella.

Gabriella opened her eyes, reached out, and put a soft silver paw on Julie’s wrist. “See?” said Nick. “She’s asking you not to hurt her.”

“No,” said Julie thickly, “she’s asking me to keep her alive. Or maybe she’s asking me to vote Yes on the school bond issue. Look, it’s only a couple of shots a day. It’s not that bad.”

“You’re saying that? Since when? What’s next? Diabetes is part of your identity; so that makes it just terrific? Or maybe it helps you grow through adversity?”

“What’s next for you, Nick? Death with dignity because you lose your dignity the minute you’re not in great shape?”

Two pairs of eyes glared at each other above the lustrous silver fur. Two pairs of hands were immobile. Then, as if propelled by a single motor, all four hands resumed petting Gabriella. “Look,” Julie said, “disability-pride types want you to love your disability; death-with-dignity types want you to hate your life. Obviously, it makes more sense to love your life and hate your disability. Let’s get the shot over with.”

She walked into the kitchen and came back with a filled syringe. The needle shone silver and bright as Gabriella. “So who’s going to do her first home shot?” Nick asked.

“I will. I’ve had so much practice on myself.” Julie turned Gabriella over onto her feet, lifted a fold of lush fur and skin between Gabriella’s shoulder blades, and thrust the needle in. Gabriella yowled, broke free, and lashed out with a paw.

“Jesus,” said Nick, as a line of blood formed on Julie’s hand.

“I’ll get a band-aid.” When Julie returned to the living room, Gabriella was lying in a circle with her plume-like tail curled over her head. “Tlap” was their special word: Tail Like A Plume. “It’s just a scratch,” Julie said. Plunging her hand into Gabriella’s chin and ears met, “and the purring resumed. “You really think putting a cat to sleep is as bad as with that Vance boy? How many philosophers would say that?”

“Jesus,” said Nick, “what if she keeps on doing that? What if her whole disposition changes?”

“Are you suggesting we should have her killed, just like Alex Vance?”

“Who?”

“Didn’t you read the paper today?” Julie asked and told him about the local woman who had gotten a Do Not Resuscitate order for her severely retarded son, who had no language, recognized nobody, and often hit and bit people. “Of course, we could just clip Gabriella’s claws.”

Nick petted Gabriella’s side gingerly, then more robustly as the purring resumed. “You really think putting a cat to sleep is as bad as with that Vance boy? How many philosophers would say that?”

“I don’t know. But there’s a concept called speciesism. It means that favoring one species over another is like favoring whites over blacks, unless there’s some relevant difference between the species.”

“So what’s a relevant difference? Can I swat a fly?”

“A fly is not a cat. A cat probably has as much mental life as Alex Vance. Anyway, this isn’t ‘a cat’; it’s Gabriella. She’s happy, she’s purring, and this philosopher says Gabriella isn’t going to be killed. She’s not even going to get any more shots for another twelve hours.”
“What about the blood tests?”

“Oh, hell, I should have done that before the insulin.”

Imagine, a diabetic forgetting about the blood tests, two more pricks a day, plus whenever anything seemed possibly amiss.

“And there’s all the stuff we have to watch out for. It’ll be like having a second job,” Nick was saying.

“Third for me,” said Julie, “but at least you can’t lose this job because you don’t publish in the right journals. And here’s something you hardly have to be a philosopher to say: don’t confuse your interests with another’s. What are you worried about—Gabriella or yourself?”

“Both. Is that so terrible?”

Julie gazed at Gabriella’s tail as if it might hold the answer.

“That’s not a right triangle,” said Nick.

“Each to count for one, and none for more than one.” Jeremy Bentham said that. He thought that the right thing to do is whatever promotes the greatest total balance of pleasure over pain.

“So a million people can torture one person if it’s just enough fun for each of them?”

“Well, that’s one problem with the idea.” Few of the Stanford students Julie had taught as a graduate assistant had come up with that objection so quickly. How tragic that Nick had been forced to leave academic life, she and Nick both, part of the lost generation of scholars who never found permanent jobs in their fields. At least she and Nick had found each other and created a home where they did not have to pretend that ending up a Social Security administrator and a bakery co-owner instead of a history professor and a philosophy professor was a blessing in disguise.

“Speaking of terrible, Jerry Rutherford came into the bakery today,” Julie said. “He bought a cinnamon bun but couldn’t be bothered to say hello to someone whose thesis he supervised but who never even got a philosophy job.”

“Maybe he didn’t recognize you,” Nick’s finger was tracing the black stripes near Gabriella’s tail.

“Do you want me to be that generous about the people who turned you down for tenure? Anyway, he knew. He must have seen the column in the paper. You know how big they are at Stanford on being involved in the community.” Raising her eyes although not her hand from Gabriella, Julie glanced at the wall. She had framed the newspaper column despite its title: “Diabetic Finds Solace in Giving Others What She Must Forgo.”

Julie had told the columnist that being around pastries was the next best thing to eating them, providing vicarious thrills, Julie had told the columnist that being around pastries was the next best thing to eating them, providing vicarious thrills, and created a home where they did not have to pretend that ending up a Social Security administrator and a bakery co-owner instead of a history professor and a philosophy professor was a blessing in disguise.

“Have you gone crazy? It’s so dangerous.”

“So is climbing Mount Everest. But no one tries to stop people from doing that or says they have a mountaineering disorder—oh, that’s so funny.” Julie began laughing, then crying, because she had taken too much insulin, or was it not enough, and she was about to go into insulin shock, or was it diabetic coma, and any minute now she would throw up; in fact, it smelled as if already—

Awakening abruptly, Julie heard rapid breathing and saw Gabriella stretched out in the moonlight that shone through the bedroom window. The carpet was sticky; there was a pool of vomit. Gabriella’s breath was fruity, and any diabetic should know what that meant. Julie picked up Gabriella, put her into her carrier, and set out for the Santa Clara County Veterinary Hospital. “My cat’s diabetic. I think she’s in ketoacidosis,” she was gasping twenty minutes later.

“Please. Take A. Seat. And. Fill. Out. This. Form.” No doubt the receptionist, wearing a tunic of soothing light blue, had been told to remain calm no matter what, and why shouldn’t she be calm, it wasn’t her cat. And what could be more irritating than someone else’s calmness when you were frantic?

“Please take her right away. It’s an emergency.”

The receptionist pointed in slow motion to a sign that said, “This is an emergency room. We do not take patients on a first-come, first-served basis.”

“This is an emergency. And there aren’t any other patients here.” How much of a fuss were you supposed to make? Too much, and they wrote you off as unbalanced. Too little, and your cat could end up like the dying man Julie had heard about whose hospice took four hours to return his wife’s middle-of-the-night telephone calls because she hadn’t sounded distressed enough.

Six minutes passed before a blue-clad technician—was that the official color here?—came and whisked Gabriella and the form away. “The doctor will see you soon.”

Eighteen minutes later, a startlingly beautiful blue-clad woman with brown skin blending into rosy cheeks and red-gold lips beckoned Julie into a small office with a desk and two chairs. Julie’s reflexive antipathy toward beautiful women dissolved into the thought that this woman must really love animals to choose a career where her appearance would matter so little. “How’s my cat?”
“She has a condition called diabetic ketoacidosis. It means—”

“Buildup of ketones. I know. Why did this happen? We test her blood every day.”

“Her diabetes may be very unstable. What we call brittle diabetes. There are several possible causes.” The veterinarian steepled her hands. “We can keep her here for testing and intensive care. But—”

“But what?”

“Some cases of feline diabetes are inherently brittle.” Unsteeping her hands, the veterinarian laid them palm-down on the desk. “In that instance, you might want to think about sparing her further suffering.”

“Do you mean killing her? And then maybe killing myself?”

The beautiful face looked alarmed, and for a moment Julie wondered whether the veterinarian was about to call security. “I’m diabetic, too.” Julie forced herself to speak quietly. “I know it’s not a fate worse than death. I want you to do whatever you can to keep her alive.”

“She should pull through this episode.” The veterinarian reached into a blue pocket. “Here’s my card. Call me in the morning or anytime tonight. I understand how you feel. I have two wonderful cats of my own.”

“Where were you?” Nick demanded as soon as Julie walked back into the house.

Julie gaped. Getting Nick up in the morning was hard enough. Awakening him in the night was practically impossible. He slept through thunder, fire engines, and once even a minor earthquake that had not been too minor to make a glass vase fall and shatter barely a foot from their bed. But now he stood confronting her in the hall, his face red as the hearts on his uniform. “Right now?” But on second thought, why not now? It wasn’t as though Julie had much chance of getting back to sleep or of avoiding Gabriella-saturated nightmares if she did.

She walked into the living room and sat down on the maroon corduroy sofa, feeling an agreeable tingle at the silver fur on the cushions. Vacuuming was boring and Gabriella’s fur improved almost anything, so why get rid of it? she liked to say.

“It’s not just guilt. I love Gabriella and I want her around.”

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“Take a breath, for Christ’s sake.”

“So she runs at both ends and doesn’t always make it to her litter box. Since when are you so fastidious?”

“She’s weak and she meows all the time. You can’t say she’s as happy as she was before.”

“She doesn’t meow all the time. She doesn’t even meow most of the time. She lies in the sun and purrs. I’m not as happy as I was before I got diabetes, either.” Julie twisted her neck until she was staring directly into Nick’s eyes. “What are you going to do when I get complications—have me killed, too?”

“Come on,” said Nick. “I know you want to be kept alive no matter what.”

“Gabriella can’t have opinions about that; so we go with the balance of pleasure over pain. Can you really deny that her life is still more pleasurable than painful?”

“What about us?” Nick swung his feet up onto the coffee table, nearly knocking over a stack of the American history journals that he still read although he had long since abandoned hope of getting an academic job or even publishing an article. “How many philosophers would say our interests don’t count? Being sick trumps the interests of everyone who takes care of you?”

“You won’t find a lot of philosophers saying that,” Julie replied and told him about a recent philosophy article whose author said he couldn’t imagine justifying burdening his children or compromising the quality of his grandchildren’s lives simply because he wanted to live a little longer. “Then another philosopher asked what would count as compromising the quality of the grandchildren’s lives. Going without tennis lessons? Going without summer camp?”

“How about going without sleep?” Nick rose from the sofa and began pacing around the room. “You think just because I don’t wake up at night I don’t notice you all stumbling and bleary-eyed in the morning?”

“Gee, thanks.” Julie rose, too, and stood in Nick’s path. “And by the way, you hardly need to be sleepless to be bleary-eyed. Have you looked in the mirror lately?”

“Come on.” Nick put a hand on her shoulder. “You know that’s not what I mean.”

Julie knew. Men were supposed to care about physical attractiveness, but Nick really did not. If you loved someone, what she looked like didn’t matter, he liked to say, and Julie had always agreed, at least when it came to people. But last December, she had worried that someone at the animal shelter might put into her lap an old, ugly cat that would start purring and licking her hands, and then, of course, she’d have to take it home. How lucky she had been to get glimmering young Gabriella instead. Gabriella was glimmering less these days. Her fur had dulled and clumped. But she was still Gabriella. “Having Gabriella killed would compromise the quality of my life,” Julie said.

“You’d feel guilty?”

“I should hope so.” Julie twisted her shoulder out from under Nick’s hand. “Feeling guilty can be a sign from your conscience that you’re doing something wrong. You know that. You’re Catholic, remember?”

“But—”

“It’s not just guilt. I love Gabriella and I want her around.” Julie’s eyes filled with tears; why hold them back because you were afraid of being manipulative? They were real tears, not faked or forced. Just last week, she had read a philosophy article on the concept of being manipulative. Like Nick, she kept up with her academic field despite having long since abandoned hope of employment or publication. Was that praiseworthy or pathetic or both? Or neither? She wasn’t sure. The article said you were more apt to call something manipulative if you considered it bad. What was bad about expecting your husband to take your feelings into account? “I can’t believe you can’t love Gabriella enough to want her alive even if she’s sick,” Julie sobbed. “What if I get sicker?”
Nick put his arm around her. “Okay, Julie.”

“If you’re so worried about my losing sleep, how about doing half the nighttime stuff yourself? I don’t expect you to wake up on your own. I’ll wake you half the time, and you can take over.”


Over the next few weeks, Nick was as good as his word. Better, in fact—he had never promised not to complain, but now, once Julie managed to awaken him, he left their warm bed ungrumblingly to do his share of the nightly monitoring that Gabriella’s increasingly brittle diabetes had come to require. During the day, he spent more time petting Gabriella than ever before. At first, Julie thought he was just trying to avoid friction. But one Saturday, coming home unexpectedly early from the bakery, she found him in a trapezoid of sunlight on the living room window seat with Gabriella in his lap. “Softest cat in the world,” he was murmuring. Looking up and seeing Julie, he turned pinkish, as if someone had mentioned sex.

That night, Julie awoke with a start and found Nick’s half of the bed empty. Incredibly, he had awakened by himself, and it wasn’t even his turn for night duty. Reaching the living room doorway, Julie saw Gabriella on the sofa, tail appealingly curled over her head. Nick stood over Gabriella, his expression indecipherable in the moonlight. Why was he there? The scene seemed unreal as a science fiction movie or a dream. How do you know you’re not dreaming? Descartes had asked, and Thomas Reid had said: You just know. Always Julie had sided in Reid, but that didn’t mean she knew what Nick was up to now. She knew only that he couldn’t see her; she was standing in the dark. Had his newfound devotion to Gabriella all been fake? Was he going to—? Julie watched as Nick walked into the kitchen and then emerged, holding something long and sleek. A syringe? I have to do something, Julie thought, but her feet were so heavy. She took a step forward, then moonlight fell into the room window seat with Gabriella in his lap. “Softest cat in the world,” he was murmuring. Julie’s and Nick’s sides lately had been blurring into each other, seemed unchanged, her life still more pleasurable than painful. But now she would have to be strong enough to decide, and how could she deprive Gabriella of mornings in the sun? How could she deny herself that? When had she missed it? Why was it so clear-headed? She picked up Gabriella, deposited her on the window-seat cushion, ran a finger from the tip of Gabriella’s nose to the back of her head, went into the bedroom, and closed the door behind her. But emotions are part of clear thinking, she reminded herself, recalling a philosophy book she had recently read; how can you decide about Gabriella without taking love into account? She walked back into the living room, sat down on the cat-warmed cushion, and settled Gabriella in her lap. Soon Gabriella’s little pink tongue was caressing Julie’s hands. Then Gabriella rolled over, exposing her soft belly, folding her front legs, and holding her paws together on her chest. Julie’s index finger traced a line across Gabriella’s chest, making the familiar triangle. What were the three sides? Gabriella’s side seemed unchanged, her life still more pleasurable than painful. Julie’s and Nick’s sides lately had been blurring into each other, although right now, finger in fur, Julie felt herself slipping back to her old side. She stroked Gabriella’s ears; Gabriella’s head was in her hands. So was Gabriella’s life. Whatever Nick’s side had become, in the end he would go along with Julie. She had always known that. He was not a strong person, which was part of what she loved about him. Strong people were cold and hard. But now she would have to be strong enough to decide, and how could she deprive Gabriella of mornings in the sun? How could she deprive herself and Nick of Gabriella? But how much more exhaustion and panic could she endure before her health failed along with her love for Gabriella? “I don’t know what the sides are anymore,” she whispered as Gabriella purred, closed her eyes, and went to sleep.

Epistemic and Ethical Implications of Expert Authority in Medicine

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Experts and Expertise: Epistemic and Ethical Implications for Medicine

The notions of expert and expertise imply that some people have more credibility than others on certain matters. While expert authority is often taken for granted, there are questions of whether expert power in some cases can be a form of epistemic oppression. Informed by various biomedical examples, this paper echoes many feminist epistemologists by arguing that the legitimacy of expert status and authority depends on how dissent, particularly from those who are marginalized, is handled.

Epistemological and Social Dimensions of Experts

To say that someone is an expert generally means that this person possesses a substantial body of truths in a target domain or field of knowledge, X, comparably more so than the vast majority of people do, and a superior ability to generate new knowledge to answer questions within this domain.2 Such an
individual possesses expertise in X, i.e., the ability to offer strong justifications for a range of propositions about X, and to apply knowledge of X to particular circumstances. She has extensive knowledge of the state of the evidence, and of the opinions and reactions to that evidence by prominent workers in the field. The vast knowledge and/or experience in the theory and practice of the domain sets her apart from others, signals that she is uniquely qualified in making judgments about various matters within X, and gives prima facie reasons for why others who cannot adequately assess the evidence in X should trust her judgment. For example, it is generally accepted that there is an epistemological gap between most patients and their physicians—physicians’ claims are more likely to increase the understanding of the human body and clinical matters and lead to such knowledge than those of lay persons. Medical paternalism was traditionally justified under the assumption that physicians have superior ability to accurately diagnose patients and come up with a range of possible solutions for various clinical problems, and as such they are in a better position than their lay patients to decide what medical options would be in the latter’s best interests.

This epistemological gap, which forms the basis for medical paternalism, brings out the social dimension of the “expert” label. In addition to denoting that someone has extensive knowledge of a certain domain, a person who is considered an expert generally also has recognized social authority on matters within that domain. Expert scientists are often invited to comment or testify on various politically and ethically charged issues (e.g., climate change, stem cell research), thereby holding direct or indirect power to persuade individual decisions, public opinion/expectations, and health-care policies. “Expert” status is generally conferred upon someone by other individuals or, more commonly, by institutions. This is especially the case for highly technical areas such as medicine. Physicians, for example, are often considered as medical experts not only because they are presumably much more knowledgeable in their particular field of medicine than laypersons. In addition to having worked hard to improve or maintain their epistemic position regarding medicine, these individuals are formally conferred expert status by the fact that they are licensed practitioners in most industrialized countries. In other words, “expert” is not only an epistemological notion; it is also a socially and/or institutionally designated identity that sets one apart from others. While some have argued that novices may turn themselves into experts by improving their epistemic position vis-a-vis the target subject-matter, such that laypersons can acquire expertise by obtaining the relevant body of knowledge and experience in the particular domain, expert status is not purely based on epistemological criteria or can be self-conferred. Self-proclaimed experts, unless backed by others or institutional credentials, are often looked upon as potentially fraudulent, narcissistic, or arrogant individuals. Moreover, even someone who is keenly interested in medicine and has gone through an equivalent amount of training as a licensed physician would not thereby attain expert status. Only those who are also certified by respective medical boards for having met various predetermined criteria are accorded that status and subsequent authority to practice various types of medicine.

Medicine as Value Laden and the Construction of Consensus

While the idea that laypersons can appeal to experts’ testimony is often taken for granted, the assumption that there is a distinct credibility gap between two separate classes, experts and laypersons, raises important epistemic and ethical questions. In particular, there are questions of how dissenting views are handled, and whether the existence of dissent may cast doubt on the credibility gap and thus the legitimacy of expert authority.

When people talk about expert judgments, they often refer to the generic expert, E, blurring the distinction between the general and the particular. News headlines regarding various biomedical discoveries, such as “experts find link between smog and mortality,” or “liver disease in fat children latest obesity risk, experts say,” give the impression that these individual experts’ viewpoints represent a consensus viewpoint among experts in that particular domain. This presumed agreement is most evident in clinical practice guidelines as well as “expert consensus” panel, committee, and agency recommendations, where the community of experts presumably endorses a unified position, such that one expert’ opinions on that particular matter are indiscernible from or interchangeable with those of other experts. Since consensus in medicine is presumably evidence-based, when delivering opinions in domain X, a particular expert, E, speaks not only for himself, but also inadvertently for E, E, or all Es on the committee, and perhaps also others in the field. Even as most would recognize different levels of experience among experts, and that inter-observer disagreement exists in even some of the “most scientific” areas such as histopathology; our increasing reliance upon technology in contemporary medicine may have fostered wrong assumptions of objective certainty or expectations that all diligent medical scientists who employ the same objective and/or scientific methods in their inquiry would reach similar, if not the same, conclusions. Nonetheless, there are questions of whether such consensus indeed exists, and if/when it does, how that consensus is reached or presented. While the contemporary focus on randomized trials as well as scientific norms of accuracy, prediction, and repeatability presumably limit subjectivity in expert observations and judgments, medical science is not absolute. Two issues are particularly salient.

First, despite its focus on quantification and statistical analysis, medicine is value-laden in the sense that social and individual values inevitably influence how medical scientists and practitioners collect and interpret data. Our knowledge in medicine results from the interaction of empirical observation and various values. The process of forming research questions, collecting medical data, and conducting medical discovery varies according to what we consider to be important as well as what we choose to be the theoretical and conceptual framework. While constellations of pathophysiological and experiential phenomena are observable, our descriptions of these configurations depend on which clusters of signs and symptoms we see as constituting a disease, and which we choose to interpret as irrelevant. How medicine is researched and practiced, including what conditions may count as a disease and/or disability, what diagnoses we attach to various symptoms, and what treatments a physician may recommend for a patient with a particular condition, are strongly (even if also subtly) influenced by personal, socio-cultural, economic, and national factors. The definition and impact of diseases are not based solely on biophysical differences. Rather, they are also based on the evolving socio-cultural system of symbolic meaning.—any description of physical findings in a sick person will already be imbued with values. Physicians’ social environment, personal background, worldview, and other values inevitably have an effect on how they observe their patients’ symptoms, how they investigate and interpret their histories, what diagnoses they offer for various reported and observed symptoms, and what among the increasing number of treatment options they recommend—different professionals may see the same symptoms differently. Researchers’ values as
well as prior beliefs and experience can also lead to different scientific findings by influencing different researchers to focus on certain issues, hypotheses, and populations while leaving out others. As some have pointed out, from heart disease to cancer treatment, the lack of attention to the needs of various marginalized populations and enrollment of mainly white, middle-aged men as participants have inadvertently led to skewed scientific conclusions regarding disease patterns.\textsuperscript{17}

Second, despite rapid technological advances, uncertainties in medicine abound. Scientific explanations for various phenomena continue to evolve and progress with emerging frameworks and technologies—new hypotheses, research questions, study designs, discoveries, and conclusions cyclically replace old ones. The availability of different treatment options for various conditions makes diagnosis and treatment assessments even more complex, reminding us that medicine is not only a science but also an art.

However, if varying social factors exist and scientific certainties are limited, then the projected consensus among experts and appearance of finality in scientific discovery require more scrutiny. As some have pointed out, disagreements among experts and uncertainties are often masked in committee or agency reports.\textsuperscript{18} When an agency announces its approval for various products and procedures, it rarely explains whether divergent views arose in the investigative process, how uncertainties were handled, what deliberative process took place in reaching consensus, and on what bases certain dissenting views or unanswered questions were evaluated and subsequently put aside.

Issues arising in one of the nation’s agencies can shed light on such problems. The Food and Drug Administration (FDA) is the American public health agency that is responsible for, among other things, monitoring, testing, and regulating the nation’s food supply as well as various medical devices, biologics, and medicines.\textsuperscript{19} FDA scientists review the results of laboratory, animal, and human clinical testing done by companies to determine what types of biomedical products will be safe and effective enough to be made available to the public. Such research activities provide the scientific basis for the agency’s regulatory and standard-setting decisions as well as risk assessment tools.

However, questions of how consensus is reached within the agency have surfaced in recent years when controversial cases regarding the safety and/or efficacy of approved products uncovered disagreement within the agency. There is currently no legislation requiring regular public disclosure of FDA safety reviews, such that the process of investigation as well as the opinions and reasoning of scientists who may disagree with the final recommendation are often unknown.\textsuperscript{20} Nonetheless, a lawsuit in the late 1990s against the FDA to obtain mandatory safety testing and labeling of biotech foods as well as testimonies from the agency’s scientists regarding their safety warnings on various FDA approved products (e.g., antibiotic Ketek, diabetes drug Avandia, painkiller Vioxx) all point to the existence and dismissal of dissenting views.\textsuperscript{21} In addition, a 2002 survey conducted by the Department of Health and Human Services as well as Congress testimonies in 2007 raise concerns that the agency allowed little dissent or stifled scientific dissent entirely even when its researchers have reservations about the safety, effectiveness, or quality of various drugs and procedures being approved.\textsuperscript{22,23} Another agency, the United States Centers for Disease Control and Prevention (CDC), also urges its staff members to speak with one voice by sharing the same information.\textsuperscript{24}

Some have pointed out that sometimes expert groups may present “consensus” views to protect their expert status of being the ones to consult and defer to with regard to issues within that domain.\textsuperscript{25} Laypersons appeal to experts partly because they lack the requisite knowledge to determine the solution for various problems. Disagreement or a sense of uncertainty among experts may raise concerns as to whether they truly understand the matter and can sort out the complexities, thereby increasing public anxiety and torpedoing credibility of experts. For example, disagreement among medical scientists regarding the safety of estrogen therapy to menopausal women have led some to worry that the search for truth in medicine is elusive.\textsuperscript{26} Dispute over the hazards posed by bisphenol A (BPA), an estrogen-like chemical used in plastic bottles, also got at least one journalist to say that “no wonder consumers are confused about the safety of chemicals in plastic.”\textsuperscript{27}

Nonetheless, suppression of divergent viewpoints and uncertainties for the sake of public confidence is not only self-serving; it masks the evolving nature of scientific discovery—many scientific “conclusions” are intermediate or qualified in the sense that they reflect the current state of knowledge, but may be disproved in the future. Downplaying uncertainties and silencing dissenting perspectives and interpretations of data are epistemologically problematic and can sometimes lead to devastating consequences, as we witnessed in the debacle of Vioxx.\textsuperscript{28} In fact, in some cases, the existence of only one perspective may be a reason for caution, if having a lone standing position is the result of excluding diverse viewpoints.

Certainly, one may argue that some situations admit of only one legitimate opinion, such that all experts with sound information and diligent observation would inevitably reach the same conclusion. In these situations, dissenting viewpoints are simply misinformed or invalid, such that there are good epistemological reasons to reject them. While this may be true, transparency of the process and acknowledgement of disagreement and uncertainties are still important to the quest of scientific knowledge. After all, we usually do not know a priori what conclusions will be reached. And without transparency of existing viewpoint and the adjudication process, it would be unclear whether the dismissal of a particular perspective is the result of scientific or other factors. In fact, if an expert is by definition one who has vast knowledge in her specialized domain and the ability to offer strong justification for various issues in this domain, then there are prima facie reasons to take her dissent seriously, since this individual likely has grounds for holding such viewpoints, and it would be epistemologically important to consider such reasons before deciding whether to reject them. As John Stuart Mill famously noted, given human fallibility, curtailment of dissenting viewpoints is illegitimate, regardless of how implausible that perspective may first appear.

In some cases a dissenting view may “supply the remainder of the truth of which the received doctrine embodies only a part.”\textsuperscript{29} Even when the contrary opinion is blatantly false, unless it is “vigorously and earnestly contested,” the accepted position will “be held in the manner of a prejudice, with little comprehension or feeling of its rational grounds.”\textsuperscript{30} If “consensus” viewpoints are reached by suppressing counter-opinions, they are dead dogmas rather than living truths.

Disclosure and careful analysis of dissenting views, on the other hand, can help to explain whether/why the dissenting position may be misguided, clarify the process the agency used to reach its recommendation, and facilitate future studies or refinement by noting potential areas of confusion.\textsuperscript{31} Concealment of disagreements and uncertainties, even those that appear invalid, risks oversimplifying a particular position. It reduces the likelihood that the dissenting opinion or hypothesis would be further studied and fosters the false
expectation that scientific findings are final and absolute. When the public understands the expert opinion as definitive based on consensus, it becomes confused when uncertainties, disagreements, or tragedies (e.g., death of patients) finally surface. In contrast, if experts would communicate and help the public to understand the evolving nature and the limits of scientific discovery, it could educate laypersons regarding the complexity of modern science and minimize their confusion or panic in the face of uncertainties.

Credibility Gap Re-Examined

The concern of expert dissent raises questions of another kind of disagreement, one between experts and laypersons. If experts themselves may disagree, can we still assume that experts’ methodologies and perspectives are generally, if not categorically, more valid than those of the laypersons’, such that dissenting opinions of the latter can be legitimately dismissed as being intellectually inferior?

On the surface, there appears to be little epistemological ground for laypersons to disagree with experts, who have extensive knowledge in a specialized ability to answer questions within their specialized domain. Given that it is generally in the interests of anyone to believe what is true and not believe what is false, it would seem that a patient who lacks the experience and knowledge in the highly specialized field should trust the experts’ opinions.

However, the fact that laypersons sometimes dispute expert claims despite their relative lack of experience in the particular domain raises interesting epistemic and ethical questions. The example of disagreement in risk assessment between experts and laypersons regarding the safety of consuming food from cloned animals and their offspring may shed some light on this issue. In early 2008, both the FDA and the U.S. Department of Agriculture (USDA) sought to present a unified message that food from clones is as safe as that from their more conventionally bred counterparts. Nonetheless, despite FDA’s “strictly...science-based” risk assessment, many Americans and consumers from around the world continue to have an unfavorable impression of food from clones. Some are also concerned about the ethics of producing cloned animals, which often have health problems.

Some may argue that experts in general are better qualified in determining risks, since their methods are likely to yield more accurate predictions than those of laypersons. Howard Margolis, for example, asserts that in risk assessment and other highly technical areas, “we very rarely would be considered anything but stupid to prefer our own opinion to an expert judgment.” Nonetheless, despite FDA’s “strictly...science-based” risk assessment, many Americans and consumers from around the world continue to have an unfavorable impression of food from clones. Some are also concerned about the ethics of producing cloned animals, which often have health problems.

The question then becomes, who should have the authority to define the issues and goals? Given the presumed credibility gap, experts have generally been given the authority to make such determination. For example, Margolis insists that experts should try to force laypersons out of their entrenched intuitions by presenting alternative or additional information and evidence, as well as to convince the public and government officials that the experts’ ways of considering risk-benefit trade-off are the superior methods that ought to be adopted.

Nonetheless, while expected objectivity in medical science may give the impression that those conferred with expert identity are defining issues and goals based on neutral factors, the conceptual framework for choosing expert criteria is in and of itself value-laden, and it is within this complex combination of social and institutional structure, historical and economic realities, as well as power relations that experts define issues and goals. As some have pointed out, experts would likely define issues and determine the appropriate methodologies that will preserve their status and authority in the community—those who may dissent, as we already saw, are often excluded from the group, such that the social practices of authorizing epistemic power generally create and sustain self-affirming ideological communities. The “expert” label confers one the power to determine what issues are worthwhile to include in his/her domain’s inquiry, how they are to be studied, and how challenges or disagreements are to be handled.

Certainly, this does not mean that criteria for determining appropriate methodologies and goals are chosen at random or without any epistemic justification. It also does not imply that experts are intentionally and unjustifiably dismissing the perspectives of laypersons simply to preserve their expert status. Physicians, for example, are not only qualified in implementing their clinical knowledge. They are also generally equipped to evaluate their patients’ competence in reaching their decisions regarding various treatment options. Nonetheless, the criteria and process for evaluating patients’ and laypersons’ reasoning are not value neutral as standardly assumed—they are embedded in a matrix of institutions and practices, and raise meta-level questions of why and how such conventions came to be adopted in the first place. For example, while mathematicians and/or statisticians may be more qualified in determining the probability of an event happening, how much weight should be placed on preventing this event is not simply a statistical issue—risk assessment is also a value matter. What methodologies are more credible in determining risks depends not only on mathematical analysis, but also on what we believe is important. When lay cancer patients, for example, disagree to consider all relevant aspects of a situation or make the appropriate risk-benefit-cost assessment.

Let us put aside the question of whether Margolis is committing the fallacy of arguing from ignorance. Just because he may not know of any cases where lay judgment may have been better than expert judgment does not necessarily mean that there have not been or will not be such cases. What is more concerning, I contend, is that any such potential cases would likely have been neglected by Margolis because of his presumption that the layperson’s methodology is inferior. However, it seems that whether the laypersons’ methodologies are inherently inferior compared to those of experts depends (partly) on the intended goals. While experts are presumably more knowledgeable in their specialized domain, what exactly the relevant domain may be, and thus whose methodologies may be more reliable, depends on the goals to be reached. For example, what would count as relevant considerations in risk assessment cannot be determined a priori—they are based on our value judgment of various forms of occurrences.

Physicians, for example, are not only qualified in implementing their clinical knowledge. They are also generally equipped to evaluate their patients’ competence in reaching their decisions regarding various treatment options.
with their physicians' recommendations for chemotherapy despite the possibility that their cancer will progress or recur, they may not be challenging the experts' clinical knowledge in their specialized domain. Rather, they may be claiming that the clinical factors as the physician understands them are only part of their considerations, or that there are other relevant factors that have not been entertained by the professional. Experts may have a superior ability to answer certain questions within their specialized domain, questions that they want to concentrate on. However, their focus may differ from that of laypersons, who may have other goals in mind (e.g., spending quality time with one's family in final days without enduring harsh side effects from chemotherapy) or believe that there are other relevant questions that have been left out, such that the applicability of the experts' clinical knowledge to their situation may be limited.

**Lessons from Grieving Laypersons**

The possibility that experts and laypersons may have different focuses regarding a particular clinical issue suggests that the expert domain may be more limited than generally believed, and that laypersons may have insights into important matters that are often neglected by experts. A bi-directional and collaborative approach between experts and laypersons that attend to their respective perspectives is thus necessary to promote well-rounded knowledge. Experience in scientific and clinical data is certainly essential in determining appropriate care, but it is not always sufficient in facilitating understanding of the full picture. Take end-of-life care as an example. As a philosopher who also works as a clinical ethicist, some of the most challenging cases I encounter involve disagreements between the health-care team and the patient's family members, particularly in end-of-life care. The typical situation involves clinicians being concerned about family members' insistence on extending life-sustaining procedures for their loved ones against their professional judgment that the desired procedure will not provide any clinical benefit and may instead prolong suffering.

In these cases, clinicians are understandably frustrated. Compared to the lay family members, they have a superior ability to answer questions and apply their knowledge regarding the progression of various conditions. Many have had extensive clinical experience working with patients in similar conditions, and can with high accuracy predict the course of deterioration. In comparison, lay family members generally appear “too emotional” to see the picture objectively—some simply “don’t get it” or are “in denial.” This is particularly salient in cases where the patient/family comes from a different culture or speaks a different language, which further complicates the communication process and increases the chance of stereotypes for both sides. The usual assumption is that, when lay family members reject the team's science-based recommendations, their reasoning is faulty. These well-meaning and experienced professionals, who are focusing on the respective clinical implications of continuing and withholding various invasive procedures, often try to provide additional clinical information or clarification to the family, with the hope that they would come to understand the “objective” facts as the clinicians see them.

However, discussions with family members who presumably “lack insight” would sometimes reveal another picture. When asked to explain their loved ones’ situation, most lay family members do not go into clinical details or discuss objective scientific data—their goals are different. While in some situations this may be a sign of their inability to focus on or understand the right kind of information, in other cases an alternative explanation is that family members are concerned about not only clinical issues, but also other matters or goals. While clinicians are focusing on the natural progress of their patients' conditions and what physiological changes medicine can or cannot induce, some families are concentrating on the symbolic meanings of their decisions. Some talk about the importance of caring for and not giving up on their dying parent who raised them, while others voice their frustration with what they perceive to be an ageist medical establishment or a lack of distinction between killing and letting die. But one common thread that underlies the experience of many dissenting lay family members is their frustration that clinicians' expert opinions are consistently considered superior to their values and beliefs regarding their loved one’s wishes or interests, even if they have been the ones living with or caring for the patient for decades, as is sometimes the case for spouses of elderly patients.

In our increasingly technologically focused health-care system, when family members disagree with the clinicians' recommendations, they are often presumed to have little insight or to be making cognitive mistakes. Scientism, or the use of science as a norm of knowledge, equates clinical science and knowledge. Laypersons' subjective experience or understanding of their abilities and barriers, which are often unscientific, are rarely deemed necessary for such knowledge. Construction of knowledge in medicine is often limited to certain methodologies and perspectives, while laypersons' methods of processing and understanding their (loved ones') health experience are systemically dismissed as mere opinions or incapable of knowledge. However, such dismissal may be unjust or discriminatory, if it creates, maintains, or perpetuates a power hierarchy that negatively impacts patients' families' ability to negotiate for care that they deem appropriate. As some feminist epistemologists have warned, in the social process of conferring expert status, some knowers are often listened to, heard, and taken seriously, while others are systemically ignored. Even as differing social situations and positions produce varying understandings of the world, situated or subjective understandings of one's situation, such as patient and family narratives, are often disregarded as irrelevant or inevitably subpar compared to the universalist or objective accounts of knowledge such as clinical data. Although many family members who disagree with the professionals' recommendations may be familiar with a patient's medical, personal, and care history, since they may have accompanied the patient to medical appointments, discussed with health-care professionals regarding their loved one's conditions, searched for information from other sources, and/or cared for the patient at home and in the hospital, the status of these perspectives and particular experiences are sometimes ambiguous in the pursuit of clinical or “objective” knowledge of various conditions and management strategies. When professionals and patients identify different clinical features as salient and have different interpretations of various symptoms, professionals' interpretation of the event would often trump the patients' or families' own situated experiences based on the presumed credibility gap. While legal requirements regarding patients' rights often give family members the authority to make substituted decisions on behalf of their loved ones, when these family members disagree with clinicians' judgment, their reasoning is often automatically considered inferior.

**Bidirectional Epistemic Collaboration**

It is important to emphasize that my purpose is not to reject the notion of expertise or dismiss experts' clinical judgment. Rather, my goal is to raise questions of how care plans are determined, whose voices are considered in the process, and how disagreement is handled. Legitimate expert authority requires that the conventions of designating certain individuals as experts...
and the social privileges that accompany such authorization do not preclude ideological views from being challenged. In particular, we need to examine how these practices determine parameters for stakeholder deliberation, and whether the process of conferring hierarchical expert status reflects subtle and unintentional bias that nonetheless systematically disadvantage certain population groups. In determining whether selective consideration of some perspectives over others is legitimate, we need to determine not only the epistemic basis of rejecting certain forms of understandings, but also the social process of doing so.

The existence of epistemic hierarchy is of significant concern. When the credibility gap is taken for granted, not only may the experts’ ability to communicate their knowledge be limited to the extent our social structures continue to be unequal; their need to reflect on their own assumptions and the possibility of learning from the layperson’s experience and perspective may also be unduly constrained. This potentially “prejudicial dysfunction in testimonial practice,” as Miranda Fricker calls it, may give experts more credibility than the situation warrants and less credibility to families than they deserve, and prematurely dismiss considerations that are important for effective clinical care. A commitment to what I call epistemic humility, on the other hand, whereby a professional recognizes the boundary of his expert domain as well as his fallibility, can help to minimize any prejudicial hierarchy and promote epistemological strength of one’s position. It can help to prevent one from being close-minded, dogmatic, or blithely impervious to criticism. As many have argued in support of patient autonomy, while medical professionals are generally experts in applying scientific data to various clinical situations, patients are the ones who are most knowledgeable of what they would like their situation to be. Acknowledgment and consideration of diverse perspectives can thus help provide other missing pieces to the puzzle. Realization that good end-of-life care is not simply about clinical indications but also other important symbolic and social meanings can help to advance creative care plans that are not only clinically sound, but also respectful of all stakeholders’ needs.

Consideration of dissent is also normatively important, particularly in the face of power hierarchy, since “experts” are gatekeepers of information and resources. Even as the Internet has given laypersons newfound opportunities to access information and to learn more about their conditions and treatment options, so much so that some are now worried that patients may self-diagnose, medical experts retain the power to decide what further information and diagnostic or therapeutic alternatives will be made available, what referrals will be recommended, and what insurance or social programs for which patients will be eligible. It is thus important to examine if the process of inquiry is itself epistemologically sound and procedurally fair, and if anyone is wronged in her capacity as a knower. For example, we need to ask whether the voices, interests, and disagreements of those who are most affected, such as patients and their families, may be prematurely rejected as not credible. We need to ensure that experts’ concept of knowledge as embedded in our clinical practices and decision-making process is not dismissive of relevant voices. To avoid prejudicially favoring the inquiry methods and perspectives of some social groups over those of others, it is important to examine the epistemic grounds for such methodological hierarchy. We need to ask what we want the processes of authorizing certain individuals as medical “experts” to do for us, and whether the practices that accompany such authorization may marginalize patients and their families, undermine or dismiss their lived experience, or exclude them from challenging the “expert” viewpoints.

Medical experts, who are highly educated and specialized in their domains, often understand the world differently from their lay patients. Despite their good intentions, the former are driven by internal problems of their domains that do not always coincide with concerns of patients and their families. When medical practices are uninformed by the experience of patients and/or their families, we are both subjecting patients/families to a form of epistemic injustice and denying “experts” a full understanding of the matter in question. By paying attention to the lay patients’ or families’ perspectives and promoting dialogues between participants with epistemic differences, a bidirectional process can refine or enhance professionals’ own understanding of their theoretical framework and also promote responsive patient care. Understanding of what would constitute the best procedures and outcomes for various patients can be sharpened by engaging those who may be differently situated. It is especially important to engage in ongoing dialogue when parties of unequal power approach the matter of the domain differently, particularly when the different understandings may have significant impact on the identity and well-being of the party with less power.

Endnotes

1. I would like to thank Dr. Dave Unger for his critical and constructive comments on an earlier draft. I would also like to thank the participants at the ASBH Philosophy Affinity Group (2008) for their comments.

2. These experts are what Alan Goldman calls cognitive or intellectual experts. For our purpose here, we will not be discussing the other kind of experts, i.e., those who are unusually accomplished at certain skills, including elite athletes, musicians, etc. See Alan Goldman, “Experts: Which Ones Should You Trust?” Philosophy and Phenomenological Research 63 (2001): 85-110.


5. Goldman 2001, 92.

6. Ibid., 89.


8. The fact that federal agencies often require researchers to include a disclaimer that the opinions and statements contained in their public presentations or published works are those of the authors only and do not represent the opinions or interests of the agencies at which the authors work...


12. It is taken for granted that one of the main goals of medical science is the pursuit of knowledge for the sake of better descriptions and treatment options. Such goal or value permeates all activities in research and practice—it is
against this ideal that a medical scientist’s or practitioner’s methodologies and professional integrity are measured. This view of medicine as being value-laden is generally accepted, and it will not be the focus of our discussion here. My main concern is how subjective values influence medical research and practice.

13. It is also important to note that conflict of interests may also influence scientists’ judgment. However, it is beyond the scope of this essay to investigate such issue. My main concern here is that, even without financial incentives potentially affecting one’s objectivity, scientists’ values and beliefs inevitably shape the way they pursue and investigate various hypotheses.


15. Ibid., 98-100.

16. As some have argued, whether various conditions, such as deafness, may disable a person depends not so much on the impairment itself, but the social structure.


20. However, in August 2008, the FDA announced several improved policies and procedures strengthening its management of FDA advisory committees. The improvements include stricter limits on financial conflicts of interest for committee members, improved voting procedures, and improvements to the processes for disclosing information pertaining both to advisory committee members and to specific matters considered at advisory committee meetings. For more information, see U.S. Food and Drug Administration. “FDA Announces Improved Policies Regarding Transparency, Public Disclosure for Advisory Committees.” http://www.fda.gov/ohrms/dockets/ac/08/notice-08-0065.htm (accessed on September 15, 2008).


28. Approved by the FDA in 1999 and averaging $2.5 billion in sales a year, the arthritis pain medication was taken off the market in 2004 over widespread concern about its safety. For long-term, high-dose usage, the drug more than doubled patients’ risks for heart attacks and strokes. In 2005, a study showed an estimated 88,000 to 140,000 excess cases of serious coronary heart disease probably occurred in the USA over the market-life of Vioxx. See David Graham, David Campen, Rita Hui, Michele Spence, Craig Cheetham, Gerald Levy, Stanford Shoor, and Wayne A Ray, "Risk of Acute Myocardial Infarction and Sudden Cardiac Death in Patients Treated with Cyclo-Oxygenase 2 Selective and Non-Selective Non-Steroidal Anti-Inflammatory Drugs: Nested Case-Control Study." Lancet 365 (Feb 5-11, 2005): 475-81.


30. Ibid., 115-16.

31. The Supreme Court model of dissent may be helpful here. Describing the external impact of dissenting opinions, Chief Justice Hughes famously said: “A dissent in a Court of last resort is an appeal…to the intelligence of a future day, when a later decision may possibly correct the error into which the dissenting judge believes the court to have been betrayed.” See Alan Barth, Prophets With Honor: Great Dissents and Great Dissenters on the Supreme Court (Random House, 1974).


35. Ibid., 31.

36. It is interesting to note that the USDA took a different approach on the issue of food from clones from Margolis’s recommendation. Partly because of such public wariness and “the emotional nature of this issue,” the USDA requested an ongoing voluntary moratorium to buy time for “an acceptance process” that consumers in the United States and abroad may need.

37. For example, not all medical schools impose the same requirements; medical boards around the world also have different licensing and accreditation criteria. Even in the same country, requirements change not only based on clinical factors, but also historical, economic, technological, and other social factors. The kinds of procedures a licensed physician in any subspecialty is expected to be able to perform, for instance, are based partly on local disease patterns, technological levels, how various specialties are defined and delineated, as well as social needs and priorities.


39. Interestingly, estranged family members who are called on to make decisions for the patients rarely disagree with clinicians’ judgment. They usually would indicate to the team that they would go with whatever the latter recommends. Some of them do not wish to understand the clinical matter—they simply want to “wash their hands” and have nothing else to do with the patient. Nonetheless, it is worth noting that these cases rarely, if ever, lead to ethics consultation requests or questions regarding the estranged family member’s understanding of the clinical matter.

40. MacDonald 2004, 182.
The Case for Applied Philosophy

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Peter Raabe’s book *Philosophical Counseling* is subtitled “Theory and Practice,” and the book, true to its claim, promotes a particular theory of philosophical counseling as well as relating a series of case studies from Raabe’s own practice. In introducing these narratives, Raabe argues that each “can not only serve as a vivid illustration of a particular method or approach, it can act as an experiential affirmation of theoretical claims. The case studies offered... are meant to both illustrate and affirm the effectiveness of philosophy when put to use as counseling in the hands of a trained philosopher” (222). This belief in the importance of cases is mirrored by philosophical counseling’s sibling discipline, bioethics. Like philosophical counselors, bioethicists have long maintained that one of the central features of their discipline, one that differentiates them from theoretical philosophers, is that their work must be shown to resolve real life cases. Cases become the data upon which bioethicists test out their theories. Bioethicists have long thought that this testing also prevented them from falling into the sins of moral philosophers who demonstrate the validity of their ideas on hypothetical cases. Dena Davis contends that “by describing real experiences ethicists can make points and draw conclusions while inviting their readers to make their own independent judgments” (13). Like Raabe, Davis emphasizes the dual function of the ability of case presentations to both illustrate and test out theoretical claims. It is for this reason that bioethicists like John Arras strongly advise against using hypothetical cases for such cases “so beloved of academic philosophers, tend to be theory-driven; that is, they are usually designed to advance some explicitly theoretical point. Real cases, on the other hand, are more likely to display the sort of moral complexity and untidiness that demand the (non-deductive) weighing and balancing of competing moral considerations...” (37).

What has remained a troubling feature of this argument for the naturalness of real cases is that cases are not natural elements but by their very narratological nature constructions of the world and thus I contend should be considered as tainted, that is, as theory-driven, as the scorned hypothetical. For narratological choices are rhetorical choices, they are attempts by authors, in the literary critic Wayne Booth’s words, “consciously or unconsciously, to impose his...world upon the reader.” Booth is particularly relevant here for his most celebrated study of narrative, *The Rhetoric of Fiction*, begins with a discussion of the difference between “telling” and “showing” in literature. Great writers are those that are said to refuse to put their opinion into their fictional works but instead simply show the world. Booth challenges this hierarchy and instead submits that it is a false dichotomy. Those that are supposedly simply “showing” are really “telling,” that is, “Everything he shows will serve to tell; the line between showing and telling is always to some degree an arbitrary one” (20). While applied philosophers may believe that they are simply showing the world the instance of a case of refusal of treatment or one of a man unable to know how to live his life following the revelation of an infidelity, narrative theorists have demonstrate that narrative choices are also epistemological and moral choices.

Let me provide one example of how narrative features can rhetorically support particular philosophical approaches.

In *Philosophy in Medicine*, Charles Culver, a psychiatrist, and Bernard Gert, a philosopher, examine a variety of philosophical issues that relate to psychiatry. One issue they analyze in depth is the ability of patients to make rational decisions concerning end of life care. Here is one of their cases they use to think through this issue:

Miss A is a 52-year-old woman with advanced and increasingly painful pancreatic cancer. She has been informed by her physician that her life expectancy is no more than two or three months and that little more than palliation can be offered to her. She has no close living relatives and few obligations. She can see no point in enduring several months of pain before experiencing her certain death. She has access to a lethal quantity of barbiturates and plans to take them after setting a few personal affairs in order. (21)

Following a similarly brief description of a man who compulsively wishes to commit suicide, Culver and Gert conclude that, “Most people feel very differently about these two cases. Miss A’s plan to die does not seem irrational in her circumstances, though of course if she chose to live out her remaining months as best she could, that decision would not seem irrational either” (22).

Now look at a similar case by Jodi Halpern, a psychiatrist and a philosopher, of a woman who is making a choice that will also result in her death. Halpern’s *From Detached Concern to Empathy* begins with “The Case of Ms. G.”

A medical-surgical team at an East Coast hospital requested a psychiatric consultation for Ms. G., a fifty-six-year-old white woman with diabetes mellitus who had just had her second above-the-knee amputation. She had a long history of kidney failure, was not a candidate for a transplant, and required dialysis three times a week. Although she had willingly come to the hospital for surgery, she was now refusing dialysis, even though she knew that without it she would die in a matter of days. She refused to tell the medical team why, so they wanted both a psychiatrist and an ethicist to evaluate her decision-making capacity....

As a trainee on the psychiatry service, I was sent first to see the patient and report back. I walked into Ms. G.’s hospital room and was shocked to see a child-sized, bony woman curled up under the covers, eyes closed, head shrouded, with her back to the world. She was

42. Anita Ho. “Using Family Members as Interpreters in the Clinical Setting.” *Journal of Clinical Ethics* 19 (Fall 2008): 229-33.
43. Interestingly, when family members agree, there is often little effort to ascertain their understanding.
47. This is particularly a concern in the age of HMOs, where physicians’ “expert” opinions may be made in the context of cost containment.
in obvious pain, face tensed and mouth wide open, as if to yell, although silent, reminding me of Eduard Munch’s painting The Scream. My first instinct was to run to her medical team and say, “Give her some morphine.” But I remember that one reason the medical team had called for a psychiatric consultation was that no safe amount of pain medication seemed to affect Ms. G’s pain. “We’re giving her enough morphine to keep a large man comfortable,” the intern said when he called me. (1-2)

Later after an initial interview with the woman, Halpern returns to find a group of Ms. G.’s friends outside her room. They are very concerned about their friend and one says to Halpern “Ask her about her husband, that creep.” After some exercises designed to relax Ms. G., Halpern asks her, “Is there anything besides your body that is hurting you?”

Her eyes shut, she began to speak to me for the first time. “Yes...but I don’t want to talk about it,” she murmured, “I just want to go to sleep.” I waited silently to see if she would say more. After a long pause she spoke very quietly. “My husband doesn’t love me anymore,” she began. “He told me that he’s in love with someone else. He moved in with her while I was in the hospital. He said that with my amputations and other medical problems, he could never be attracted to me.” She started to cry.

Listening to her story, I imagined facing a future in which I was literally cut off at the knees and abandoned by my husband, with no legs to stand on. But before I could say anything, Ms. G. turned to me and looked me in the eyes of the first time. She looked furious, and I felt almost afraid that she would throw something at me or hurt herself. She screamed out, “Why the hell did you ask me to talk about this? I told you I didn’t want to talk. I just want to be left in peace, to sleep and never wake up. Making me think about what he said is the cruellest thing anyone has ever done to me. Don’t ask me any more questions! Get out of here!” (2-3)

Simply for the sake of brevity, I wish to examine briefly the issue of the narrator used in both of these cases. Narrative theorists have been attentive to the variety of narrators that can be constructed for any particular story. One distinction—one relevant to these cases—is between absent narrators and mediated narratives. All narratives are assumed to be told by some personal entity but in some stories the narrator is not an explicit feature of the narrative event. Instead an impersonal or absent narrator tells the story but such stories “avoid the appearance of being told” (34). It is this kind of narrator that we find in the case by Culver and Gert. Such narratives by hiding the teller give the reader the impression that the information given is objective, that nothing is being concealed for the gain of the person telling. A second kind of narrative is one that has a mediated narrator. In this the narrator is an explicit part of the telling, even if this narrator does not participate in the story action. In Halpern’s case we have a mediated narrator, and it is a narrator that we identify with the author of the story. In fact, Halpern’s case is unique in the degree in which the case narrator and the philosophical narrator are explicitly the same entity. In Culver and Gert’s book, the case is presented as if it were taken from another source; it is separated from the rest of the text and by doing so, it gives the appearance that the case is simply quoted material told by an effaced narrator. Both of these narrator constructions supports the particular positions of these books, supports them even prior to the authors analysis of them. Culver and Gert take a traditional analytical approach to bioethics; they argue their primary purpose is to use philosophy to clarify psychiatry. They use this case to demonstrate an example of a desire for death that is clearly “rational.” Halpern wishes in her book to show quite the opposite. She argues that her case clearly shows that psychiatric issues can assist our philosophical analysis. The narrator constructed in Culver and Gert’s case inherently supports their rationalistic position. Halpern’s mediated narrator tries to present a complex world of hidden desires and unattended psychiatric issues. Everything is not as it first appears, but rather there is a world that needs to be revealed over time. Culver and Gert wish to show that philosophy can provide clarification to psychiatry’s dilemmas; Halpern wishes to show that psychiatry can complicate philosophy’s solutions. Each would have difficulty proving their point with the other’s case.

Cases tend to rhetorically support arguments in bioethics rather than challenge them, and, I contend, they are constructed to do so. I wish to argue today that the same can be said of cases in philosophical counseling, that is, rather than provide “experiential affirmation of theoretical claims” they tend to affirm the theoretical claims by tainting the evidence through the style of the narrative. While for the bioethics cases above I examined the issue of who sees, I will look at three different ways in which the issue of voice, or who speaks, can affect one’s evaluation of a case in philosophical counseling.

Peter Atterton’s essay “Philosophy as a Practice for Life” is essentially a case study of one of his clients in a series of philosophical counseling sessions. The case entails Tim, who has come to Atterton because “he was unfulfilled in his work and also undecided about his future” (89). In his introduction to the case, Atterton explains that he adopted “an existential mode of philosophical counseling” for Tim’s case for he believes that such an approach is particularly “well suited for expressing life-affirming values” (89). Yet what is particularly telling about this case presentation is that Tim has not come to Atterton because he does not find his life to be fulfilling but rather because of work and his future. Throughout his five sessions with Tim, Atterton transforms Tim’s problems from ones about work to ones about existential crisis. Although the sessions are unsuccessful from Tim’s point of view, the text persuades us that this is due primarily to Tim’s inability to see the true root of his own problems. One of the most interesting narrative features of Atterton’s case is the continual movement from direct speech to free indirect speech. Direct speech are instances where speech is represented directly through quotation: he asked, “Are you a philosophical counselor?” Indirect speech entails representation without quotation marks: he asked the man if he was a philosophical counselor. Finally, free indirect speech are representations which lack any indication of a separation of the narrative voice from the quoted voice: was he a philosophical counselor? Below is an example of how Atterton moves from direct to free indirect speech.

I asked Tim what it was about his job he didn’t like. He said he was not “respected” and that his friends and acquaintances “looked down on him.” That Tim had internalized these negative evaluations became clear to me when he referred to himself in self-deprecatory fashion, with no hint of irony, as a “mere teller.” I asked him what he meant by that. Surely, he did not want to say that he was just a teller, and nothing else? He exclaimed “Of course! I am a teller. That’s what I do.” I explained to him the existentialist view that human beings have no fixed or permanent essence. While it was true that he was a teller in the sense that he conducted the routine transactions of a bank, it was...
This transformation in the representation of speech coincides with Atterton’s transformation in the narration of Tim’s problems from an issue of his job to an issue of existential freedom. In her study of the way consciousness is represented in narrative Dorrit Cohn observes that one of the rhetorically powerful features of the use of free indirect speech is that it “creates the illusion of a fiction that ‘tells itself,’ without the ministrations of a narrator” (169). This form of presenting interpretation, that is, as if it simply tells itself, permits Atterton to metamorphize Tim’s case into one that focuses on existential problems and it does so with the impression by the reader that this is simply a natural way of seeing Tim’s case for it is done as if the interpretation is self-evident.

My second example is from Raabe’s Philosophical Counseling. In this work, Raabe argues for a four-stage model of philosophical counseling; these stages move from an initial free-floating stage of listening to the counselor working to resolve the client’s immediate problems to the counselor acting as a teacher to a final stage where the client is able to challenge his or her own worldview. Raabe is careful to point out that clients may only need to arrive at particular stages or may themselves already be prepared to move to a more advanced stage prior to the counseling sessions. His first case study in Philosophical Counseling concerns Veronica:

Veronica... is reluctant to begin our philosophical counseling session. She speaks hesitantly almost apologetically, and in a quiet voice. She seems somewhat confused when she tells me she has come to see me because she has too much pride and needs to do something about it. It seems odd to me that this attractive, twenty-four-year-old, and well-educated young woman sees herself as having to reduce her pride. When I ask her why she thinks she has “too much pride” she explains that her boyfriend, with whom she has had a long-term relationship, often tells her so.

“He says I ought to be careful not to be so proud,” she tells me, “because it’s just not good for a person.” (222)

Raabe’s case begins with a young woman who is “reluctant to begin” and then speaks in an apologetic, quiet voice. When she is quoted directly it is actually a quote of an indirect quote, that is, of her boyfriend’s criticism of her. For the first half of the case, it is only Raabe that is given direct voice and Veronica is quoted indirectly only permitted indirect quotes. It is when Raabe enters into the second stage of his method that he gives Veronica direct quotes.

Then I ask, “Are you a good researcher?” She seems at a loss for words; she hesitates for a long time. I give her time to think but she looks increasingly uncomfortable.

Finally I say, “This is not a trick question,” and she bursts out laughing but quickly stops herself. I ask her to describe what she thinks would be a poor researcher.

“That’s easy,” she says. “It’s someone who isn’t thorough; who doesn’t do the legwork; who isn’t on time and on budget.” So I ask her if she is like this. “No,” she says immediately. “I’m not a bad researcher.”
Response to Chambers

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I would like to attend first to the title of Tod Chambers’ essay: “The Case for Applied Philosophy.” Ordinarily we might assume that what is meant by such a title is that the author will be making a case or presenting an argument on behalf of something. An expectation is awakened—that the idea of “applied philosophy” is itself at stake in some way and that an argument is to be presented in support of it. Giving this argument would be “making a case.” But here we see that the other way of reading the title is that what is under consideration is rather the use of the case within applied philosophy. By emphasizing the case and the role it plays for applied philosophy are we somehow led back to another goal, that of making a case for applied philosophy? One thing we see when we ask these questions is something that Professor Chambers is trying to demonstrate—that a case is something that is made, constructed. When we say that someone is “making a case” for something it implies various activities: marshaling evidence, an attempt to use this evidence to set forth an argument in the attempt to convince. In the cases he discusses, Professor Chambers sets out to show that because cases are made, not found, it is precisely the rhetorical elements which threaten their suitability for use by applied philosophers in making the case for their own activity. This is because the cases are made in such a way that they tend to rhetorically support the argument.
being made leaving a roadblock or a blind spot for an effort to challenge theory on the basis of the case as presented.

Chambers, in addressing the issue of case narratives within the literature on philosophical counseling, calls upon us to be aware of how narrative features rhetorically support particular philosophical approaches. A comparison is being made here between two “Applied” disciplines of philosophy—that of bioethics and that of philosophical counseling. He refers to them as sibling disciplines. Working within the distinction of applied and theoretical philosophy, he identifies the “ability to resolve cases” as a feature shared by both bioethics and philosophical counseling. I think Chambers is right to direct our attention to rhetoric as a crucial component in understanding moral reflection. I find the examples he uses to be quite effective in making his point that the case is constructed in such a way as to rhetorically support the position of the philosopher. It also rhetorically supports a view of philosophical counseling which is somewhat clinical and therapeutic in its orientation, oriented towards what philosophy can offer to counseling. Rather than predictably avoiding the cases he analyzes, as a theoretical philosopher might be expected do, I want to look at those cases, as well as offer up some brief reflections of my own about the rhetoric of cases within the philosophical texts I teach and use pedagogically in my own practice of philosophy.

I want to examine Chambers’s claim, taken over from Peter Raabe, that the ability to resolve cases is a crucial shared feature of the two disciplines. In what has been called “quandary ethics,” where what is aimed at is a decision or a decision-method, achieving a “resolution” seems to be a somewhat narrowly defined goal. In the case of psychoanalysis, Freud once stated that the goal was to replace neurotic suffering with ordinary human misery. What does “resolve” mean in the case of philosophical practice? It is in this light which we should ask whether the case narrative is really used in the same way in a bioethics text and in the reportage of philosophical counseling sessions, such as those offered by Atterton, Raabe, and Cohen. By focusing on the narrative we are driven to question the notion of “resolving a case” which is at work in philosophical counseling.

Robert Walsh, in his article “Philosophical Counseling Practice,” offers a view of philosophy which calls for a consciously articulated autobiographical expression or personal admission on the part of the philosophical practitioner. Chambers and I have at least one thing in common: neither of us has a philosophical counseling practice. Still, on occasion I find myself not only confronted with the earnest hypothetical questions of college students trying to make some points of contact between the philosophical texts we study and their personal worldviews, but also on the receiving end of pressing questions such as “Should I have an abortion?” she may be expecting that I will have my own philosophical “answer” based on the application of a certain philosophical viewpoint or argument and that I will want to convince her of my conclusion. This would be a flatfooted conception of “applying” philosophy—taking a general conclusion about what is right or wrong in principle and applying it to the specific case at hand. In a similar vein, Raabe states in his book “Issues in Philosophical Counseling” that:

Philosophical counseling is not applied philosophy. Applied philosophy is a largely academic endeavor involving the insertion of preconceptualized formulas, recipes, and principles for correct thought and action into hypothetical, and predominantly moral, dilemmas. Philosophical counseling is an activity or process that develops meaningful and useful insights and puts those insights to use in significant real-life issues in order to alleviate suffering, distress, and confusion. It is the agreed-upon cooperation between two…to establish an investigative atmosphere which is meant, in one stage of the process, to lead to the resolution of immediate personal problems and concerns.

Rather than give a monologue, I initiate a dialogue which takes into account what I know of the situation, the person asking the question, their emotions, and a whole host of considerations that bear upon my relationship with the person who is seeking answers with me. Rhetoric, it has been said, is the study of the appropriate speech by the right person, at the right time, in the right manner. In this way, philosophy is “applied” to the specific case insofar as a particular way of questioning and clarifying concepts and inferences takes place and rhetoric will play a role in a counseling session just as it will resurface in the recounting of that session. The fact that in both cases the rhetorical constructions would support the philosophical approach is only to be expected, if the philosopher herself is an active participant in the case, as a dialogue partner
whose views and concepts are being tested along with the views and concepts of the client.

In the realm of bioethics, the empirical case narrative is sometimes said to be superior to the hypothetical case because the latter is theory-driven while the former, being drawn from reality, supposedly is not. Furthermore, the empirical case is supposed to allow the bioethicist to test theories because they display elements of “complexity” and untidiness that the streamlined hypothetical, constructed to prove a theoretical point, does not. We have been invited to reflect on these presumptions. Chambers argues that because cases are constructed narratives, mediated representations, not “the thing itself,” they should be taken as “tainted”—as “theory-driven as the scorned hypothetical.”

Being told that your “case narrative” is “tainted” by a rhetoric which implicitly supports the theory you are propounding is potentially worrisome if you are attempting to test your theory against the case. According to Chambers, “All representations must adopt a particular point of view and that point of view will always carry with it a partial and limited understanding of the world.” Despite the admission that a “view from nowhere is impossible,” the very distinction between the reality and the representation carries with it the deeper implication that philosophers are supposed to have an “adequate normative perspective” which can offer a ‘basis’ for our moral obligations to others. In The Fiction of Bioethics, Chambers raises the issue of the ultimately fictional nature of the bioethics case in order to make the discipline more “self-reflective” just as “a more self-reflective posture has been developed in other disciplines.”

The bioethicist, aiming to test theories with cases, and ultimately give guidance to professionals such as surgeons, health-care policymakers, scientific researchers, and even health-care consumers is thus charged with a certain naiveté about cases as mere uninterpreted data. So the aim, according to Chambers, is not to write “unbiased” case narratives, but to become more adept at reading these narratives. If we become more adept we can separate the theory from the representation and see that the representation was biased by the theory all along.

We must realize the fictional nature of our cases, he says, and bring the tools of narrative to bear on reading the philosophical text. We have come to the broader question: How is philosophy itself to be understood when it approaches the precinct of literature?

I cannot help but wonder if underlying this concern with rhetoric is really a distrust. It is as if the rhetorical component is somehow a dangerous aspect of the text which the philosopher has lost control over and which needs to be regained. I am reminded of Arthur Danto’s remark in his book Nietzsche as Philosopher that Nietzsche’s language “would have been less colorful if he had known what he was trying to say.” The claim is that his style of writing is inseparable from his failure to know what he was trying to say. The colorful nature of his prose is seen to be the element which makes his thinking non-philosophical. Danto also claims that there has been enough progress in philosophy to put us in the position of being able to understand what is philosophically important in Nietzsche better than Nietzsche himself was able to do. But Nietzsche’s style does not just obscure what is philosophically significant. It is itself intrinsic to his thinking. His thought challenges common sense, so what he has to say might often seem like nonsense.

But let’s return to the consideration of the cases. It is significant that in all the cases from philosophical counseling sessions which Chambers discusses, he approaches the analysis of the narratives by way of the question of voice, particularly the use of direct versus indirect or free indirect speech. Recounting a session is, after all, making a dialogue into a story. Although Chambers says that the rhetoric of a case always conceals as well as reveals, and even serves to thwart the reader, he shows with the analysis of narrative that cases constructed to support a theory can also be used to question or undermine the theory or argument being made.

The case in applied philosophy is important because it allows for testing of theory. The theory is tested to the extent that the case is resolved.

But the last case mentioned, that written by Elliott Cohen to show the use of logic in counseling, is particularly important. We might be tempted to think that rhetoric and theory are opposed. One, after all, seems poetic, subjective, and irrelevant to good philosophy at best, coercive at worst, while the other signifies detachment and objectivity. But what the gloss on the last case shows us is that the opposition which should be of more concern to the philosophical counselor is that of monologue versus dialogue.

What the analysis of the narrative can show us is the extent to which truth-seeking in philosophical counseling has not been fully dialogical, but monologial. In the example of Cohen’s case, even a direct quotation of the exchange between counselor and counselee, which is written in the most explicit dialogical form, is described as exemplifying the later Platonic dialogues in which conversations are merely used as dramatic mountpieces for presenting already-determined truths. There is no real truth seeking when the dialogue is thoroughly one-sided. If rhetoric is the art of implanting a view into the soul of the other, as Socrates claims, then we might see rhetoric as the tool of mono-logic and thus as the true enemy of philosophical counseling practice.

Chambers says that if we ignore the narrative features of a case we risk our ability to verify the arguments. At one level this means that we risk losing our ability to judge whether the case has been resolved in such a way that truly tests and confirms the theory being offered. In the dialogue given by Cohen, we see that the counselee has been led, logically, to admit that her belief that the man should make all the decisions is false. The counselor helps to produce a counterexample to the belief and shows her concluding that: “I should make the [decisions] I’m best at making.” But we should wonder whether this fragment of dialogue is really evidence that logic was useful in this counseling session or not. Because the verbatim transcript gives us no rhetorical cues to the emotive quality of the exchange we are left, in a sense, without the closure of knowing how this bit of logical reasoning was “taken to heart” so to speak. Did it result in any sort of insight which was integratable into the whole life of the counselee? We see that this is really the bottom line criticism of Atterton’s case as well. Chambers uses the move from direct speech to free indirect speech on Atterton’s part to show that the counselor in this case transforms the counselee’s perceived problems (regarding work fulfillment and uncertainty about the future) into what the philosopher’s method demands: that these specific problems are evidence of existential crisis which must be confronted. This case, we are told by Chambers, was one in which the counselee believed the sessions to have been unsuccessful. How can a case which did not “resolve” to the satisfaction of the counselor, provide evidence to support the theory that the man should make all the decisions is false. The theory being offered. In the dialogue given by Cohen, we see that the counselee has been led, logically, to admit that her belief that the man should make all the decisions is false. The counselor helps to produce a counterexample to the belief and shows her concluding that: “I should make the [decisions] I’m best at making.” But we should wonder whether this fragment of dialogue is really evidence that logic was useful in this counseling session or not. Because the verbatim transcript gives us no rhetorical cues to the emotive quality of the exchange we are left, in a sense, without the closure of knowing how this bit of logical reasoning was “taken to heart” so to speak. Did it result in any sort of insight which was integratable into the whole life of the counselee? We see that this is really the bottom line criticism of Atterton’s case as well. Chambers uses the move from direct speech to free indirect speech on Atterton’s part to show that the counselor in this case transforms the counselee’s perceived problems (regarding work fulfillment and uncertainty about the future) into what the philosopher’s method demands: that these specific problems are evidence of existential crisis which must be confronted. This case, we are told by Chambers, was one in which the counselee believed the sessions to have been unsuccessful. How can a case which did not “resolve” to the satisfaction of the client or indeed we must imagine to the satisfaction of the counselor, provide evidence to support the theory that an existential approach in this case was the most appropriate? Chambers sees the use of free indirect speech as a way of persuading the reader that the fault lies with the counselee and not with the method.

The discussion of this case is infused with critique. What is at issue for the counselee is the extent to which he identifies himself with his work-role. The example Chambers uses to elucidate the difference between the forms of direct, indirect,
and free indirect speech is “Was he a philosophical counselor?” This question, when reading through initially, seems linked to the case as a question the counselee, Tim, might have asked Atterton. Just as Tim is invested in the question of identifying one’s essence by one’s work role, we are interested in whether the philosopher is guilty of the same bad faith that he sees in his client. In free indirect speech one is no longer sure who the narrative voice represents. Thus, when Chambers states, “Was he a philosophical counselor?” we imagine that Chambers himself is asking, or that we ourselves should ask—does this case narrative reflect what one would hope to see happen if the philosopher were truly engaging in dialogical truth-seeking rather than monological truth-telling? The irony is made all the more clear when we see that Tim’s job is to be a teller at a bank. And this, indeed, is what Chambers seems to be suggesting that the counselor is, narratively, and perhaps was within the counseling situation itself. He is a “teller” because his use of the indirect creates an illusion of a fiction that tells itself. But, connecting the issue of “telling” with the question “Was he a philosophical counselor?” perhaps we are being persuaded to ask if the case itself does not serve to show the counselor as someone who is “telling” truth to the counselee in a way which leaves him unaffected and unchanged.

It is worth noting here that perhaps indirect speech is more useful as a tool within philosophical counseling than it is within the writerly reconstruction. Kierkegaard, the father of existentialism, believed that existential truths could only be communicated indirectly. His narrative constructions involved the use of pseudonyms, parables, and rewriting the same event from different angles. The effect of his narrative choices is to communicate something which cannot be stated directly—something which places the reader into a state of decision, which is to say, opens the person to her freedom. In order not to be a philosophical expert, sophist, monologist, or to use shorthand: a Teller, the counselor who seeks truth with a counselee would, according to Kierkegaard, “deceive the hearer into the truth.” Indirect communication challenges us to make imaginative choices, to see alternative possibilities of self-understanding that call for decision. And an example of this is, according to Kierkegaard, composing “jest and earnestness into a dialectical knot,” which the other must unknot. We see something of this in Raabe’s report of the session with Veronica. He asks her if she is a good researcher and she doesn’t know something of this in Raabe’s report of the session with Veronica. According to Kierkegaard, the experience of freedom is crucially related to the experience of anxiety and this view is taken over by Heidegger and Sartre. Counseling which would free one from anxiety rather than for anxiety would thus, on some construals, not be a philosophically coherent “resolution” of a case. This supports the placement of the resolution of immediate problems, on Raabe’s four stage model, at stage Two. The self-distancing and reflective freedom which comes with the ability to challenge one’s own worldview is not a picture of closure, but of opening, and beginning, rather than ending.

By focusing on narrative construction, the rhetorical element, we are brought back through Chambers’s delicate critique of the cases to what I identify as the tension between monologue and dialogue. Tendency to monologue, either in the counseling session or in the narrative reconstruction, is to be avoided by the truth-seeking counselor.

But saying this is not the same as saying that rhetoric is to be avoided. Chambers believes that it cannot be avoided in fact. I would go further and say that it should not be avoided in principle.

Here we see the basis for a different sort of kinship—not between philosophical counseling and bioethics, as sibling disciplines of applied philosophy. Understood in a certain way, philosophical counseling is not, as Raabe would argue, a form of applied philosophy. The kinship is that between the art of rhetoric and the art of medicine.

Philosophical counselors often trace their lineage back to Socrates, and his method of elenchic dialogue. It is thus important to remind ourselves that Socrates, in the Phaedrus, crucially identifies the proper practice of rhetoric with philosophy itself. The true rhetorician is a philosopher. As a psychagogy, or “soul-leading” enterprise, rhetoric is concerned with the health of the individual soul, just as medicine is concerned with the health of an individual body.

Socrates: “Rhetoric is to be considered the same as medicine.”

Phaedrus: “How so?”

Socrates: “In both cases there is a nature that we have to determine, the nature of the body in one, and of the soul in the other, if we mean to be scientific and not content with mere empirical routine when we apply medicine and diet to induce health and strength, or words and rules of conduct to implant such convictions and virtues as we desire.”

The Phaedrus also privileges the interplay of speaking over the composition of written texts, which Socrates says are a poor form of rhetoric. The text does not answer our questions, it is as silent as a painting. Indeed, the Phaedrus begins with the reading of a text on love by a famous rhetorician. Socrates, as in Raabe’s stage one, patiently listens to the monologue. We find that rhetoric is not envisioned here in its coercive form but in its “ideal form.” In the Gorgias, Socrates claims that rhetoric is a certain empirical knack for flattery and deceit which actually harms those who practice it. But in the Phaedrus we find that “Only someone who has seen the truth can recognize what the right kinds of discourse are” for leading another soul, a particular individual, to knowledge. “The only individual capable of being the right kind of rhetorical speaker will be the true philosopher and practitioner of dialectic.” The philosopher, according to Plato, must draw on the “true insight” to find the “right word which will influence” the listener.

Endnotes

Renewing the Stuff of Life: Stem Cells, Ethics, and Public Policy


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Cynthia Cohen’s Renewing the Stuff of Life: Stem Cells, Ethics, and Public Policy (Oxford 2007), is a terrific book, a welcome addition to the literature on stem cell research. It begins with a helpful overview of the science, which is as up-to-date as is possible in a field that changes from day to day. The book was written before the latest development in stem cell research: the direct derivation from adult somatic cells of induced pluripotent stem cells (iPS cells). This development has been widely touted as having the potential to defuse the ethical debate, since iPS cells are created without using eggs or destroying human embryos. This remains to be seen, since it is not yet known whether iPS cells can develop into fully functional somatic cells that can be used to treat disease. Moreover, iPS cells have sometimes turned into malignant cells. If these challenges are met, iPS cells might be a viable substitute for hES cells, but, at present, this remains to be seen.

Cohen provides a clear analysis of the moral significance of early human embryos in both secular and religious thought. There is, she argues, “no iron law of nature or morality that says that embryos created in vitro must only be used for procreation” (86). They can play a regenerative role in medicine, a role that is equally as worthy as the creation of new life. Early human embryos have moral significance and are owed special respect “not just because they symbolize the coming into being of human life in the procreative sense, but also because they symbolize the renewal of human life in the restorative and regenerative sense” (87). This broadened view of their moral significance “provides justification for the careful, well-consideration creation and use of human embryos in stem cell research.” This may seem to be at odds with Roman Catholic and fundamentalist Protestant views, but Cohen argues that the Christian Church did not regard early human embryos as individual human beings up until the nineteenth century. Moreover, recent Christian thought has resurrected the distinction between the unformed (or early) embryo and the formed fetus. Thus, some scholars thought the question of whether the early human embryo is a living human being as still under discussion in the Roman Catholic Church. Several Protestant groups regard the early human embryo as a potential, rather than actual, person, which is consistent with research that has well-justified objectives. The Jewish, Islamic, Buddhist, and Hindu traditions all are consistent with research on early embryos for therapeutic ends.

In the two penultimate chapters, Cohen provides an overview of stem cell research policy overseas and at home. I found particularly interesting her account of President Bush’s stem cell policy. The president considered the possibility of funding research that derived ES cells from embryos left over from infertility treatment, with the consent of their creators. The argument in favor of using discarded embryos is that they would perish in any event, and it is better that they be used for good purposes (scientific and medical research) than simply be discarded. Bush rejected this rationale, arguing that it is immoral to destroy human life, even for good purposes, and even if the embryos would die anyway. However, he did not rule out federal funding on hESCR altogether. The Bush approach allowed for research on stem cell lines created prior to 9 pm, August 9, 2001, the time of his speech to the nation, thus avoiding research that involved killing embryos. By refusing to fund research that killed embryos, Bush thought to avoid the charge of complicity, as that was elaborated in traditional Roman Catholic doctrine. However, as Cohen persuasively argues, Bush failed to understand that doctrine. As set out by the Pontifical Academy, it not only prohibits directly killing human embryos, but also research that depends upon the killing of embryos. Engaging in such research makes the researchers, and by implication, those who fund their work, complicit in the destruction of human life. Politically, it may have seemed to Bush and his advisers be a good compromise between unconditional backing of stem cell research and rejecting it entirely. However, the result was, as Cohen says, “a flawed ethical justification for their stem cell research policy” (176).

One of the more controversial issues in stem cell research is the creation of chimeras, that is, organisms that combine human and nonhuman cells. Traditionally, a chimera is a creature that has features from different kinds of beings, such as the chimera in Greek mythology with the head of a lion, the body of a goat, and the tail of a snake. Many people are either fascinated or repelled (or both) by the idea of chimeras, and associate the idea with science gone amuck. This has unfortunate results for the public’s understanding of the role of chimeras in research or clinical medicine. Chimeras are not the inventions of mad scientists. They are fairly commonplace in clinical medicine, as in the use of pig heart valves to replace defective human heart valves. The person with a pig valve in his heart doesn’t look like a mythical creature, although technically such a person is a chimera, as he has both human and non-human cells in his body. Such chimeras are no longer controversial.

Chimeras are crucial to stem cell research as a way of determining if the tissues and organs derived from human stem cells actually work. While scientists can derive stem cells in vitro, and even grow tissues from the stem cells in the laboratory, ultimately they need to find out whether the tissues will grow and function properly inside a living animal. One way to find this out would be to transplant the tissue into human beings, but this would unethical, since the risks are unknown. To determine safety and efficacy, experiments need to be done first on non-human animals, which means creating chimeras. Thus, so far from being mad science, the creation of chimeras is required by ethical stem cell research.

Another use of chimeras in stem cell research comes from nuclear transfer technology, or cloning. Cloning is a way to create embryos from which stem cells can be derived. The DNA from a somatic cell is placed inside an enucleated egg cell, and the resulting cell is electrically or chemically stimulated to start dividing. Once the embryo reaches the blastocyst stage, the stem cells are removed (which destroys the embryo). The advantage of cloning over fertilization as a means of creating embryos is that the resulting stem cells, and any tissue derived from them, will have exactly the same DNA as the donor. This means, in theory anyway, that the tissue could be transplanted into the donor’s body without fear of rejection, a huge problem in transplantation medicine.

So cloning has definite potential advantages, as a source of embryos. However, there is a problem with cloning, namely, that it requires a supply of eggs. If the eggs are human eggs, they must be removed from the bodies of women, at some risk and considerable inconvenience and burden. This raises a number of ethical questions. Should women be asked to provide eggs at all, or does this impose undue risks? If it is...
permissible to ask women for their eggs, should this be done on a volunteer basis, or is compensation justifiable, or perhaps ethically required? One way to avoid these ethical conundrums is to use non-human eggs for the cytoplasm into which human DNA is inserted. In both Australia and the UK, licenses have been granted to centers to use enucleated cow eggs in the derivation of hES cells. Cow eggs apparently are as good as human eggs for this purpose, but the embryos combine human and non-human cells, i.e., are chimeras. Is this morally acceptable?

Cohen examines four arguments that have been given against the creation of chimeras: (1) it is unnatural, (2) crosses species boundaries, (3) is morally repugnant, and (4) violates human dignity. Cohen easily dispatches the first three arguments as resting on questionable assumptions or failing to provide a sufficient basis for making moral judgments. However, she thinks that human dignity is morally significant, despite attacks in recent years from philosophers like Ruth Macklin. Cohen says very little about why she thinks human dignity is an important moral category. Instead, she simply appeals to its centrality in Kantian moral thought. For Kant, human beings have an unconditioned moral worth or dignity because they are moral agents, responsible for their actions and choices. In other words, dignity is equated with unconditioned moral worth, and is based on moral agency, the capacity to engage in moral reasoning and decision making. This itself might be questioned. Why should moral agency, which can result in doing evil as much as good, be the basis for unconditioned moral worth? However, even if Kant is right to accord moral agents unconditioned moral worth, this does not show that human beings, that is, members of the species homo sapiens, are possessed of this moral worth or dignity. For, as a number of recent philosophers have pointed out, not all human beings are moral agents; not all human beings even have the capacity to become moral agents. Therefore, either dignity is not possessed by all human beings, but only by moral agents (human or otherwise), or the attribution of dignity to all human beings is not explained in terms of moral agency (and is left unjustified).

Put that problem to one side. Most human beings are or will be moral agents and therefore have, on a Kantian view, unconditioned moral worth or dignity. What implications might this have for the creation of chimeras in stem cell research? Cohen maintains that it would be wrong to deprive beings with a capacity for moral agency from exercising that capacity. That’s why slavery is intrinsically wrong, even when it is not accompanied (as it usually is) with the infliction of suffering. The slave is a rational agent, who is not permitted to act as a rational agent, but rather is used as an instrument of another’s will. Taking the argument a step further, Cohen argues that it would be wrong to create beings whose capacity for rational thought and moral agency would be restricted. This might happen if non-human animals with human brains were created through the implantation of human neural cells in non-human brains. The concern, Cohen says, is that “certain human bodily components that are closely connected to the capacities associated with human dignity might be transferred to human-nonhuman chimeric beings and in that setting would be severely restricted in their exercise or even destroyed” (126).

Admittedly, this is only a very plausible theory in neuroscience, not something that is known with certainty. But given that it is very likely to be true, why talk as if it were a realistic possibility, and something about which recommendations are needed? This just plays into public fears and reinforces ignorance.

Moreover, even if it were possible to create a mouse with a human brain, why would that violate human dignity? Cohen’s explanation is that the resulting creature would be unable to exercise its distinctively human capacities because the rest of its body would not be human. But why assume that a human brain can function only in a human body? From a purely conceptual point of view, it does not seem necessary to have a human body to have human cognition. Think of Stuart Little in the children’s story by E. B. White. He wasn’t frustrated or incapable of exercising autonomy or moral agency. His human dignity wasn’t violated by having a mouse body. The real problem, I suspect, in creating chimeras is not that their dignity would be compromised, but that we wouldn’t know what to do with them. But that is a separate issue.

Finally, I do not think that it is politically wise to appeal to human dignity in the discussion of chimeras. This will be readily exploited by opponents of stem cell research. Consider the Human Chimera Prohibition Act of 2005, introduced by Senator Sam Brownback, which makes it a felony punishable by ten years in prison and a civil fine of at least $1 million, to create or attempt to create, a “human chimera.” The Act not only prohibits the creation of non-human life forms with human brains, but also the use of non-human eggs in the creation of cloned embryos, which, as I mentioned above, has decided ethical advantages. And it does all of this in the name of “respect for human dignity.” While such appeals to human dignity would no doubt be rejected by Cohen, we can expect that they will become a staple in the arsenal of those opposed to stem cell research. To avoid such broad-based use, bioethicists should limit appeals to human dignity to contexts where they clearly make sense, such as torture, slavery, the humiliation of prisoners, and the international sex trade, especially involving children.

This disagreement does not in any way diminish my respect for Cohen’s book, which deserves a careful reading by anyone interested in the ethics and policy of stem cell research.
Endnotes


ANNOUNCEMENT

The 13th Annual Philosophy of Nursing conference is being held at the University of the West of England in Bristol, UK, on 7-9 September 2009, on the theme of “Nursing in an Interdisciplinary World: Cooperation, Collaboration or Compromise?” The organizers have issued a call for papers. Submit abstracts of 300 words by May 1, 2009, to derek.sellman@uwe.ac.uk. Information and preliminary program available at www.ipons.dundee.ac.uk.