To be a philosopher is not merely to have subtle thoughts, nor even to found a school, but so to love wisdom as to live by its dictates. . . . It is to solve some of the problems of life, not only theoretically, but practically.

—Thoreau [1854] 1971, 14–15

Much of modern philosophy swirls around the question, What is philosophy? The agonized debates, especially in the twentieth century, about what constitutes bona fide problems and approaches ultimately fractured the discipline. There are many ways of characterizing philosophy, sometimes divided by technical interests and sometimes by deeply held opposing metaphysical visions: by schools (existentialism, pragmatism, analytical philosophy, phenomenology, and so on); by subject matter (ethics, political philosophy, philosophy of science, aesthetics, history of philosophy, metaphysics); by orientation (idealism, rationalism/empiricism, skepticism, realisms/antirealism, and so forth); and, for our purposes, by the theoretical versus the ordinary or the practical. In this last opposition, and through its incomplete resolution, we find the origins of medical ethics and its sustained vitality.

Beginning with the romantics, a philosophy of the ordinary has gained momentum and analytical acuity. Notable twentieth-century philosophers have extended earlier critiques primarily through the philosophy of language (Wittgenstein and John Austin), pragmatism (Dewey), and phenomenology (Husserl, Heidegger, Merleu-Ponty). And these traditions are actively pursued today by Richard Rorty, Stanley Cavell, and Stanley Rosen, among others. They answer the question what is philosophy? with surprising modesty: most directly, philosophy attempts to
capture “the elusiveness of the ordinary” (Rosen 2002), a tradition with a venerable heritage (see chapter 5, note 8). These philosophers share a concern with replacing a deconstructive skepticism with a constructive understanding of pretheoretical, everyday experience. They obviously differ as to how this goal might be achieved, but all are part of the movement against philosophical formalisms.

Instead of constructing a theoretical structure on which to hang the messiness of the world to order it and to penetrate the bewildering swirl of the mundane to the deeper reality or significance of human life, philosophers of the ordinary seek to grasp everyday life on its own terms. This approach to the prosaic requires more than theoretical constructions. Philosophical formalisms, with their carefully crafted definitions, rhetoric refined over centuries of debate, and various kinds of logic, are replaced with an orientation that combines theory and practice. In a sense, this movement is an attempt to recover philosophy’s original intent. Whereas the pre-Socratics like Heraclitus and Parmenides devoted themselves to theoretical speculation on nature, ignoring or belittling day-to-day concerns, Socrates tied together the theoretical and the practical as the two dimensions of philosophical reflection. More to the point, “The dramatic form of the Platonic dialogue exhibits the tacit thesis that theory and practice are not so much two distinct lives as two aspects of human life. . . . They are not ways of understanding life so much as ways of living” (Rosen 2002, 3). In other words, for philosophy to attend to its full agenda, the theoretical and the practical must be synthesized, for in their sundering, the point of theory is lost.

For Socrates, philosophy begins in the everyday, but the “erotic ascent” allows the enlightened to witness the perfect Ideas and return to the ordinary with an insight that helps direct human behavior. So philosophy both transcends and remains deeply rooted in ordinary life, beginning and ending at the same spot, so to speak. The key for a philosopher like Rosen (2002, 10) is to see that ordinary experience is saturated with the extraordinary and that philosophy’s present task is to recover “the origins of human experience, that is, to remove the sediment deposited by traditional rationalism” (p. 6). In this view, philosophical formalisms, with their meticulously argued precepts and rules, enable the philosophical edifice to be built on carefully laid layers of
argument, but the process becomes self-absorbed and too easily loses sight of philosophy’s true goal. Rorty, in reviewing Cavell’s *In Quest of the Ordinary* (1988), succinctly captures the problem of why philosophers kick up the dust and then complain that they cannot see:

[Certain philosophical] problems could only be stated in a particular jargon, in Philosopher’s Talk. They cannot arise if we speak Ordinary Language. Descartes and Ayer had discussed, for example, whether the external world was real. Real? Austin asked. As opposed to what? A plywood stage set? A hallucination? A computer simulation? In the ordinary, human world these are the sorts of alternatives that give the word “real” its use and its force. In the philosophers’ world, there is nothing to do the same job. That is what Wittgenstein meant when he said that Philosopher’s Talk is language “on holiday.” (Rorty 1989, 39)

Cavell, claiming Wittgenstein and Austin for support, and enlisting Rorty, wishes to overcome skepticism and renounce the quest for purity to recover the human dimensions in which we live as the site for philosophical discussion.

This “metacritique” of contemporary philosophy has direct relevance to our own concerns here. Lurking behind every corner of the hallway in which medical ethics finds its various “rooms” of thought (here the principles of autonomy, beneficence, justice), reside the questions of applicability and relevance: What are the limitations of any system of philosophical ethics in addressing the practical concerns of patient care? Each philosophical approach is curtailed by its own perspective. Ethical theories—utilitarian, deontological, liberal individualistic, casuistic, coherent, pragmatist, communicative, existentialist, and so on—each restricts in its own way by framing ethics in its own characteristic fashion. Building on certain axioms—for instance, the standing of rationality if one is a Kantian, or the bias of gender if one is a feminist—allows the moral philosopher to develop his or her argument toward some end. Again, if a Kantian, the primacy of autonomy and freedom, or, if a feminist, the correction for gender prejudice serves as the telos of the entire argument. Along the way, these contending ethics slip past their detractors and other contestants in seeking dominance. There may be active debate within a Kantian or feminist group, but when contested by those holding a different point of view, discourse rarely engages the core issue separating the disputants. After all, no final arbiter or gold standard exists. In short, theories, for all their power to structure debate and
persuade skeptics, have inherent limits: they refract the world and human behavior in their own characteristic fashion.

So, for all the hope, and conceit, of providing comprehensive accounts of ethics, reality, knowledge, and so on, the project always fails. No doctrine, no school, no titanic intellect can overwhelm other views, and while philosophy has an enormous influence on human life, few would be so bold as to claim that philosophy is “comprehensive.” Suffice it to admit that no system is hegemonic, and while each contributes to constructing our notions of the Real, the True, and the Good, none—either singly or in concert—captures it all.

These truisms point to a cardinal admission: at a simple level, I have been dissatisfied with any singular approach to understand the ethics of clinical medicine, and so I have mixed various elements—most prominently, utilitarian, feminist, communitarian, and virtue ethics—to define an ethics of responsibility. The “vocabulary” has been principles (Beauchamp and Childress 2001); the strategy, pluralistic; the mode of justification, reflexive equilibrium (Rawls [1971] 1999); the overriding metaphysics, a Levinasian variant of phenomenological and existentialist orientations (Tauber 1999a)—heavily sprinkled with a relational understanding of selfhood (Mackenzie and Stoljar 2000), and governed by a broadly humanistic conception of virtue (Pellegrino and Thomasma 1993) and beneficence (Pellegrino and Thomasma 1988; Frankena 1988). Perhaps only by creating this web of interlocking components could I reveal my understanding of the “structure” of moral medicine. And so after placing each of these components into the net that I am calling the “ethics of responsibility,” one might well ask, What orders or orients that structure? The short answer, moral self-reflection.

I have called on doctors to become more self-reflective, more aware of the moral dimensions of everyday care, more keenly aware of their respective roles and degrees of freedom. This perspective offers physicians a way of seeing themselves as having, beyond certain functions as actors in the clinical drama, a group of obligations and responsibilities that arise from their ordinary encounters with their patients. We need not, indeed, should not articulate the ethics of medicine exclusively in response to acute crisis, but rather draw the parameters of moral conduct by examining the structure of physician commitment and identity in the
setting of the everyday life of the hospital or clinic. The utility of this orientation is to make explicit the social currency of ordinary interactions and their rules of exchange. Finding the meaning of this ordinary experience (i.e., engaging in a hermeneutic analysis) hopefully offers enhanced self-awareness.

Physicians would do well to look about themselves and more fully recognize the value-laden world in which they function. Bedazzled by the power of machines, drugs, and techniques, rushed through the hubbub of hectic schedules, answering to diverse professional calls and demands, beholden to, and restricted by, external economic and political forces, doctors require an ethics of the ordinary, an ethics seeped in a cognizance of the *Mitsein* (Olefson 1998) of social interactions. There I believe they will find a moral mandate of care, an abiding sense of responsibility for another, and the professional demand for excellence in the techne of clinical practice. Here is where trustworthiness must be established and enacted. It is the basis of their patient’s trust, which is the essential ingredient of the healing arts.

Inescapable and overdetermined, clinical medicine is governed by its ethics, and when mentors and their students better recognize the complex moral reality in which they live, the more likely their craft will be transformed from its technocratic and bureaucratic obsessions to a more humanized life form. When thus understood, the conclusion is inescapable: clinical medicine is, among other competing agendas, a moral exercise. Framed by the standards of care, by empathy, by cost-effectiveness, and so on, some hierarchy of interests prioritizes clinical choices in answer to patient needs, and each health-care provider is governed by a particular set of standards and the morality that legitimates them. The medical crisis dramatically reveals this process. What I have emphasized is the ordinary moral character of the healing praxis.

On this reading, some form of ethics is implicit in all that doctors optimally do in their daily performance. Why then is medical ethics a specialty field? Why is risk management too often the substitute for ethical reflection? Why, indeed, does moral self-consciousness wane under the glare of the objective stare? Undoubtedly, reasonable responses appear effortlessly, but the dictum remains that in the clinical universe, values structure all facts so that their meaning and significance only take form
when they are sorted, organized, prioritized, and acted on as determined by the rules governing the value-based choices optimizing patient care. In this sense, the medical world is, indeed, “startlingly moral” (Thoreau [1854] 1971, 218).

I turn to a philosophical novelist to make a final comment in support of medicine’s moral locus in the ordinary. Leo Tolstoy retells the story of the painter Bryullov, who corrected a student’s sketch:

“Why, you only touched it a tiny bit,” the student exclaimed, “but it is quite a different thing.” Bryullov replied: “Art begins where the tiny begins... That saying is strikingly true not only for art, but for all of life. One may say that true life begins where the tiny bit begins—where what seem to us minute and infinitely small alterations takes place. True life is not lived where great external changes take place—where people move about, clash, fight, and slay one another—it is lived only where these tiny, tiny, infinitesimally small changes occur.” (Tolstoy, “Why Do Men Stupefy Themselves?”; quoted by Morson 1988, 521)

Such awareness has immediate moral consequences: because intentions are shaped continually by small, usually imperceptible influences, every moment of our lives has moral value (Tauber 2001). Each action has potential effects we cannot predict, but for which we still remain responsible. We must be morally alert, because decisions, far from being reduced to a set of rules to follow, require that attentiveness be marshaled for deliberate action. Rules, principles, and maxims may guide our choices and deepen our understanding, but in daily life traditional philosophy typically ends and prosaic ethics begin (Morson 1988).

This orientation relies in large measure on Aristotle, whose fundamental question is not “What ought I do?” but “What should I be?” In other words, “Morality is internal. The moral law... has to be expressed in the form, ‘be this,’ not in the form ‘do this.’... The true moral law says, ‘hate not,’ instead of ‘kill not.’... The only mode of stating the moral law must be as a rule of character” (Leslie Stephen, The Science of Ethics, 1882; quoted by Thomas and Waluchow 1998, 38). In many ways, the moral reality of the clinical encounter is well served by including this depiction, for it captures the “ether” in which we live our moral lives. In the confusion of everyday life, the process of ordering the unique interactions with particular people in particular settings demands that we make unique ethical choices, constantly. The Aris-
totelian perspective captures this state, for moral behavior expresses virtues or qualities of character, and these are expressed at every moment of consciousness. This fidelity to ethical behavior is the demand of caring for another, an ongoing, unwavering responsibility. I maintain that this obligation is the ethical heart of medicine. Responsibility does not end with signing an informed-consent agreement or mollifying a family about terminating care of an aged relative, because the legalities of care shape, but hardly define, the ethics of physician responsibility. Ultimately, care for another is a question of character.

A moral philosophy based on character emphasizes how we are held responsible for even the most mundane actions. But more, to be self-consciously moral in the context of the prosaic also provides the potential for one’s ordinary choices to produce meaningfully different outcomes. And this is an individual accomplishment, one integral to a creative, productive, and morally responsible life. As Bakhtin wrote (with Nietzsche looking over his shoulder), “That which can be accomplished by me cannot be accomplished by anyone else, ever” (quoted by Morson 1991, 218). This is not some narcissistic conceit, but rather the acceptance of moral accountability, which for the health-care provider, is the fundamental moral maxim of caring for another. This has been the theme of my earlier work (Tauber 1999a) and it remains central here. Patient autonomy offers no challenge to this formulation, because respecting individual dignity is a fundamental precept of an ethics of responsibility. The practical task remains how to heighten such moral vigilance and couple it to vitalized, humane health care. We have begun by excavating to the foundations of our predicament. On that understanding, we can proceed with confidence toward a renewal of an ethical medicine.