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Is There a Philosopher in the House?

Jonathan D. Moreno (Ph.D.!)

"Certainly. A party of four at seven-thirty in the name of Dr. Jennings. May I ask whether that is an actual medical degree or merely a Ph.D.?"

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Direct correspondence to Jonathan D. Moreno, SUNY Health Center at Brooklyn, 450 Clarkson Ave., Box 116, Brooklyn, NY 11203-2098.

HERR/FRAU PROFESSOR DR.

As a philosopher who teaches in a medical school, this cartoon has special meaning for me. Like many others, I have long wondered about the business of using academic titles as part of one's name. Is the use of "Dr." a mark of arrogance, or is its omission self-denial and non-disclosure? The most prestigious college I was associated with before I turned away from traditional philosophy teaching identified all its instructors as "Mr." or "Ms." in the course list. But I also recall my senior colleague in another philosophy department who invariably introduced himself, with a broad smile and hearty handshake, as "Professor" so-and-so. I remember thinking that he said it as though that was his first name.

I started out in bioethics by team-teaching in medical school courses, offered in the medical school building. I noticed that my medical colleagues would usually introduce me as "dr." to the students. It was apparent that everyone was comfortable with this mode of address, or at least not uncomfortable, including the philosophy majors taking the course for philosophy credit who knew me as "professor" elsewhere on the campus. The physical location of the course supported the "dr." emphasis, including the meeting room itself which was a lab suitably arrayed with cabinets, beakers, bunsen burners and emergency shower heads.

Under these circumstances it would have been pointless to note that the title indicating degree is less prestigious than that indicating rank. First, my rank wasn't really professor at that time (where's the prestige in being an assistant professor?), and, second, the marks of status in the German academic tradition don't apply in the New World, where even generic "doctors" have at least as much clout as generic "professors." My dissertation director once recalled his work for a think-tank on contract with the Navy. When operational issues came up the brass said, "Let's call the doctors." "Let's call the professors" wouldn't have been believable enough on its face to be a cute inside joke. A medical school administrator with a doctorate in another humanities field told me that he permits himself to be called "dr." within the institution since otherwise he would not be taken seriously by the medical and science faculty, though he would loathe to be so addressed in any other context.

When still shuttling between liberal arts college and medical school I was also able to adapt any doubts I had about the propriety of being titled one way or another to the context. This adjustment worked well until my first summer on rounds in an oncology unit. Joining the team for its tours of the bedside was an opportunity to learn more about the physicians' workstyle. With this experience I could formulate more relevant suggestions when we gathered around the conference table to discuss their more difficult cases.

Upon entering a patient's room I would be introduced by the attending physician as one of the many doctors on the team. Indeed, on morning work rounds there were ordinarily eight or ten of us huddled around a bed, several of whom were no more medical doctors—and indeed less "doctors"—than me, but medical students or pharmacists. The attending oncologist was invariably polite to the patient, but rather than running through the whole list of people assembled would often simply say something like, "These are some of the doctors who are on the team caring for you."

Since truth-telling was supposed to be a matter for my watch the experience was unsettling, though my colleague, the attending physician, assured me that I had every right to be part of the team and to be introduced in a like fashion. In one sense I could hardly argue, since the psychologists were also undifferentiated as "doctors" and had the appropriate degree. My stumbling block was the knowledge that none of these people would have expected a philosopher to be among those privileged to witness their vulnerability, so how could I presume their acquiescence?

Though not the primary reason I was drawn to spend more clinical time in the neonatal intensive care unit, the title issue is less of a problem with those tiny patients. In the NICU it is easy for the attending neonatologist to introduce me as "Dr. Moreno, our medical ethicist" to the staff without raising eyebrows. Sapient patients, on the other hand, might well wonder why such a presence is needed.

TEACHING ETHICS, DOING SOCIOLOGY

Whatever sensitivity I brought to these matters can be attributed partly to my close association with Barry Glassner and his other colleagues who founded this journal twenty years ago. At that time, fresh out of graduate school, I could not have anticipated my bioethical turn. I enjoyed reading the manuscripts submitted to QS and attending sociology conferences (the issues were delightfully different from those that drove my philosophical colleagues), but I had no idea that this way of thinking would ever have direct relevance to my working life.

About ten years after my initial experience with qualitative sociology, I conducted a weekly ethics seminar with pediatric nurses. They were a marvelous group, smart and dedicated. The first several sessions were on various standard issues in medical ethics, and we then focussed on the peculiar stresses inherent in the nurse's role. One of these is the need to deal with various attending physicians who have different practice styles and make very different demands on the staff. An important part of learning

how to nurse in a particular unit is learning how to deal with the attendings. Some annoyance was expressed, but mostly resignation.

Then I suggested that the young residents, who are after all on wards a lot more than the attendings, must present another sort of challenge. I mentioned my impression that nurses don't deal with all these physicians-in-training in the same ways. This general remark immediately elicited smiles of recognition, some more bashful than others, and a few amused glances at one another. Emboldened, I then allowed that I have sometimes observed nurses "game" or manipulate the housestaff to get what they want. Confirming anecdotes then poured forth freely, most on the order of knowing which resident to approach to deal with a problem, and how to do so. An especially memorable conversation followed about nurses' relationships with female residents. For at least some of these nurses those dealings were freighted with a great deal of complexity.

In retrospect, what I found especially fascinating about this discussion in the nursing ethics seminar was not the content of their stories about gaming the residents with whom they worked, but the zeal and amused delight with which some of them talked about it. The affect in the room differed considerably from our previous discussion of their relations with the attendings, for in that dynamic they were subordinate. When it came to the housestaff they were in a position of power by virtue of knowing more about the way the unit and the institution worked, and often by virtue of knowing more about medicine than the newer residents. Of course the young doctors had to learn, said one, but it was hard to watch them learn on the patients that they were also charged with caring for, especially when the nurses had to clean up after their mistakes. On the whole, while they were not unsympathetic to the new doctors' plight, it was pleasurable for these experienced women who perceived themselves as often under-valued by the institution to exercise a little dominance over some of the supposedly best and brightest.

I was delighted with this session and how much it had revealed about the interstices of the hospital regime. The nurses themselves also expressed their enjoyment at having a phenomenon framed for them, for though they were roughly aware of it they had not fully articulated it before or talked about it with one another. In fact, the last minutes of that class were devoted to a heartfelt discussion about interpersonal honesty and authenticity, and how hard it is to achieve in the highly scrutinized, hierarchical and closely regulated modern hospital.

Talking openly about power and dominance is an agenda I have tried to pursue with residents themselves; even though this is arguably not "medical ethics" in a strict academic sense, the constraints on health care workers' efforts to take good care of their patients obviously has moral

overtones. I meet regularly with groups of residents in conferences in which ethical issues are given the stage. If these sessions are defined as "core curriculum" rather than "patient management," they enjoy the great advantage of having no attending physicians in the room, but only the house officers themselves. After a few meetings I am usually able to engender a level of trust that enables topics to be opened in the ethics conference that are not spoken of in any other formal setting. The most powerful such session I conducted had to do with the way that mistakes are dealt with in the department, a topic I was able to introduce by describing Charles Bosk's classic observations about a surgical residency program in *Forgive and Remember.*

ALIENATED ALIENS

In the hospitals where I work in Brooklyn most of the residents in primary care departments are graduates of medical schools in other countries, usually foreign nationals on special visas. One might have thought that they would be less inclined to criticize systems of authority, especially as tenuous accredited guests, than those who are citizens and who were socialized and educated in American institutions. But in fact I have found them remarkably willing to question their situation and, because of their cultural perspective, far sharper in their critiques of our system. On rare occasions they are deeply embittered. A Russian surgeon attempting to gain credentials to practice here denounced the American colleagues he had observed as motivated entirely by greed; at least in the old Soviet system, for all its faults, there was room for compassion, he concluded, and the treatment was actually better than what he had seen here. The others in his cohort, some also Russian and some from other parts of the world, were obviously taken aback by his caustic outburst, and quickly asserted that his observations applied only to a minority of American physicians they had met.

Coming from such countries as The Phillipines, Pakistan and Argentina, these exceptionally capable people often have practiced medicine at home, have not set foot in the United States before, and within days of their arrival are at work in some of our busiest inner-city hospitals. They tend to be among the best products of their country's system of medical education, but are viewed as second class in the United States, and they know it. Current federal policy changes call for a vast reduction in the number of positions available for "international medical graduates," who give most of the in-patient care in places like Brooklyn.

For some who have difficulty obtaining a visa in time to begin their residency, the indignities begin even before they arrive. For others the shock comes later: one young man arrived in this country in mid-June, days before his orientation, settled his family in a tough neighborhood near the hospital, and had his car stolen before he even began to work. He immediately moved his wife and children to suburban New Jersey and took the long commute several times a week.

The first time I met with a group of new arrivals I realized that because they had no understanding of the American legal system and little familiarity with many of our cultural assumptions, they could hardly make sense of discussions of patient autonomy or informed consent. Sometimes their reactions to our system achieved comical proportions. One melodramatic chief resident told me facetiously that in his country "when one of my patients died the government sends me a letter—thanking me! Because there are too many people! Here, if one of my patients dies I get a letter from a lawyer!"

More usually what I have found in these sessions, which I think of as anthropologic focus groups, is amazement at our cultural contradictions. For example, one Latin American who had been a professor of histology in a medical school back home was non-plussed at Dr. Kevorkian's ability to "get away with murder" in public. In his country, he said, that would be impossible. When he was questioned, he admitted that assisted suicide probably does happen, but if a doctor did that in a publicized manner he would certainly be imprisoned. The example enabled me to explain that our constitution gives the states authority to create their own laws on matters such as the regulation of health care professionals, and that at the time Kevorkian started, Michigan had no law on physician-assisted suicide. Although the group was frankly puzzled by the moral inconsistencies of a society that rhetorically insists on the sanctity of human life, those from Catholic countries had to admit that the same was true of their homelands, where abortion is illegal but common. In the end these young physicians are candid that they are not here for philosophical consistency but for professional training and economic opportunity. They are willing to accept American social conflicts as minefields they must be willing to navigate in order to reap personal rewards.

TAKE TWO LOGICAL CONNECTIVES AND CALL ME IN THE MORNING

Many of the venues in which I work are more or less academic rather than mainly clinical. They include conferences with residents in which issues

in medical ethics are discussed, as well as grand rounds about topics like euthanasia. These events are in many ways extensions of graduate and continuing education on philosophical and policy problems. When these academic exercises shade into finding solutions to clinical issues with ongoing cases, a new and different role for the philosopher, the most fascinating experiences I have had in the sociology of the professions are engendered. Requests for concrete advice about managing what the physicians involved perceive to be ethical problems are, of course, common and expected for one touted as the "ethicist." More often than not the problem with a current case has to do with a concern or disagreement with a patient's family about the most appropriate course of treatment. Under these circumstances, negotiating skills are as important as philosophical insight.

Sometimes, however, requests for advice go beyond what can be viewed as ethical issues and into technical medical questions, such as what order and technique for the withdrawal of life-sustaining treatment should be adopted. Now sometimes these questions do have ethical implications, since deciding to stop antibiotics for a dying patient is distinct from turning off a ventilator, though the end result is the same. On the other hand, I have also been asked how much sedation should be given when the respirator is being withdrawn (to prevent a feeling of suffocation), or at what rate the supply of oxygen should be reduced. These questions have been asked by physicians who are quite aware that I am not a medical doctor, but they ascribe to me a level of experience with technical matters by virtue of the clinical issues that animate my intellectual work.

Another reason for this exaggerated notion of the philosopher-ethicist's knowledge-base is that some (but by no means all) ethicists have medical titles. At my medical school my rank and tenure are in pediatrics, and I hold a "courtesy" appointment in medicine, as well. I am sure that my opinions would be taken far less seriously if my professorship was in philosophy, as it was at my previous institution, rather than in central clinical departments. The assumption is that I have somehow "earned my stripes" to have these appointments; while I would like to think that is true, contingent factors are also at work in the way that ethicists are assigned their academic titles.

These generalizations are, of course, severely limited, and in particular cases attitudes toward the non-physician presuming to speak to clinical issues varies wildly. At one extreme, even close colleagues have sometimes trumped my arguments about physician paternalism by appealing to *ad hominem* tactics that I heard more ten years ago than I do now: "Well, it may look that way to a philosopher, but it's different for the physician who is actually giving the treatment." At another extreme, I have been appointed to *ad hoc* committees on sensitive administrative problems (such

as what to do about a resident who was HIV+ but wanted to stay in the program), even though ethical expertise was not much needed. In such cases I have come to see myself as cast into the role of a "secular priest": even in a pluralistic and multi-ethnic society someone must sanctify such delicate proceedings. If responsible authorities can announce that the ethicist was part of the committee, then they are generally perceived to have taken into account something important, though it is not easy to say exactly what that is.

IS THERE A DOCTOR ON BOARD?

In spite of my frequent public professions that my goal is not to be a physician *manque* but a philosopher of medicine, immersion in a medical environment and collaboration with medical professionals has deeply affected my self-identification. I was not aware of how much I have come to identify with the physician role until a long airplane flight several years ago. I was seated in a wide-body aircraft in a row on the side of the plane in front of an emergency exit and near the galley, the kind of seat in which there is an open space that permits even the economy traveler to stretch out. With no seats in front of me and the seat next to me unoccupied, I congratulated myself that on this flight I had first class space for a lot less.

Several hours after dinner, night descended, and I managed to drift off. Not long after that I felt something landing on top of my feet. It was a female passenger whom the flight attendants were attempting to place in a position where she could be examined. The cabin was darkened and the voices muffled by engine noise, but I gathered that the passenger had collapsed after leaving the toilet. The flight attendants hoped it was only airsickness, but they feared a heart attack. Quickly the call went out for a physician on board, and first class seemed to empty as an international group of medical personnel huddled over a shrouded figure below me.

All this happened in a few moments, of course, while I was semi-conscious, but I remember being struck by an urgent desire to answer the flight attendants' call for assistance, and then to join my "colleagues" at the "bedside." That I could contribute little or nothing to the ministrations being provided (which consisted mainly of a brief medical history, a self-report of symptoms, and the provision of some oxygen), had nothing to do with my reflex sense that I had a place with the "team." Since then I have had another such experience, and again I wanted to announce myself to the flight crew: "I'm not a medical doctor but I am an ethicist. Can I be of assistance?" Fortunately for all concerned, I have resisted such urges and

concentrated instead on the introspection for which my training more properly qualifies me.

On the other hand, maybe someday I will answer that call....

REFERENCE

Bosk, C. (1979). *Forgive and Remember.* Chicago: University of Chicago Press.