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MEDICAL PRACTICE AND SOCIAL AUTHORITY

ABSTRACT. Questions of medical ethics are often treated as especially difficult casuistical problems or as difficult cases illustrative of paradoxes or advantages in global moral theories. I argue here, in opposition to such approaches, for the inseparability of questions of social history and social theory from any normative assessment of medical practices. The focus of the discussion is the question of the legitimacy of the social authority exercised by physicians, and the insufficiency of traditional defences of such authority in liberal societies (voluntarist, informed consent approaches), as well as traditional attacks on such strategies (ideology critique). Seeing such authority as institution bound and role based, it is argued, can help reframe, more broadly and more adequately, what is an "ethical problem" in medical practice and why.

Key Words: authority, medicine, social theory

During the same twenty-five year period in which medical or bioethics established itself as a serious discipline in mainstream philosophy and medical education, an extensive literature on medical institutions and practices, work in the history, sociology and anthropology of medicine, also appeared. However, philosophical problems have often been posed in ways which have not allowed such social scientific analyses of medicine to contribute much to what have come to be regarded as the major ethical issues in the field. My attempt in the following is to suggest a way of framing the ethical problems in modern medical practice so that consideration of the historical, social and cultural dimensions of medicine must play an essential, not merely illustrative or incidental role, in what comes to count as an ethical problem and its possible resolution. This will require some (inadequate) attention to quite a comprehensive claim – the dependence in principle of any philosophical assessment of norms on a comprehensive social theory – but for the most part the defining issue in the following will be the problem of the social authority of physicians. The attempt will

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be to draw out from a consideration of this issue implications which suggest a possible alternative to liberal, voluntarist (or informed consent) accounts of "legitimate authority," as well as to familiar attacks on such liberal notions of authority, attacks which might all be loosely labelled "ideology critique."

(Another large issue surrounding these problems, especially the latter issue, which should be mentioned but cannot be pursued: the long history of attempts to render problematic or to criticize social modernization itself, attempts to attack the philosophical presuppositions underlying the official self-understanding of Enlightenment culture. In this context, the link between the social authority of modern science, and eventually in the twentieth century, the scientific status of medicine, is straightforward. In fact, in many ways, medical practice involves the most direct, everyday example of the social and ethical transformations involved in "Enlightenment culture" and so in the social implications of the growth of the authority of modern natural science. See, for example, Pippin, 1991.)

I shall not want to deny that, however described, framed, or posed, individual physicians face very difficult concrete ethical "dilemmas," calling for unusual casuistical and reflective sophistication. But it is reasonable to suggest that a number of aspects of what come to be experienced *as* dilemmas or problems, at a time, within one sort of social configuration of production, power and culture, and not another, cannot be fully understood without some attention to the function of institutions and institutional roles, the authority of institutional roles, and the historical origins of the sources and even the meaning of such authority. As noted, this is particularly true of the growth of professional authority in the United States, and the role of technological and scientific expertise in that story. Within this modern context, if the radical social critic Ivan Illich is even roughly right about the relatively recent transformation of doctors from artisans of a sort exercising a skill on a personally known individual, to a scientifically trained technician applying an institutionally sanctioned procedure to a class of patients (Illich, 1976), then many interesting questions arise about the nature of the social authority exercised by those who possess technical expertise (understood within modern norms of expertise), especially when that exercise is also a market function (and so where we might have reason to suspect the beneficent motives of the entepreneur-physician), and when it must take place within

a modern political culture where notions of liberty and egalitarianism exercise quite a strong social constraint on the conferring of any authority.

I.

I will be suggesting the following thesis: that contemporary medical practice raises the problem of medical authority, of what a physician is entitled to do, prohibit, interpret, etc., because he or she is a physician, and that we can only understand the legitimating sources of such authority in terms of *the secular resources of public or official Enlightenment culture as a whole*, by reference to a theory of such a society, and not primarily in terms of *the formal characteristics of the exchange or therapeutic relation between the individuals*. This requires discussion of a few points about the notion of authority.

Most obviously: you exercise *authority* if you can get someone to do or forebear from doing certain things. You tell someone what to do and he does it, because you told him and because you "have authority." Somewhat less obviously, you also exercise authority if you can get others to accept your view of the meaning, significance or value of some deed or state of affairs. These capacities count as authority if you can compel such compliance without direct reliance on coercive force or persuasion. The former is simply power; the latter suggests equals searching together for the resolution of problems. Obviously the sources of authority have something to do with legitimacy, and some sort of sanction. A professor's authority to credential students who take exams from her stems partly from some trust that her decisions are based on superior knowledge and judgmental fairness; a manager's authority in a business is linked to some acceptance of legitimacy, but usually has more to do with the power to dismiss someone from work (Starr, 1982, who also relies on Lukes, 1978; Weber, 1968; and Sennet, 1980).

Authority relations then are relations of inequality, involving some sort of suspension of private judgment; in the cases we are interested in, a voluntary suspension, based on some assumption of superior competence, and usually some fear of the bad consequences of acting "disobediently." In Mommsen's general description of authority, it represents more than advice but less than a command; advice which one may not safely ignore.

Now, to get the discussion started here, we should simply assume that the physician does in fact exercise some such form of social and cultural authority. Physicians, and credentialed physicians alone, are authorized to determine what must be done in various cases, or what forbidden, and are the only ones who may authoritatively state in various circumstances, what is happening, what is "serious," or even what is "hopeless." These capacities obviously include access to drugs and treatment; diagnostic authority difficult for the lay patient to comprehend or question; unilateral ability to frame and explain options; ability to determine with real social effect when a complaint can be labeled a symptom, whether someone can be pronounced sick even if he does not complain, and when to deny another the social benefits of being labelled "sick," even if the individual is in great distress.

In one sense, pointing out that physicians exercise authority is just to point out that physicians, like other professionals, fulfill functions determined, and limited, *by law*. They are licensed to do some things, dispense medications, certify injuries in disability claims, and are proscribed by law from other things (having sex with patients, experimenting on their own with drug therapies, etc.) In Flathman's sense they are "in authority," and we can at least in part explain their authority in the way we explain much *political* authority, by pointing to the existence of publicly sanctioned rules and procedures, and by reference to the legal institutions which originally instituted, and so legitimated, such rules and roles (Flathman, 1980).

However, a physician is also "*an* authority" in Flathman's sense, entrusted with authority by an ill or injured person not just because that physician is authorized or permitted to intervene, but, much more positively, because of a belief in the physician's superior expertise, and (here a much more complicated point) because of some sort of trust that a physician will make use of such expertise beneficently, in consideration only or mostly of the patient's welfare and/or autonomy, and not for mere profit, or in consideration only or mostly, of the outcome of some peer panel's evaluation in an HMO review procedure. So, while the issue of the status of the legal, rule.bound authority of a physician might be an independently interesting question, the larger problem at stake here encompasses both the role of the physician in authority and as an authority. This is because the basis of the willingness of societies to create positions of authority, backed by legal sanction, and

a willingness in private social exchanges to entrust physicians with authority to act, recommend, and interpret, reflect, to speak loosely, the same "societal attitudes," historical conventions, values, and so forth. (At least, this would be so for anyone who is not a strict legal positivist; see again Flathman, 1980, chapters two, three and four.) In the following, I'll be concentrating mostly on the normative status of the social, and not on the legal, character of a physician's authority, but the outcomes could apply, *mutatis mutandis*, to any consideration of the *bases* of legal authorization.

Several interesting problems arise here, even if one just concedes this much. The most immediate is the empirical and historical question: in what ways and on what basis *do* societies come to authorize suitable uses of a physician's capacities and the appropriate entitlements deriving from possession of such capacities? This, I take it, is the proper topic of much medical history, medical sociology and medical anthropology. In the case of the United States, the question of how a profession held in low esteem and mired in a complex and unwieldy competitive system, managed to create a degree of professional sovereignty and social authority unprecedented anywhere else in the world, is a fascinating one (told with great intelligence in Paul Starr's book).

To understand, though, that this issue (the historical and variable bases of such social authority) raises a variety of *normative* questions (and it will be those questions, rather than the sociological and historical controversies, with which I shall be concerned), one also has to concede a potentially controversial point: that the putative link between a physician's abilities to predict certain outcomes and intervene successfully, and the degree of her social authority, is not simply a direct or transparently rational one (as if the *entire* basis of such social authority is a rational assessment of the benefits to be gained and the harm avoided from trusting the professional judgment of a physician, from submitting to such authority).

In the first place, even if this rationalist account were true, it would still raise as a question how some collectively assigned "value" or meaning to the particular sorts of benefits a physician could provide were originally assigned or authorized, in competition, if you like, with other possible benefits and goods. As is familiar from many well known discussions of contractual or preference satisfaction models of rational exchanges, we must assume that the partners in such an exchange not only know what they

want, but have come to want what they want in some sort of undistorted or acceptable way, all in order for the whole account (at least as an account of rationality) to get started. In the case of trusting a physician's competence in exchange for some benefit, the ambiguities inherent in the notion of "benefit," and the way the commercial nature of the exchange suggests a potential conflict of interest, create immediate problems. We shall return to such issues in the discussion of "ideology critique" below.

But the basic problem in such a naive approach is that it ignores that we also authorize physicians to frame the question for us originally, and do not merely authorize them to perform a specific, mutually agreed to service. So whatever contractual relation exists is complicated by many more ambiguous technical and even psychological dependencies, all surrounding matters whose meaning and significance have come to be perceived as central to all of life. In other words, *we authorize physicians to tell us, in effect, what we are authorizing them to do*. When it is a question of alternative treatments, "quality of life" evaluations, risk assessments and so on, physicians do not merely transmit information. We must even depend on them to help us find ways to be able to disagree with them.

To some extent, this complexity arises in all exchanges which involve specialized expertise and, as in all such cases, can be addressed by conscientious and patient explanations by the more technically competent and (at least for some middle class consumers) by second opinions, reading up in physician reference books and so forth. No one pretends, however, that such measures compensate for years of medical school, training, experience, etc., or, therefore, that the rational transparency, contractual model tells us all we need to know about the bases and meaning of physicians' authority.

That model also ignores the fact that physicians are socially authorized to do or recommend in ways that greatly *exceed* any empirically strict account of their healing capacities (this is of course particularly true of psychiatrists). And, in general, the difficulty of containing or precisely defining the meaning of the *desideratum* of a "health benefit" is becoming widely appreciated.

Moreover, if it were simply rational to suspend private judgment and cede authority for the sake of a benefit, one could safely ignore the fact that in consenting to treatment for a disease, one would grant wide authority to affect other aspects of one's life

affected by such treatment. This would imply that all sorts of indenturing and submissive practices would be acceptable, if benefits could be produced by a competent technician, in a non-coercive original bargain. And it also ignores the wide cultural and historical varieties of social authorization.

As conceded, there are certainly inequalities in knowledge in many other professional transactions, and many of the same questions about the social function and meaning of various professional roles would have to be raised about the authority of those occupying such roles. But the very general point at issue now is simply that there is something distinctive about medical authority, a distinctiveness that makes the relation between ethical and social issues quite prominent. We do sometimes suspect that the social authority claimed by other professionals (chiropractors, say, or some psychotherapists, some education experts) is more easily challengeable or is based more on chance than defensible criteria (corporation managers, perhaps). And it is certainly true that the relative wealth of physicians, the litigious nature of American society, feminist criticism and other dissatisfactions have come to complicate the issue of physician prestige and even authority. But the relatively higher and in some sense unique status of physicians with respect to other professions clearly has to do with the "authority" of science itself, something that helps set the social function of physicians apart from lawyers and accountants. Because of that, we simply do authorize doctors to intervene in and control individual lives to a far greater extent than other professions and a great deal more (life or death, a quality life) is at stake in such authorization. (The unique nature of patient dependence in medical cases, and the corresponding issues of trust and, therewith, authority, are discussed in Zaner (1988).)

Once this normative problem about authority is admitted, the more clear-cut question about physicians' authority can be raised: independent of what a given society might authorize, what *is* the best, most fitting, just, fair, morally sensitive exercise of such power.

Now, for reasons I do not need to go into, these simple facts alone (the physician's social authorization to act in some respects unilaterally, or at least without many of the usual constraints) can, in a modern, democratic ethos, generate ethical worries about injuries to a person's general right of *self*-determination, or to *the* fundamental "natural right" in modern societies, freedom. So, at

the first level, this concern represents the most obvious problem with the exercise of social authority by physicians. This worry would obviously be increased if one also suspected that persons were being encouraged to be or even manipulated into being, excessive or profligate consumers of health care for essentially commercial reasons. If we think that people are being manipulated into thinking that more and more aspects of their daily lives are "medical problems" which they are not competent to manage and so must be turned over to experts, whose advice must be strictly followed on pain of irrationality, our worries about paternalism and manipulation will increase (Illich, 1976).

In general, traditional discussions about the compatibility between the exercise of professional expertise and the egalitarian ethos of liberal democratic society often focus on this paternalism problem.

The outcome of such worry about paternalism and a potential conflict with the supreme modern normative principle – respect for patient autonomy – is usually an ever greater, and sometimes utopian, standard of "informed consent." (That is, once the importance of such autonomy is conceded and the centrality of beneficence in physician-patient relations is replaced by the centrality of autonomy.) So, one way to allay worries stemming from a rights based political culture, where human dignity and self-respect are essentially tied to the capacity for self-determination, is simply to integrate such an ethical consideration much more self-consciously and in a much more detailed way, into the transactions between patient and doctors. Thereby the fundamental liberal principle: *volenti non fit iniuria*, is preserved. No injury can be done to the willing, or here the well informed health care consumer. (See Goldman, 1980, and for the definitive treatment of the legal status of the notion, Faden and Beauchamp, 1986.) (One should already note the importance of framing the problem of paternalism and autonomy in a relatively abstract way, as typical uniquely of *modern* civil societies, dominated by exchange relations among, essentially, strangers, who experience no other ethical relation (family, nation, religion, class) binding them together except a presumed shared commitment to a maximum liberty for each consistent with a like liberty for all. Keeping this larger frame in mind could suggest other aspects of the history and implications of such a social form which might be relevant to the social authority issue. It might also help raise the question of

how much "weight" such a thinly shared ethical principle can, and cannot, bear.)

This informed consent solution, though, is obviously still a much debated question. In the first place, the approach does tend to make some of the "rational transaction" assumptions we were just discussing. These assumptions are clearly reasonable, but only up to a point. Part of the issue they raise is the social conditions that define that "point." That is, the underlying assumption is that the authority of physicians basically stems directly from the consent of those affected, on the rational expectation of the benefits that will follow (once various obvious worries about subtle coercion, self-knowledge, real consent and so forth are somehow allayed). Aside, though, from the problem of what could count as autonomously conferred consent in situations of such dependence and ignorance, this model of authorization frames the ethical issue in a relatively thin or formal way. It must, that is, concentrate attention on procedural issues surrounding conditions of voluntariness, and so is "doubly permissive" as Engelhardt points out: it is a model that permits all interventions to which the participants have consented, and it makes that permission the key element of all bioethics (Engelhardt, 1991). This would mean that on *strict* (and thereby fairly radical) libertarian assumptions, and without further considerations of greater social harm, we would on such contractarian assumptions, permit the sale of spare organs, all sorts of euthanasia, or assisted suicide, new industries like commercialized surrogate parenting, or volunteer experimental subjects, etc. (All as long as the putative great measure of legitimacy, consent, were not feigned, or coerced, or in some other sense non-voluntary.)

Moreover, and more famously, some claim that just providing "lots of information" inevitably produces misinformed consent or resistance, that in some contexts some sorts of information are necessarily misunderstood, that most patients are incapable of understanding rudimentary probability figures and become unreasonably terrified of statistically irrelevant side effects, that encouraging patient autonomy in decision making often creates intense, unmanageable anxiety and makes people sicker, that false optimistic prognoses can produce beneficial "placebo effects" otherwise unavailable, that it is possible to determine what a patient "would really want" to know and especially not know, no matter what they say (such that their "real" consent is being protected),

that the whole issue is a fixation of the educated upper middle class and irrelevant to the realities and limitations of most medical practice, and that, anyway, modern specialized medicine makes adequate explanations of procedures and implications simply impossible. (I am thinking here of such things as Anna Freud's famous warnings about the inevitable role of "transference" in physician-patient relations, and Howard Brody's narrative of the classic clash between more authoritarian and more consensual medicine at the beginning of *The Healer's Power* (Brody, 1992).)

To such standard doubts about the vagueries and utopian implications of the informed consent justification of the social authority inherent in medical practice, one can add (and I think should add) some concerns that begin to raise even larger issues. A hint of such concerns can already be detected in something of a shift in discussions of normative issues in medical practice, away from micro-ethical issues towards more macro-analytic accounts of institutions, distribution of resources and what might be called the "original position" within which any negotiation between physician and patient already goes on. What, let us say, "The Institution" itself already makes possible (and impossible) for both physician and patient, is now often regarded as a crucial *constraint* on self-determination and autonomy on any action by an individual physician. Most obviously this can be an economic constraint, where treatment and long term care options are severely restricted by economic class and insurance status. Or the exercise of medical authority may not only threaten a paternalistic injury to the right of self-determination, it might be, in ways independent of individual judgment and fault, institutionally unjust, no matter the good will, conscientiousness, or casuistical sophistication of individual physicians. Extending this point alone, along with others relevant to section II below, might already begin to show that such constraints on authority and judgment, even meaning, do not just raise other, different sorts of medical ethics problems; but that any such problem is misconceived if framed independently of such a context, as if, in the traditional sene, a moral problem arising between an individual physician and patient. (Along these same lines, criticisms that health care makes little or no difference in general health, or may even have a negative effect, or that there was no longer any correlation between greater expenditure and greater health, all began to be voiced in

the late seventies. See Fuch, 1974; Wildavsky, 1977; and Illich, 1976.)

There are various responses to such worries. Perhaps the most intuitively obvious autonomy-based solution would be Kantian or Rawlsian in spirit. Individuals must not only consent to the authority exercised over them, it must be possible to assume that they would have consented, without prejudice or special interest, to the whole system of health care delivery, and this on considerations of maximum benefits consistent with equal opportunity of access (i.e., with universal conditions of consent). However this would work, the problem of legitimating the institutional authority of health care also raises an even broader class of criticisms.

Here the question is not whether the transactions at issue are consensual, well informed, consistent with moral notions of autonomy, or of real benefit. The question is what has originally come to count as consent, relevant information, the meaning of free action or what counts as a benefit or even health. The worry is that such issues are obviously not themselves objects of free and open negotiation, have always already been decided and, so goes the suspicion, are very likely historically contingent manifestations of the interests of entrenched wealth and power, demonstrably shifting as such interests shift, socially authoritative in ways so deep and unreflective as to avoid critique or open interrogation.

II.

While aspects of such charges can be found in many well known indictments of the medical profession (the work of Ivan Illich, Barbara Ehrenreich, Susan Sontag, etc.) the best known examples are in the works of "ideology critics" (neoMarxist, or critical theory writers) and more recently in the institutional histories written by Michel Foucault and those influenced by his genealogies and "discourse analysis." In the former or critical theory case, the general idea is this: suppose that there is a growing tendency in modern society, shared by both doctors and patients, to think of doctors as highly skilled body plumbers, whose job is to attack a disease and kill it, or mend a body part, that a greater and greater reliance on technology has changed the very experience of sickness and injury, transforming it into a technical problem and patients into malfunctioning objects, or essentially consumers. The

central claim of *Ideologiekritik* is simply: this should not be understood as individual moral failure on the part of individual physicians, a kind of secular sin, a dehumanizing indifference to others for the sake of selfish ends, all of which can be rectified by moral enlightenment and the exhortations of professional ethicists. The problem, supposedly, is much deeper and requires another kind of analysis, one sensitive to the issue of a fundamental "false consciousness," and the connection between privileging a wholly "instrumental" reason, and the inexorable expansion of capitalism and the culture and social relations unique to capitalism. (Of course for some such second generation critical theorists, like Adorno, the fundamental problem is common to *both* capitalism and instrumental reason, and is something like the whole dynamic or "dialectic" of modernization, or "Enlightenment" itself.)

For the technology issue (and, throughout, the same kind of analysis could be given, *mutatis mutandis*, of the commercialization of health care) the question thus is: has our "relation to objects" and to others been so influenced by technical instruments, the power of manipulation and production, etc., that our basic *sense* of the natural and human world has changed and changed so fundamentally that our reflective ability to assess and challenge such a change is threatened? Our very "consciousness" is "false"?

And with this sort of claim we reach another level of abstraction, arguing now that the central modern issue in caring for the sick is not respect for and the realization of autonomy, and not the economic constraints on any possible such realization, but the very meaning of autonomy or beneficence, or rationality at issue in any such social negotiation. The problem is not the personal moral obligations of physicians nor the problems of distributive justice but the inevitable (because inherited and deeply prereflective) ways in which health care is experienced in a highly technological, modern bureaucracy. In the last case, the assumption is that the influences of entrenched wealth and power, and the presumed "reifications" and "fetishizations" of Enlightenment culture, have already "distorted" the ways in which such assumptions constrain the very perception of alternatives and courses of action. (The "medicalization" of birth and of death are frequent topics in such discussions.)

Foucault's case is even more radical. His histories of modern psychiatry and modern medicine raise as many methodological questions as they do about those subject matters. Yet it is obvious

that books like his 1963 history of the origin of modern medicine (as he puts it, the transition from the question, "What is the matter with you?" to the question "Where does it hurt?") are meant to be deflationary and skeptical, even if, on the surface at least, much less so than his account of psychiatry. The final move in the origination of a distinctly modern medical paradigm, Bichat's success in moving pathological anatomy to the center of medicine, is portrayed as a contingent social decision, one made possible and necessary by new bourgeois institutions, and one linked to the emerging social values of the French Revolution, and not to the ever better march of science.

Accordingly, this enterprise is a familiar example of the cultural politics of, let us say, the post-socialist left. The assumption here is that, now, uniquely, at center of the nature of the authority of most modern institutions is not primarily representative legitimacy, as in traditional liberalism; or consensual exchange relations, or beneficence, the optimum satisfaction of collectively satisfiable desires, or even traditional class conflict, but *a claim to a kind of cognitive authority* (or perhaps thereby a new sort of class relation), the possession of the most universally and disinterestedly certifiable method for solving problems. Possessors of such a method alone know what sorts of desires *can* be collectively satisfiable; know who is sick, who healthy; who sane, who not; as if a firm, objectifiable criterion of normalcy, health, and especially, rational calculations of interest, etc. is possible. The major institutions of late modernity are not states and churches; they are hospitals, prisons, universities, bureaucracies, MBA managed corporations, etc. and the basis of the willingness of subjects to grant such authority is the founding claim for epistemic privilege. This claim is not simply false, it is claimed, but the extent of the authority claimed on its basis is due to contingent social and class interests (or more broadly, the "interests of power"), not a necessary or rational implication of the possession of such a competence itself.

Aside from the theoretical complexities of such analyses, the approach immediately raises a number of very good questions, particularly about contemporary approaches to public health issues, and helps show that any discussion of the problem of medical authority must attend to the issue of who gets to define what *is* a medical problem and on what basis. That is, for more concrete examples, we know that a very high percentage of people who smoke will get any number of diseases, so we think of

smoking as a public health problem. But do we know "what causes smoking?" Is *that* question a "public health" question? We "know" that people without a high school diploma are much more likely to smoke. Should we define "the problem of education" as a *health* issue? Is urban violence a health care issue, to be classified and investigated as such by epidemiologists (in the way in which the Center for Disease Control might take under its wing the problem of homicide against children?)

Whatever the questions raised, though, the recurrent problem with such an approach can be stated briefly, if therefore also somewhat unfairly. The notion of some fundamental distortion of consciousness, or the notion that the historical rise to prominence of some scientific authorization in medicine is a prejudiced illusion, presupposes that a nondistorted exchange between physician and patient is possible, or that some alternate history could have been written under less biased, more ideal conditions. This in turn then raises the question: within the resources available to a modern, secular public culture, and given the unavoidable requirement that some basic social transactions will be authority based, and so inegalitarian, under *what* assumptions could we assume that the normative constraints or ethical norms relevant to the trust and dependency necessary in relations with physicians could be anything *other* than the limited, thin, formal appeal to respect for patient autonomy, or the narrow and easily abused appeal to technological competence and scientific authority? Neither source of authority may provide us with very pleasant implications, leading either to a consensual commercialization that is at once both naive (about consent) and cynical (about what is permitted), and the other to the authoritarian, paternalistic practices which few defend today.

(It is true that in Foucault's case, it sometimes seems as if for him any discourse of legitimation is itself a contingent exercise of power, rather than a kind of redemption of its use. I do not think this is true of his position, especially in its later manifestations. But for the moment I shall simply assume that the rhetoric of his histories, especially in offering to speak for those who have been silenced, promises or hints at an emancipatory moment that would necessarily lead to questions like the above.)

Another way of putting this would be to concede that ideology and genealogical critics have identified an important problem in any reliance on consent or rational expectation of benefit as the

source of medical authority. But the better way to put the point would be to claim, not that such consent or expectation is itself distorted or the result of some social manipulation, but that such consent and expectation is *insufficient* to account for the kind of authority a physician must exercise. This would mean that we may not ignore considerations of respect for autonomy and the various thorny problems of impaired consent, surrogate decision making, contractual obligations and so on which flow from such a concern. But it would be a distortion of the nature of the physician's social authority to rely on such a necessary condition as if it were sufficient. (An even stronger and much more theoretically complicated claim would involve showing how attention to such an ethical requirement – respect for the patient's autonomy – itself requires the physician and many others to do various things and participate in various institutions in norm-bound ways not themselves the results of respect for autonomous subjectivity; that such a norm is itself embedded in some wider ethical practice.)

III.

This brings us to the following results. First, we can safely assume that in patient-physician relations, some sort of uncompromisable respect for the patient as the subject of her life, as an autonomous agent, however ignorant, or superstitious, or strategically irrational, must be some sort of historical given, an unavoidable starting-point. For any number of reasons, we could not be the modern agents we are without such a starting assumption. Let us also assume that, in cases of great and momentous uncertainty in patient lives, some sort of general trust in the institutionally sanctioned results of modern scientific research procedures is rational, or at least more rational than any available alternative. (On the more general issue of trust, and the role of dependent, ill patients in creating and sustaining medical authority, see also Zaner, 1988 and Pellegrino and Thomasma, 1993.)

The problem is that this is all much too minimal a set of assumptions. We still face all the relevant worries. Yes, there ought to be informed consent, but observing that norm only rules out grossly impermissible acts of domination or paternalism, and leaves unresolved all the ambiguities.

What could count as true consent in situations of great pain, confusion and dependency?

What could count as informing someone about options within the economic constraints of modern institutional life, and the often quite contingent, historically variable assumptions about "relevant" or "significant" information?

This does not even begin to mention all the libertarian, commercialized nightmare situations to which I have already alluded.

On the other hand, treating a physician as some sort of representative of an institutional power whose history is basically or primarily a story of class interest, or the maintenance of power, while it might tell us a great deal about what contributed to the modern administration of medicine, psychiatry, or prisons, and the way in which claims to cognitive authority helped (unjustifiably, perhaps) to legitimate quite contingent configurations of power within such administrative structures, does not exhaust the account we would want to give of medical authority in general. Such an approach leaves unclear what sort of alternative history, and so what alternative source of authority, could have occurred, consistent with all the manifold concomitant events of modernization: the collapse of (at least public) religious authority, the intellectual collapse of hierarchical, teleological views of nature, the centralization of authority in the modern nation state, the proliferation of new markets and the growth of privately controlled capital, and on and on. (At least Marcuse realized that his critique of "one-dimensional man" and technological dependent societies would simply be Luddite without some account of an effective "alternative" technology, a solution that traded utopian romanticism for Luddite opposition.)

This would be a confusing and disheartening result. But it is not at all obvious that these dissatisfying options are the only clear sources of authority consistent with the implications of social and intellectual modernity, to put the problem in its most general terms. If it were, then (a) conscientiousness about patient autonomy, (b) a general, good faith dedication to fairness and social justice in the institution of health care, and (c) a general watchfulness about various forms of bias and prejudice already built into the language or discourse of health care negotiations, would be all we could expect with respect to the proper exercise of a physician's authority. A certain Weberean resignation about the Faustean costs of modernization would be the appropriate

response to worries about the limited, formal, excessively procedural aspects of such norms. However limited and formal, it is the price of modernization.

However, this would also mean that anyone who is worried about the limitations of such approaches to the ethical dimensions of medical authority, for reasons like those cited above, has got a *far* greater task ahead than might at first appear. Reconceiving some sort of modern social fabric, some inherited ethical and political culture, still consistent with a vast diversity of religious and historical traditions, and with, forever expanding numbers of citizens, the great absence of such traditions, is what is at stake. Among other things, such a reconstruction would involve showing what forms of social cooperation and institutional norms must already be involved just in the pursuit of respect for individuals as autonomous agents, the origins and so the full meaning of such an ideal, and what else must be involved in such practices besides fair contractual relations or procedural neutrality about the good. This seems to demand that, to do full justice to the conditions under which the individualism and autonomy assumptions central to social modernization could be respected, a full theory of the norms of modern society, and so a full theory of society, must be presented. (Writers who object to the role of a principle-based moral theory in modern medical ethics, and who defend the idea of a "moral community" and a virtue ethics, like Pellegrino and Thomasma, 1993, and in a different way, Zaner, 1988, or in May's account of covenants, cited below, 1983, also seem to me committed to the task of this sort of complex, daunting historical reconstruction. It is not enough, in other words, to argue that the moral discourse necessary to articulate a satisfying, rich medical ethics is impoverished without the recognition of the importance of communal roles or the role of virtue in moral judgment. Our moral discourses may simply *be* unavoidably impoverished, given what else we cannot give up if we are to remain "us". See also Engelhardt, 1991.)

In fact, of course, critical theories of society have been concerned to understand such associations and activities for some time, and I have tried to suggest that there is clearly merit in the critical theory suspicion that individual, moral problems of conscience are misunderstood in isolation from the modern ethos in which they are experienced. But many classical critical theories have not sufficiently freed themselves from either a basically

materialist methodology, on the one hand, or a satisfaction with a purely "negative" dialectic, on the other, in providing an account of such a presumed and determinative distorting ethos.

Of course, it might be possible and suggestive to point to the need for and priority of such an account. Providing it, while avoiding the classic failures of the materialist and counter-Enlightenment traps, is another story. But the considerations offered above at least begin to suggest some of the dangers in considering the field of medical ethics as a kind of sub-discipline, dominated by problems of judgment in hard cases, once some basic commitment to a deontological or consequentialist or religious principle frames the discussion. Inevitably in all such cases, some sort of a decisive and usually silent commitment to one or another narrative of modernity and theory of society itself will also come into play. Some notion of the normative status of the modern family, the real authority and duties of parents, the status of religion, the ethical dimensions or relative importance of exchange relations, the nature of institutions in modern societies, the function of law in modern states, even the notion of modern nation states. The fact that we cannot properly understand one crucial element of medical ethics, the legitimate authority of a physician, without implying such an account, and the fact that it appears so sweeping and hard to manage, does not mean that an implied reliance on such notions of modernity and modern societies is any less pervasive or foundational.

With respect to physicians' authority, such a project would have to involve some re-examination of the (putatively misleading) ways in which modern assumptions about any fair or just or good exercise of authority have come to dominate our discussion of these issues. On the one hand, the autonomy ideal itself, which enjoins us to work towards some full, free, fair exchange between reflective, adult reasoners, who in effect bargain fairly with each other over some real transfer of goods, is itself so thin, so much an expression of what is often simply presumed to be an absence of any common ethical culture, that it is an easy target for skeptics and inspires all the predictable counters. It is in reaction to such an idealized and mostly unreal assumption, that critics of the liberal tradition and those suspicious of the role of markets and power in social relations make the contrary assumption: that everyone's position in any social dealing is already some sort of reflection of some power relation, that everyone is always a witting or unwit-

ting partisan of such on-going struggles, and never a detached, critical, or autonomous agent. The wholly negative or dangerously utopian and revolutionary implications of such an attack are well known.

A central move among those who have argued that this situation, and the dead ends which lead from it, could be avoided, is the claim that we should discard the presupposition that only individual, voluntary associations generate ethical obligations or norms of all sorts (and so the counter-assumption that all contemporary social relations, in the very large respects in which they are not "really" chosen or autonomously chosen, are "really" involuntary and oppressive, no matter how they seem.) The question (and I recognize that nothing has here been established about the prospects for answering such a question) then would be whether there would be some sorts of *involvements in institutions*, some on-going participation in some sort of public life, which are *not voluntary* (as in individually "chosen," consensual) but *not thereby involuntary* (as in unfree, not what would have been willed in a wholly undistorted context). This would mean that it might be possible to discuss what a physician, all things considered, ought to do, where that notion is not tied strictly to what she promised to do, what any reasonable consumer would expect she would have pledged to do, and so forth. It is not after all counter-intuitive to appeal to such considerations in determining what a statesman, or parent, or teacher "should do." (There are the briefest of hints about what such social ties between physicians and their colleagues, profession, and patients would look like in chapter four of William May's discussion of "covenants" in medical practice (May, 1983).)

As already noted, I don't believe much detail will be forthcoming in such accounts without a fuller account of the distinct characteristics of modern, now even late modern societies, and the sorts of norms consistent with such societies. (Again, my account here is clearly only a prolegomena to such an account, and is meant mostly to argue against the insulation of medical ethics as a sub-field, and the predominance of casuistical, dilemma case, and libertarian issues in it.)

Again, the motivation behind examining institutional roles and role-based norms stems directly from a recognition of the character of late modern ethical life, as fragmented and tension filled as it is. In the exercise of their professional capacities, a physician

simply cannot act exclusively as a paid agent of the patient (although she certainly is at least that); and in accounting for what, as a doctor, she ought to do, she cannot rely wholly on scientifically sanctioned therapies (although she must at least do that). Moreover, it will not be of much help to insist that, in response to the patient's suspension of judgment, she must act conscientiously, or in terms the doctor would herself approve, were she the patient. The patient is not a physician and not that particular person, his physician. It is clear that in acting conscientiously, the physician acts in recognition of the norms of the profession itself, and that these (a) always reflect much more than technical competence and (b) are themselves unintelligible apart from a general theory of modern civil societies. These norms, that is, reflect a common view of our stake in some social whole.

We certainly tend not to believe there are such norms in late modern societies, and think that suggestions about such roles leads us towards a nostalgia for a "my station, my duties" approach to normative issues, or a vague and so dangerous communitarianism. And yet participants in such societies constantly evince an interest in issues like reputation, pride, professional respect, and act in ways that cannot be accounted for by attention to consensual exchange relations or the maximization of expected utility. Medical practice, and the problem of medical authority, I have suggested, are cases in point.

I make no claim here about the prospects for such a reconsideration of these sorts of norms. I only want to claim that the basic ethical issue in medical practice should be seen to be the issue of authority, and that the conventional understanding of the sources of such authority, and the familiar criticisms of such authority, do not do justice to the problems faced by anyone wishing to understand what, to invoke a famous phrase, Hegel called modern "ethical life."[1]

NOTE

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