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Philosophy and Medicine: The Oxford Connection

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Three aspects of the approach to philosophy advocated by the Oxford philosopher J. L. Austin are outlined: his conception of the nature of philosophical problems, essentially as a mixed bag; his method of linguistic analysis, namely, clarification of our concepts by active observation of the ways in which they are actually used rather than by passive reflection on their meanings; and his views on the organisation of philosophical research, that in some areas it should be pursued rather as a science is pursued, as a corporate rather than merely individual venture. It is suggested that Austin's approach provides the basis for a potentially fruitful two-way relationship between philosophical theory and medical practice.

Philosophy is a many-sided discipline and its connections with practice are correspondingly diverse. In this paper I focus on an approach to the subject which is especially associated with the Oxford philosopher J. L. Austin. This approach has a considerable though as yet largely unrecognised potential for creating new and mutually beneficial links between philosophical theory and medical practice.

The gap between philosophy and practice

Philosophical theory stands in marked contrast to scientific theory in being remote from the contingencies of everyday clinical work. This state of affairs is so well established that it is largely taken for granted. Yet it is odd. Historically, especially in classical times, medicine and philosophy were closely associated. The two subjects, furthermore, share many areas of interest: medical ethics, notably, but also the mind–body problem, questions of free will and responsibility (in forensic psychiatry, for example), of individuation and the concept of a person (in developmental psychiatry and in psychogeriatrics), of the relationship between hermeneutic and causal explanation (in psychoanalysis), and so on. Nor is there any lack of cross-border contact. In recent years there has been a positive epidemic of articles, books and journals concerned with philosophy and medicine: and in the Royal College of Psychiatrists, the recently established Philosophy Group had in excess of 200 members even before its inaugural meeting.

So why the gap between philosophical theory and day-to-day medical practice? Clearly, what philosophy lacks is results. This is the bottom line, and rightly so, for medicine. Science has delivered results; philosophy, by and large, has not.

J. L. Austin

John Langshaw Austin was born in 1911. His biography (Warnock, 1969) is that of the quintessential academic: a classical scholar, first at Shrewsbury School and then at Balliol College, Oxford; a Fellowship at All Souls College when he was 22; a distinguished war record as a senior officer in the Intelligence Corps (he co-ordinated all intelligence work in the preparations for D-Day); and, after the war, a Chair in Oxford as White's Professor of Moral Philosophy. He died after a short illness in 1960 at the age of only 48.

In Austin, the philosophy follows the man. A scholar, with scholarly instincts, he brought to his philosophical work a detailed, methodical approach, rigorous and disciplined. He made no large claims for the subject, but his experience as an intelligence officer gave him a sense of the possibility of progress, even with apparently intractable problems, by, of all things in philosophy, corporate effort. Add to this his gritty, no-nonsense personality, and you have the ingredients for a potentially fruitful approach to philosophical work in medicine.

I consider Austin's philosophy under three headings: first, his understanding of the nature of philosophical problems; second, his ideas about philosophical method; and finally, his views on the organisation of philosophical work, his conception of philosophy as a corporate rather than a purely individual venture.

The nature of philosophical problems

It might be thought that an understanding of the nature of philosophical problems is an essential preliminary to philosophical research, that we need to know the nature of the beast before we can tackle

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it. Austin, however, took matters the other way on. He mistrusted comprehensive, grand-design theories of philosophy, regarding even the logical positivists (with whom he was contemporaneous) as having fallen prey to the same delusions of grandeur that they had so despised in the metaphysicians. Instead, Austin considered philosophical difficulties to be essentially a mixed bag of all those problems that we have so far failed to find satisfactory ways of tackling. The mixed bag used to be much larger. It used to include, for example, the now distinct subjects of mathematics, natural science, and logic. Our approach to what remains must necessarily be open, experimental, and opportunistic; we must be ready to try out new ideas. What matters, on this model of philosophy, is not the *a priori* cogency of an approach, still less the elegance of some grand vision of the subject, but simply that, in some part or in some respect, progress is actually made. According to Austin, therefore, in philosophical research we learn the nature of the beast *by* tackling it (Warnock, 1969).

This view of philosophy seems especially well suited to the mixed bag of problems with which doctors are concerned in everyday medical practice, as distinct from purely scientific medical research. Medicine is characteristically pragmatic. So, too, in Austin's view, is philosophy. Within this mixed bag, however, there is one kind of philosophical problem which, according to Austin, we have at least a method for tackling, namely *conceptual* – conceptual confusion, obscurity, misunderstanding. Problems of this kind are certainly common enough in medical practice. They arise in classification and diagnosis, for example, in psychological medicine notoriously (Hempel, 1961; Rachman & Philips, 1978), but also in primary health care (Helman, 1981; Jenkins *et al*, 1985): in both these areas the disease concepts derived largely from hospital-based physical medicine are proving in important respects unsatisfactory. Similarly, in medical ethics the conceptual basis of even such intuitively well established procedures as compulsory psychiatric treatment remains wholly unclear, with consequent risks of inadvertent misuse, or even actual abuse, of medical authority (Szasz, 1963; McGary & Chodoff, 1981). Philosophy, therefore, by helping to clarify conceptual problems in medicine, has an important potential contribution to make to everyday clinical work.

Philosophical method

The essence of Austin's philosophical method is to replace mere passive reflection on the meanings of our concepts with active observation of the ways in which they are used in everyday language.

This method, sometimes called the linguistic analytical method, owes something to Wittgenstein's view of philosophical problems as a kind of illusion. The basic idea is that philosophical problems arise from philosophers taking too narrow a view of the concepts with which they are concerned. They get stuck with a restricted view. Our concepts, however, are reflected in the things we say. Hence, one way to gain a more complete view of the meaning of a given concept is to observe the ways in which it is actually employed. This much Austin shared with Wittgenstein, although where Witgenstein sought to draw on ordinary language to dissolve philosophical problems – to show in effect that they are pseudoproblems – Austin saw in it simply a resource. Ordinary language, for Austin, was a resource of fine distinctions, built up with the evolution of language itself, upon which philosophers could draw as a useful first step towards elucidating some of the problems with which they are concerned (Warnock, 1989).

Austin's method, as a way of tackling philosophical problems, has been widely criticised, although perhaps more through misrepresentation than in its own person. It has been said, for example, that it is too restricted, that it fails to address the real meat of philosophy, the deep problems of general metaphysics, such as the mind–body problem. Problems of this kind, it is believed, are implicit in, and hence incapable of explication in terms of, ordinary usage (Ayer, 1976). Austin would not have disagreed with this however, observations of ordinary usage being, as he once put it, only the first word in philosophy, not the last. All that Austin claimed is that it may sometimes be helpful to start by observing ordinary usage. Then again, it has been said that his method is too subjective. True, ordinary usage may include any species of non-philosophical usage – technical usage, as in law and medicine, as well as colloquial – but it has been said nonetheless that Austin's method fails to draw sufficiently on the objective techniques of linguistic analysis developed by linguists (New, 1969). Yet here, too, Austin would not have disagreed. On the contrary, an important feature of his method is that it is open to progressive improvement.

Still, the real test of Austin's method is his own pragmatic test – does the method work, does it produce results? So far as general philosophy is concerned, Austin was interested in several areas, to all of which he made useful contributions. His nearest approach to medicine, however, was a passing reference to abnormal psychology as one of

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those areas in which technical usage (e.g. terms like 'compulsive') offered a philosophically useful extension to the resources of colloquial language. This comes at the end of his paper "A plea for excuses" (Austin, 1956–57). His general point in this paper is summed up in his typically pithy aphorism to the effect that, in philosophical work, it is often the negative concept that "wears the trousers". What he meant by this was that in exploring the meanings of our concepts we may learn more from situations in which things go wrong than those in which they run smoothly. A direct medical parallel to Austin's thinking here is the way in which we learn about normal physiology from circumstances in which bodily functioning is impaired, diabetes leading to the discovery of insulin for example. Similarly then, in Austin's paper, free action (the positive concept) is illuminated by looking at the circumstances in which we take our freedom of action to be impaired, that is, by the range of (negative) concepts that constitute excuses, including – and this was where abnormal psychology comes in – mental illness.

With his early death, Austin was unable to follow up his pointer to abnormal psychology, and he did no other work directly relevant to medicine. However, his method may be illustrated by considering the role of evaluation in our use of the key medical concepts of illness and disease. I have written about this in detail in section II of *Moral Theory and Medical Practice* (Fulford, 1990). All I try to do here is to give an indication of the potential value of Austin's method for philosophical work in medicine.

Illustration of Austin's method

Notwithstanding the importance of science in medicine, the concepts of illness and disease (*ill*ness, *dis*ease) are *prima facie* evaluative in nature. The question that arises, therefore, is whether these concepts can be defined, at least for technical use in medicine, in ways that are value-free. Most doctors, and many philosophers, reflecting an essentially science-based view of medicine, have argued that they can. It is acknowledged that value judgements may be involved in the ethical questions that arise in management, but the disease concepts employed in diagnosis, it is felt, are essentially value-free. A particularly careful argument along these lines is given by Christopher Boorse, a professor of philosophy at Delaware University (Boorse, 1975). The essence of Boorse's approach is to seek to resolve the clinical problems associated with the medical concepts by confining the evaluative element in medicine to the concept of illness while defining disease in terms that are value free.

Following Austin, then, we can ask of Boorse's proposed value-free definition, how is the concept of disease actually used? We can ask this question not by exploring ordinary usage generally (in which, even in medical contexts, disease may be used evaluatively), but by looking at Boorse's *own* use of the concept of disease. This is rather like a crucial experiment in science. The question is how far Boorse himself is able to operate with his own value-free definition of disease.

What do we find? First, we must look at Boorse's value-free definition of disease. "What makes a condition a disease," he says, "is its deviation from the natural [by which at this point in his argument he means statistically typical] functional organization of the species . . ." (Boorse, 1975, p. 59). Well, that is certainly value-free. It is a matter of straightforward fact whether the functional condition of an organism differs from that which is standard for the species to which it belongs. However, three lines later, Boorse writes "In general, deficiencies in the functional efficiency of the body are diseases . . .". Thus, notwithstanding his proposed value-free definition, as soon as he uses the concept of disease, the value-free statistical deviation becomes the value-laden deficient functional efficiency.

A second example of this shift from value-free to value-laden terminology appears on the following page. The definition of disease is now extended to include (in addition to statistical deviation) the value-free notion of environmental causation. This is to meet the objection which he notes to his earlier definition, that disease may be endemic or statistically normal. However, disease is then said to be "attributable mainly to the action of a hostile environment". Once again, therefore, the value-free environmental causes shifts to the value-laden "hostile environment".

Additional examples are found further on in his 1975 paper, and again in a later paper (Boorse, 1976), when he considers mental disease. Some of the value terms that occur here are 'interference', 'excessive', 'grotesque', and 'absurd'. It is important to emphasise that this is not a matter of crude inconsistency. On the contrary, Boorse's arguments are thorough and persuasive, but when we look, with an Austin-sharpened eye, at the actual words he employs, we see that, despite his value-free definition of disease, his use of the concept continues to be value-laden.

There is more than one possible explanation for the persistence of value judgements in Boorse's use of disease. It could be simply a matter of habit, for example, of everyday usage breaking through. This is unlikely, however, given the careful way in which Boorse's paper is written, and the central importance to his argument of a value-free definition of the term.

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An alternative explanation, therefore, is that, notwithstanding his proposed value-free definition, disease is inescapably, and even in technical usage, an evaluative concept. If even Boorse cannot make a value-free definition stick, as it were, this suggests that there is an essential element of evaluation in the meaning of disease. There is of course an essential factual element as well, but take away the evaluative element – as Boorse stipulatively tried to do – and disease is simply unable to continue doing its full linguistic job.

If this explanation is right, the effect of linguistic analysis in this instance has been to give us a more complete picture of the concept of disease. Boorse's view reflects the widespread medical view that disease (as distinct from illness) is a purely scientific concept. This view is natural enough given the success of science in medicine. Observations of the actual use of the word 'disease' suggest, however, that this is a one-sided view, a view which concentrates on the factual side of the concept while neglecting its evaluative side.

It is this more complete view of the medical concepts that is at the heart of the potential practical usefulness of linguistic analysis. As Sir Denis Hill once described it, linguistic analysis is in this respect rather like psychoanalysis, a consciousness-raising exercise. Again, I have written about this elsewhere (Fulford, 1990, sections IV and V). It can be seen in general terms, however, that linguistic analysis, in the form advocated by J. L. Austin, could provide a more comprehensive framework for tackling some of the conceptual problems in medical practice – in classification, in diagnosis, and in medical ethics. It is inherent in Austin's own view of philosophy as a mixed bag of problems that we should not expect any one approach to provide a panacea, but to the extent that the problems in these areas of medicine really are conceptual in nature, we are more likely to make progress towards resolving them if we have a full-field, rather than hemianopic, view of the conceptual structure of medicine.

The corporate organisation of philosophy

The practical outcomes to be expected from work of the kind just described are mostly of a rather general nature: for example, better understanding, clearer communication, and co-operation between disciplines. These are important outcomes, certainly, but they are perhaps still somewhat remote from the particular clinical problems faced by individual doctors (and other health-care professionals) in their everyday work. It is here, at the point of entry of philosophy into day-to-day clinical practice, that Austin's views on the organisation of philosophical work could prove decisive. Austin was perhaps unique among philosophers in believing that philosophy, or at any rate linguistic analytical philosophy, should be pursued rather as science is pursued, not by isolated specialists but as a corporate activity. What Austin had in mind was not just discussion, an essential element in all philosophy. It was rather that large problems, or at least some large problems in philosophy, could usefully be broken down into smaller parts and distributed across a team or community of researchers.

This is the least discussed of Austin's philosophical views. It seems to have been largely dismissed as an aberration. Presumably this is because it is so far removed from the solitary working methods of the majority of classically trained professional philosophers. Even with Austin, the corporate approach seems to have been inspired by his experience of intelligence work in the war, rather than by any conscious attempt to model philosophy on science. Yet as Warnock (1969) has pointed out, this approach to philosophical research has been dismissed without actually being tried. It is not obviously mistaken, and in medicine, in particular, it could well be the way forward. Doctors, after all, have the advantage over philosophers in this respect, being scientifically rather than classically trained. Furthermore, the wide variety of the phenomenology of illness, mental and physical, offers precisely the right kind of extended 'data base' for work of this kind. This data base, moreover, recalling Austin's aphorism about the negative concept "wearing the trousers", represents a rich and largely untapped resource for general philosophy. An example of this is provided by the phenomenology of the clinical concept of delusion, which has implications for ethical theory, for epistemology, and for the philosophy of science (Fulford, 1990, chapter 12).

Medicine, therefore, seen through Austin's philosophical eyes, has as much to offer philosophy as philosophy has to offer medicine. There is thus every incentive for the two subjects to move closer together, to establish the two-way connections between theory and practice that already exist, and exist to such good effect, between medicine and science. Even in medicine we are still a long way from establishing the structures, administrative and professional, required to make Austin's corporate approach to philosophical research possible. At the very least, research funds will be needed, and the nature of philosophical problems – Austin's mixed bag – precludes the kind of forward guarantees of success that grant-giving bodies rightly require. But Austin's linguistic analytical method, as I have

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illustrated, shows promise, and if we are to see that promise fulfilled, a corporate, rather than a merely individual effort, involving a close-working relationship between doctors and philosophers, will be required.

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