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Self-Conflict in Ethical Decisions

Eric Cassell

THE NOTION OF PERSON is fundamental to any consideration of medicine as a moral profession, concerned with the welfare of individuals. It is not sufficient, however, to require physicians to treat the patient as a person without providing a wider understanding of the concept. One important aspect of being a person is that a person is someone who valuates—who makes decisions based on alternative values. In an earlier discussion of valuational thought,[1] I believed that I could move forward to see how that mode of thinking is used to make value decisions and the relationship of the thought to action. I was stopped by the realization that the same individual could make contradictory moral or value decisions, depending on circumstances, and yet the decisions, even though conflicting, would seem authentic to the person. This essay is an attempt to describe conflicting ethical decisions made by the same person to see how conflict arises and how it is resolved.

Let me begin with the cases that caused me difficulty and that seemed to require an explanation.

In 1971, I took care of a woman, Dora S.,[2] who was dying of an inoperable cancer of the esophagus. The diagnosis was confirmed by biopsy and, prior to my seeing her, she had received adequate radiation therapy. Cancer chemotherapy available at that time offered no real hope of improvement. The decision to

maintain her comfortably rather than just keep her alive was made in concert with the family and indirectly in conversation with the patient. She developed pneumococcal pneumonia, which was not treated, and died of the infection. House officers connected with the case vigorously opposed the decisions. They felt that every available treatment should have been tried, that no patient should simply be "allowed to die." Their position was common in 1971. In 1977 I took care of Esther R., who was developing generalized paralysis from amyotrophic lateral sclerosis. As the paralysis spread, she experienced difficulty in breathing. Although she knew her life would be short (perhaps months), she wanted a belt-type respirator that would keep her comfortable and allow her to remain at home until she died. Her sons agreed with the decision. Because her respiration was dangerously impaired, she was admitted to the hospital for a few days until her belt respirator arrived. The house officers objected to putting her on a mouth respirator for fear that she could not be weaned off. Despite assurances that the belt respirator would allow her to go home, they were against "just keeping her alive." She died during the first night of hospitalization, apparently because no respirator assistance was provided. Similar cases are now becoming common. Dr. Mark Siegler tells of a ninety-year-old man, otherwise well, who was admitted to his hospital with pneumococcal pneumonia. The house staff did not treat him because they did not believe patients should be merely "kept alive." After all, they said, he *is* ninety years old.

The decision of the house officers in the 1971 case and the 1977 cases were the exact opposite of one another. Further, both examples, especially the woman with terminal cancer of the esophagus, but increasingly, cases like Esther R., are typical of their respective times—1971 and 1977. In both Dora S. and Esther R., the individual nature of the patient did not seem to enter the decision. Dora S. could not be helped to maintain a meaningful life and the family agreed that she should be allowed to die without further cancer treatment—a position with which the patient apparently concurred. Esther R. and her sons knew her situation and wanted the belt respirator.

What accounts for these paradoxical decisions whose only major difference was the period in which they were made? I am

going to suggest that in each instance a *physician self* made the decision. Why suggest an entity such as *physician self,* rather than merely saying the young physicians made the decisions? Using physician *self* rather than young physician suggests that another or at least a different self might have existed in each of the young physicians. It seems possible that if, in each case, the physician had been not only a doctor but also the child of the patient, he or she would have made a different decision—a decision similar to that made by the actual children of the patients. Two alternative possibilities present themselves. The first possibility is that as the patient's child and also as a physician, more information would have been available and, perhaps, have altered the decision. The other possibility is that as the patient's child, despite also being a physician, a different self would have been presented with or have made the decision.

If it is simply the case that as the child who is also a physician, more information would have been available, then it is true that in the actual instances these young physicians could have sought more information. They are trained to know that information about the person of the patient is important to medical decisions. The families were available, the patients were of approximately the same social background as the physicians and there was no language barrier—all factors that might otherwise have prevented their knowledge of the patients. Furthermore, there was so much discussion about the cases that the young physicians knew the wishes of the actual children and even those of the patients. Thus, the information was available to them. But on what basis can I entertain the possibility that if they had been the children as well as physicians, they might have decided differently? In other words, if one is the child of a dying patient, might one decide differently than if one is the physician of a dying patient?

Another case sheds some light on that possibility. A middle-aged female writer was traveling a far distance to get to the bedside of her aged and dying mother who had just been transferred from a nursing home to a hospital. En route, the daughter had firmly resolved that she did not want the doctors to do anything to prolong her mother's process of dying. When the daughter arrived, the doctor suggested that her mother was indeed

dying but he believed that because the mother was bleeding she might be helped if she was given blood transfusions. The mother's situation was essentially as the daughter had believed (the mother was dying), and precisely as discussed with herself en route. Nevertheless, at the bedside, after talking to the doctor, she found herself in conflict and sought outside help in making a decision. It would be common to say that while traveling she was using "reason" and "logic," but that at the bedside "emotion" prevailed. But, as she said herself, and as our own experience of the world testifies, she was also filled with emotion during the trip.

If we add this case to the previous situations, the evidence suggests that in the instances of the young physicians (and the adult intellectual en route), a physician "self" (or an adult-intellectual "self") made the decision. In other words, it was not that the young physicians (or the adult intellectual en route) were lacking information when they made a decision contrary to the wishes of family and patient (or daughter-at-bedside). Rather, it seems that the decisions were made by a "self" particular (discrete) to the entity, young physician. A particular "self" in this context should be read as a "self" separately identifiable in action and across time but inseparable from the whole person.

Before explaining further what I mean by "self," I should explain what kind of definition I will try to give to the word. Stephen Toulmin, in discussing the kinds of knowledge we can have about the self (and about self-knowledge), makes clear that the concept cannot, usefully, be seen as a hypothetical-explanatory one "to help us explain newly observed phenomena outside the normal range of our psychological experience." Rather, the concept as used here is descriptive and meant to "mark new complexities and relationships within psychological phenomena that have, in less exact and detailed terms, been long familiar."[3] I am merely trying to clarify a behavior that seems, on reflection, to be quite common—apparently different and conflicting judgments made by the same person about similar issues (in the examples it is the care of the dying) and in trying to clarify the behavior, I hope to enlarge the conception of "self," its maintenance, and integration.

An earlier way of seeing the self comes from George Herbert

Mead: "The Self has a sort of structure that arises in social conduct that is entirely distinguishable from the subjective experience that forms it." "The Self . . . arises where the conversation of gestures is taken over into the conduct of the individual form." The awareness of the Self (self-consciousness) "is not simply because one is in a social group and affected by others, and affects them, but because . . . his own experience as a self is one which he takes over from his actions upon others. He becomes a self in so far as he can take the attitude of another and act towards himself as others act."[4] In these citations, Mead makes clear that the self that he describes is cohesive and internally consistent, not something called up for the moment or immediately changeable. He goes on to say that "The essence of Self . . . is cognitive: It lies in the internalized conversation of gestures which constitutes thinking, or in the terms of which thought or reflection proceeds. And hence, the true origin and foundation of self, like those of thinking, are social."[5] This is, essentially, self as a learned role.

We can extend the word cognitive. As Toulmin points out, it would be "highly artificial to treat the 'understandings' existing between different human agents as something restricted to the cognitive sphere to which affective and volitional components happen to be annexed quite accidentally."[6] Except for specific or particular uses, it would be well to drop those distinctions as not being generally useful. As I leave my car and proceed down the block, my hand tells me that I forgot to lock the car door. When I examine a patient, my hand tells me that the lump in the breast is larger than the last time I felt it. Following previous distinctions between (say) cognitive or affective, I could not begin to know in which category to place what my hand told me. It does not injure Mead's insight to include with the cognitive, affective, and volitional functions, as well as what the hand says to its owner and to others.

Remember that my inquiry is prompted because the original cases suggest that a person can have more than one "self" and that these "selves" can make different ethical decisions in the same setting. The ethical decisions can be in conflict and, therefore, the "selves" can be in conflict. The problems to be addressed are a better understanding of what I mean (and do not

mean) by the entity "self"; how conflicting "selves" could be maintained within the same (normal) person, i.e., what maintains the borders and how adjudication between conflicting "selves" takes place and ultimately how, from such adjudication, the individual might grow more mature.

As a first step, I accept that the word "self" is a poor word because it already carries too much baggage, is too fuzzy, and means too many different things to different people. But I think the word is troubling precisely because some of the matters being considered here are unsettled within us as individuals and in the use of the term. The notion of "self" is fundamental to ethical concepts such as autonomy where a unity of self is implied despite the fact that in the exercise of our own autonomy we are often "of two minds." Or, in attempting to clarify autonomy of belief, Gerald Dworkin has difficulty finding that which is uniquely from the self and only from the self because there is no "self" that can be seen entirely separate from other persons.

As noted earlier, a "self" is an aspect of person separately identifiable in action but inseparable from the whole person. The actions (that make it separately identifiable) are in response to things, other persons, or their actions. The "self" is, in other words, relational. Since it is relational, the self is inseparable from language. One could arrive at the conclusion that the self is relational from the opposite direction—starting from language. It is possible to stand in relation to a person or an object, or to act or decide to act without language, but it is inconceivable that the relation, decision, or action will not be described or justified by language at that time or later. As Roberto Unger points out, "consciousness displays a peculiar paradox that poses the preliminary issue with which a theory of mind must deal. Consciousness implies autonomous identity, the experience of division from other objects and from other [persons'] selves. But the medium through which consciousness expresses itself is made up of the symbols of culture and these . . . are irreducibly social. When you speak of language or make a gesture, you perceive and communicate meaning in categories that are the common patrimony of many men. By what power can you and they speak to one another? It must be possible for each to view the other's statements and acts as signs of certain intentions. These inten-

tions can, in turn, be understood, because they are intentions you too might have. It follows that consciousness always presupposes the possibility of viewing other persons as selves that could, under favorable enough circumstances, see what one sees and believe what one believes."[7]

The properties of (spoken) language allow individuals to place themselves in relation to concepts, things, persons, or their actions by the way words and syntax are used. Verbs, adverbs, adjectives, and pronouns are used to create what might be called a semantic space in which the self as speaker is central and the object of conversation is at a valuative, affective, or attitudinal distance from the self. A different relationship is described by "my mother is dying" and "my dying mother." Or, "my mother is suffocating to death," "my mother is dying because she can't breathe anymore," and "the woman is dying from respiratory paralysis." Although the sentences in both sets describe the same phenomenon, the distance between the speaker and the person dying is different as is shown by the varied usages. The self identifies itself in semantic space and is identified by others through relations expressed by language.

With this seeming paradox in mind—that the self is uniquely personal and thus constitutes the individual, but that it cannot be seen apart from symbolic interactions with the group—let me go on to other views of self. Jung would use the word "persona." From his viewpoint, persona is not the legitimate individual. "Fundamentally, the persona is nothing real: it is a compromise between individual and society as to what a man should appear to be. He takes a name, earns a title, represents an office, he is this or that. In a certain sense, all this is real, yet in relation to the essential individuality of the person concerned, it is only a secondary reality, a product of compromise, in which others often have a greater share than he. The persona is a semblance, a two-dimensional reality to give it a nickname."[8] Jung does go on to point out that in calling the persona unreal, he is being somewhat unfair because there is something individual in the peculiar choice and delineation of the persona. It is also clear from his description that more than one persona is possible, though he does not say that. For him, growth is the emergence of the individual as an adjudication between persona and the personal

unconscious (as he sees it) in the process he calls individuation.

Perhaps for the Greeks there was no individual, totally personal (and essentially private in the Jungian sense), and for them the word persona did not represent a semblance but was indeed the "real" self. The modern sociological view of role most closely approximates the thing of which the Greeks spoke, as in the role of physician, child, mother, or even philosopher. As often used, and possibly to exaggerate slightly, I shall say that the Goffmanesque role seems to be for Erving Goffman pretty much the whole person. As used by me, a "self" is decidedly not the whole person, just as a "self" as I have portrayed it is not an unreal person. Nonetheless, in these two almost opposite views, Jungian and Goffmanian, both supported by experience, one can see why the word remains so fuzzy.

I suppose it is necessary to mention one other way in which the existence of more than one self has been handled in normal individuals, that of transactional analysis. There the existence of a child self, parent self, and an adult self are acknowledged and the aim of treatment is to bring to dominance the presumably healthy adult self. The immense popularity of transactional analysis derives, I suppose, both from the simplicity of its concepts and from their approximation to something recognizable within each of us. Although such concepts may be popular and lend themselves to group activities, amusements, or even effective therapy, they do not answer the essential questions raised by this essay: How are borders between selves maintained and how does adjudication between selves take place? And, ultimately, they cannot explain the conflicting ethical decisions raised by this essay in the first place.

For the purposes of this discussion, I have bracketed the domain of the unconscious. I am aware of its existence and I believe it is one of the determinants of the form and content of the "self" which I am describing. Indeed, in some people and under certain circumstances, it might be a major determinant of the expressions of self. But the relationship of the unconscious to the self is, to say the least, unclear; thus, I cannot deal further with it at this time and remain coherent about the self beyond saying that to postulate the self as I have done, without recognition of the fact of unconscious determinants, would be as barren

as suggesting that the self is an entity solely determined by the unconscious. In one sense, the paradox of consciousness exposed by Unger applies also to the unconscious. It is clearly a uniquely private part of the individual and yet it has no coherent meaning in development and expression apart from others, and in that sense must penetrate consciousness. But the self is consciousness, and consciousness is more than an expression of the unconscious. In this discussion, for definitional purposes, the unconscious can also be bracketed and included in the realm of unknown and possibly irreconcilable conflicts, whereas the conflicts in ethical decisions of which I am speaking are reconcilable and result in action.

Acknowledging the unconscious and the fact of unconscious determinants in its constitution will make it impossible totally to subsume the self of which I speak under role. The self as role alone is also denied by the fact that the several "selves" in each person are authentic to that person, although someone may say of his actions, "I was surprised at what I did," or "I did not know I felt that eay."

I have been saying that in certain decision-making situations, different "selves" within the same person come into conflict. For example, the child versus the physician, where the child of a dying patient is also a physician. Or, as in the case of the woman flying to the bedside of her dying mother, the "adult intellectual" versus the "child." In that instance, the "adult-intellectual self," on her way to the bedside, seemed to contain or have access to information useful in deciding whether aging, sick parents should be "allowed to die." And this information translated itself into a formulated behavior or set of actions. In this instance, and in many others similar to it, the behavior did not arise out of previous experience with the situation, which would speak against the "adult-intellectual self" being a stereotypical behavioristic entity—for that person had never been in that situation before. Furthermore, information concerning, and "ideal" behavior toward, dying parents has changed in recent times (what is considered "right" in 1977 is different from what was considered "right" in 1967 or 1957). Thus, behavior is capable of change not subject to direct experience. With regard to information/behavior, two other things seem to be true; information/behavior does not

seem to be especially tentative—people can act sure of themselves and also can be very sure of themselves about a reality they have never seen.

Now, however, the "adult-intellectual" self arrives at the bedside of her dying mother and inner conflict arises. That is, the previously determined decision about allowing the mother to die is called into question. There are several reasons for this. First, the reality of the situation is not as clearcut as was previously believed. Is the mother actually dying? It is suddenly apparent to the woman how little she knows about dying patients. Would a transfusion save the mother's life or merely prolong the process of dying? Would she be a bad child if she refused this to her mother? Was the doctor being a good human being in his recommendations, or "merely a doctor"? But, most importantly, the patient in the bed is suddenly not just a member of the intellectual category "dying patient," but "my mother who is dying." With that perception, the child self comes to the fore. For one thing, children do not make decisions, parents do (although role reversal between children and elderly parents commonly occurs). And, of course, a child does not want to lose a parent, and the suffering of a parent, more than that of anyone, is (usually) intolerable. Conflicts arise. The child wants it to be over for both altruistic and selfish reasons, but for it to end, the parent must die. Certain overriding rules come into play, such as "Thou Shalt Not Kill" and "Honor Thy Father and Mother." Lesser rules not strictly related to the situation also have force—rules of etiquette. It is not polite to continually question a doctor or make a scene.

Thus, the "adult intellectual" en route to the bedside of her dying mother finds, on arrival, that the reality of the situation is not nearly as clearcut as her previous well-defined beliefs about it, and that the person she has become at the bedside is no longer "adult intellectual" but rather "child." With that case in mind, let me reexplore the two similar cases in which the young physicians acted in an opposite manner, one in 1971 and the other in 1977. What had changed? I do not believe the role (in the strict sociological sense) of physician changed significantly, although there have been some changes of style. It is difficult to imagine that a change in the unconscious domain of the 1977 physicians was responsible. Patient-doctor and doctor-to-doctor etiquette is

essentially similar now to that of 1971. The reality of the two cases was also the same: in one the young physician protested allowing the patient to die, although family and (apparently) the patient were for it, and in the other instance, the young physicians allowed the patient to die when family and patient wished life to continue.

At this point it is worth trying a tentative conclusion. It appears reasonable that the self is a rule-constituted entity and that between 1971 and 1977 the rules changed. Before going on to clarify what I mean by rule-constituted, I must discuss something that would merely trivialize the conclusion. Why say that the cases suggest that the self is possibly a rule-constituted entity instead of saying merely that what is considered good medical practice has changed? This is similar, for example, to saying that in 1971 it was good medical practice to give oral antidiabetic drugs for diabetes even if the patient wanted insulin, and in 1977 it is not (usually) good medical practice to use oral agents even if the patient wants them. Changes in medical practice in regard to diabetes are technical changes that result from new scientific evidence. The doctor's decisions are based on analytic thought—careful analysis of the situation and weighing of the relevant facts. The patient's wishes can be examined and rejected (or heeded) with an explanation offered to the patient in which all the factors can be made explicit. The issues of value are implicit and would probably not enter into the discussion because both patient and doctor probably agree (although not necessarily so) that it is more important not to be made sick by diabetes than to be merely happy about the kind of medicine one takes.

The cases of change in regard to dying patients are distinctly different. Here the explicit medical evidence did not play the largest part in the decisions. Indeed, on the medical evidence alone, the young physicians were wrong in both instances. Rather, in these cases, the issues were fundamentally issues of value. This kind of thinking is primarily not analytic but rather valuational, a kind of thinking, I have argued elsewhere, that is necessary to medicine but neither explicitly taught nor honored.[9] The evidence on which such decisions should largely be based is moral, not technical, and the source of such moral evidence (the wishes of family and patient) was avoided in both these in-

stances. Thus, the conclusion that it is a change in rules that has occurred, not merely a change in medical practice, seems warranted. In defending the conclusion, however, it appears that the rules that help constitute the self are value-laden. Let me now discuss further what I mean by rules.

I admit at the outset that I am going to have difficulty explaining what I mean. Providing alternative words like precepts, principles, injunctions, or what have you, will not clarify the matter. The principal reason for the difficulty is the very wide range of rules that seem to constitute the self. First there are almost universal rules such as "Thou Shalt Not Kill," or "Honor Thy Father and Mother." Then there are rules that are implicit in professional roles, such as the requirement of physicians that they respect their patients' confidences. Some rules are culturally derived, such as the father sits at the head of the table, or the older brother will speak to the doctor. Rules can also be more personal and part of a family's habits, as in the way a woman arranges her refrigerator. Or they may be entirely personal, as in the way an individual may always precede an aggressive statement with a self-deprecating phrase or gesture. It is readily apparent that as one goes from the more universal to the most individual, what are being called rules appear less like rules than behavioral traits. What function is served by calling all of them rules? In the sense that they all determine the self as "separately identifiable in action," they are all precepts that guide the action of the self. The self is a particular and idiosyncratic mix of rules or precepts that are cohesive over time. The fact that some rules are universal and others almost totally unique to an individual confuses things. The hugely varied origins of the rules make consideration of self difficult and allows such argument between those who see individuals as role-sets and those who have a more existential view. Indeed, to use the word rule for "Thou Shalt Not Kill" as well as for my child's aggrieved cry, "No olives? We *always* have two kinds of olives at Thanksgiving," seems to trivialize the universal. In respect to their vastly greater importance, we call the universal rules moral laws and by doing so acknowledge the harm that comes from their transgression. No such harm arises when there are no olives on the Thanksgiving table.

I can understand that it may be disturbing to include within the

same discussion universal moral laws and what seem to be merely habits. Indeed, if the purpose of this essay were to explore the origin of overriding goods in human interaction, the disquiet would be justified. But my purpose here is to explore the self and see of what it is constituted, and, further, to show that one can have more than one self and that these selves can come into conflict in ethical decisions. The rules or precepts of the self do indeed range over so wide a spectrum. But at whatever level, laws, rules, precepts, or habits are based on a belief or beliefs about the world; the very large world of all persons or the very small world of this individual physician or that "adult intellectual." Dorothy Emmet has provided considerable thought and discussion about the difficult problem of the relationships between the various classes of rules and precepts.[10]

Such a constitution of self is parsimonious or at least efficient because, it seems to me, the fundamental problem to be solved for the self is the constantly changing and uncertain nature of the reality in which decisions must be made. Where the self, faced with a decision, is able to determine merely what rules apply in (relatively) general terms, uncertainty is considerably reduced.

If we return to the "adult intellectual" en route to the dying mother, we understand why she is able to make a decision in an area in which she has no direct experience. She does have beliefs about the care of the dying, and those beliefs have been formed by the experience of others, recent readings, discussions, and so forth. Those beliefs have changed in recent years so that the former belief that one should keep the dying alive because "you never know when they will develop a new cure," changes into a belief that prolonging dying will increase suffering. The beliefs of young physicians have also changed between 1971 and 1977 and in the same direction. Where "keep alive at all costs" was the humane thing to do in 1971 (for young physicians), "allow to die" becomes the humane thing in 1977. If, as I believe, uncertainty is the problem to be solved for any self, we can understand why the young physicians acted, both in 1971 and 1977, seemingly without regard to the wishes of the respective parents and their families. As long as the situation conformed to their belief, a precept existed for action. Talking with the families and getting more information would not decrease uncertainty, but

rather increase it. It would, for example, place the young physician at emotional risk, for (as it is said) identifying with the children (near his age) and thus seeing the case from the perspective of both a child self and a physician self could only result in ethical conflict. In just that manner, when the writer arrived at the bedside of her dying mother, both uncertainty and change in perspective occurred; she could not be certain whether the realities of the situation conformed to her "adult-intellectual" belief (i.e., was the mother really dying), and in addition, she became a child at the bedside of her mother.

Earlier, I indicated that between 1971 and 1977 the rules changed for the young physicians. Now I suggest that beliefs changed. Indeed, the rules may have stayed the same ("humane") and only the beliefs changed, or both may have occurred. However it may be, it is clear that rules and beliefs are intimately related. Beliefs, as Gunnar Myrdal has said, are ideas about how the world works. But if that is the case, then both rules and beliefs are intimately related to another vital element—perception. The problem of percepts and beliefs is similar to the problem of beliefs and actions and still revolves around the issue of uncertainty. When the person merely "sees" what existing percept (perceptual gestalt) applies to that which is perceived, less uncertainty is created and a decision can be made more efficiently than if a person had to constitute a whole new percept for each occasion. For a belief to remain intact, the perceived world must support that belief, and the belief must remain stable if action is to be unambiguous.

Self as perceiver and self as decider are intimately linked. It may be the case that different selves simply perceive the same situation differently. For example, the young physician perceives a dying old woman, the child perceives a dying mother. We all know of the classic blind men and the elephant, but blindness need not be literal blindness. "Rashomon" is a story whose interest lies in the totally different perception of the same events by different participants in the action. Once again, the possibility is raised that the rules for the different selves are all the same but the perception of events is different. As a physician at the bedside of a patient in pain, I am relatively insensitive to the pain

and I do not suffer with the sufferer. As a child at the bedside of my parent in pain, even though I am a physician, I suffer.

Three possibilities now exist to account for what appear to be the existence of different selves within the same person. The first is that the self is a rule-constituted entity and the different selves are separately identifiable in action because each has different rules or precepts for actions (although clearly some or even many of the rules may be held in common). As Paul Ramsey has suggested, one would then have to see these selves as parallel strings of conscience which must ultimately come into conflict. An alternate possibility is that selves are constituted from different beliefs and that the rules may or may not be different. However, if the beliefs are at variance, different actions may result. Or, whether rules are the same or different and beliefs are the same or different, the selves are held as distinct entities by differences in perception. I am unable to distinguish which of the three alternatives is most likely. Whichever one might choose, difficulties arise. At the present I am unable to resolve the issue and I leave it reluctantly because I know how important it is.

Some have objected to the notion of self as I have portrayed it, believing instead that a person can be of "two minds" about something, or hold conflicting opinions about what to do, or simply be in conflict. I may be of two minds about which candidate to vote for simply because neither meets my single desire. But in the case of conflicting opinions, since most, if not all of us, are in conflict many times in life, I must ask whether the differing opinions within us are random occurrences? Clearly they are not. Opinions are rooted in beliefs. Each belief on which an opinion is based and even each rule and percept has a history. Each follows from a previous belief or rule or percept and the fact of conflict between opinions suggests a differing, nonrandom history. Then what holds these histories if not different selves within us? What more logically cohesive or parsimonious solution to the simple fact that we each hold often deeply conflicting opinions can be offered than the proposal that a person is constituted of more than one self "separately identifiable in action across time"? I can conceive of none.

No matter which, or which mix of, rules, beliefs, or percepts

are the primary constituents of the selves, ethical conflict between selves is inevitable.

My original interest in this problem arose not so much from an attempt to show that there are different selves, but from a consideration of the fact that the same person can come into a situation in which he or she is in conflict about an ethical decision. I was interested first in understanding how the borders of the conflicting interests were maintained, and second, how adjudication between the conflicting selves takes place. For if action is to follow, adjudication must occur.

I believe it to be true, as Jung says and as Mead implies, that the process of growth, maturity, and ultimately of becoming wiser is a result of the multitude of resolutions between the different selves that constitute the person. Further, the process of becoming mature, if it occurs, involves learning the fact that adjudication can take place and how it is done, and how to tolerate the uncertainty that is inevitably involved.

Let us look at the original problem in a somewhat different way. The identifying characteristic of the actions of the young physicians in both 1971 and 1977 could be considered that of dogma or ideology—the application of rules and/or beliefs with a relative insensitivity to the actual facts of the situation. These dogmas or ideologies are systems of rules for action and perceptual gestalt (or systems of beliefs—for by this time, it is becoming clearer that no simple distinction can be made between rules, percepts and beliefs) often learned far in advance of the reality to which they are meant to apply. Two things are true of these ideologies. First, they are made up of relatively simplistic views of the world. That is, the beliefs seldom contain subtle distinctions or allow of many exceptions or extenuations. Second, it is characteristic of young adults that their different selves may be alarmingly sure of themselves (often inversely proportional to their knowledge of the world). Thus, it is in young adults that the concept of different selves "separately identifiable in actions but inseparable from the person" is most easily substantiated. Self as child with sure opinions about the parents, and at the same time self as young wife/husband or mother/father almost stereotypical in behavior (sometimes strikingly similar to the parent that the self as child criticizes) and self as young physician. Such ide-

ological cohesiveness is quite functional in that it is a solution to the problem of uncertainty. But in the situations that I posited, where selves (and thus ideologies) come into conflict, even greater uncertainty is created and must be resolved.

The uncertainty, the contradiction is intolerable. However, although at this time I cannot give as firm an account of the resolution as I have of the problem and its genesis, I must try. Where can the resolution come from if not from allowing more information to enter the decision-making process. That information must derive from reperception of events or reinterpretation of the original perception. As more facts are allowed to enter, the problem that created the conflict becomes increasingly specific. In increasingly specific problems, the general rules and/or ideological beliefs that constitute each individual self become less useful as absolutes, serving only as guidelines. Indeed, some rules, some whole ideologies, and the self dependent upon them might conceivably crumble in the face of new information. That must be, when it occurs, a profound event. We hear people say, "After that happened, I was never the same again. I never saw the world the same way as before." There are images for this in all cultures—the phoenix, rebirth, true conversion, and others. For most conflicts no such deep change occurs, rather, the rules that cover the new circumstance are thought through, considered and reconsidered, until action results. The action serves to produce more information (since most acts occur over time) that reinforces or helps solidify the new interpretation.

But where is the original perception that is available for new interpretation or wider recognition? There must be something within us—an experiencer—able to perceive and store perceptions more "true-to-reality" and not as guided by unconscious determinants or conscious beliefs.[11] An experiencer whose fresh interpretations or understandings of the original experience can serve to adjudicate between selves. If this is so, then selves are not experiencers as much as assigners of understanding to experience. This may be the case because we often say of someone, "How can he believe that (or say that, or act that way) in the face of so much evidence to the contrary?" There the self plucks from experience a percept, a construction of the experience that best serves to maintain itself.

Ideally, however, with growth and maturity, the experiential increasingly dominates, uncertainty becomes more tolerable, and the distinctions between the selves blur. When and if this happens (for it is by no means necessary, but rather to be desired) the person that emerges and comes to dominance is an amalgam of the selves (though one self may persist to a greater degree than another). In this process, previously learned beliefs and their rules, even profoundly important ones, such as belief in God, come to be truly the property of the person. The paradox of consciousness—between the person as authentic individual and the person as only socially validated—is reduced as the individual becomes more essentially self-referring and self-made, and at the same time more at home (though not necessarily happy) with society and its symbols, less afraid of uncertainty and conflict.

What have I tried to show? Starting from situations in which individuals were in conflict with themselves over an ethical decision, I have postulated that different selves within the individual are in conflict. At first it appeared that selves were rule-constituted entities, but quickly it became apparent that they are also constituted of beliefs. The distinction between rules and beliefs began to blur as though one could not clearly distinguish between them or say that they are truly separate. And then the place of perception in the maintenance of self became apparent as precept, belief, and percept merged as the constituents of self, serving the fundamental need of reducing uncertainty. Finally, resolution can be achieved when fresh experiential knowledge is allowed to enter, and in this process, occurring through multitudes of resolved conflicts, distinctions between selves blur and an individual emerges, authentic to itself and authentic in relation to its experiential world.

NOTES

1. Eric Cassell, "Preliminary Explorations of Thinking in Medicine," *Ethics in Science & Medicine,* vol. 2, pp. 1-12.
2. Eric Cassell, "Permission to Die," *BioScience,* August 1973.
3. Stephen Toulmin, "Self-Knowledge and Knowledge of the Self," Ms.