

Artificial Agents, Good Care, and Modernity

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Abstract. When is it ethically acceptable to use artificial agents in health care? This paper articulates some criteria for good care and then discusses whether machines as artificial agents can meet these criteria. Particular attention is paid to intuitions about the meaning of “care” but also to the care process as a labour process in a modern organizational and financial-economical context. It is argued that while there is in principle no objection to using machines in medicine and health care, the idea of them functioning and appearing as “care agents” raises serious problems. It is recommended that the discussion about MCAs be connected to a broader discussion about the impact of technology on human relations in the context of modernity.

1 INTRODUCTION

Is it ethically acceptable to use artificial agents in health care, and if so, when, under what conditions? While most philosophers recognize that there is a potential tension between the quality of care and the use of machines in health care, some are more optimistic than others about the possibility to bridge that gap. For instance, while some think that the solution lies in trying to create ethical machines (Anderson and Anderson 2007; Wallach and Allen 2008), whereas others have voiced concerns about the reduction of human contact (Sharkey and Sharkey 2010; Sparrow and Sparrow 2006), which seems especially problematic in the case of vulnerable people such as people who are ill, young children, and elderly people (Whitby 2011).

In this paper I side with the latter concerns, but further discuss what specific role machine can or cannot be given within health care (when exactly is it not acceptable to use a machine – even an intelligent one and one that can be trained), and draw attention to what has usually been neglected in discussions within the field: the relation between the quality of care and the labour process, and more broadly, the relation between the quality of care and modernity.

First I articulate some criteria for good care and then discuss whether machines as artificial agents can meet these criteria.

2 GOOD CARE

Let me articulate a normative ideal of good care: Good care involves a significant amount of human contact. Good care does not only mean physical care but has also psychological and relational, e.g. emotional dimensions. For example, a nurse talking to a patient is not something that stands outside the care process but that should be part of it. Good care is not only professional care but should also involve relatives, friends, loved ones to a significant degree.

Good care is not (only) experienced as a burden but is also experienced as meaningful and valuable.

Good care involves skilled engagement with the patient (know-how), next to more formal forms of expertise (know-that). Elsewhere I have called this “care craftsmanship” (Author 2013).

Good care requires an organizational context in which there are limits to the division of labour so as to not make the previous criterion impossible to meet.

Good care involves an organizational context in which financial-economic considerations are not the only or not even the main criterion in the organization of care.

Good care requires of the patient to accept some degree of vulnerability and dependency on others.

These criteria of good care are not uncontroversial; there are certainly less broad definitions, and some readers will disagree with one or more criteria. But for the sake of argument let us assume this rich normative ideal. What does this mean for the question regarding MCAs?

3 ARTIFICIAL AGENTS AND CARE

Let us now evaluate the idea to introduce MCAs. By itself, the involvement of technology is not problematic. Medicine and health care have always used tools. The key question, however, is what happens in a situation where machines *appear* as artificial *agents*. Of course all artefacts may have a minimal form of agency in the sense of having some influence on how things are done and even on what is done. But the “MCAs” concept includes a far stronger idea of “agency”, one that is similar to human agency. As the introductory text of the symposium says, we are considering machines here that will be “working with people”. This raises a number of problems in relation to the criteria just articulated.

First, even philosophers who argue that we should have MCAs or ethical machines in health care will not want a situation in which there are *only* machines in medicine and health care. Human contact is necessary. Moreover, most philosophers will agree that emotional and relational contact also belongs to good care. Now if this is right, then it means that MCAs are not acceptable in so far as they take over this particular human task. And this happens *in so far as they appear as agents*. If the robot is perceived as a tool, then the agency of the human care giver and the corresponding responsibility to provide human contact and “care” in the sense of “care about”, concern, remains intact. Then the care giver gives care *with* the tool, *with* technology. The machine mediates but does not have agency. But in so far as the machine takes on the role of a care agent, even if only in appearance, then it seems that something would be expected from the machine that the machine cannot give, and that in a situation of time scarcity (which is the condition in

this world) time is taken away from the human care giver to take up this role and responsibility.

Of course this argument assumes that machines do not have emotions, cannot be really concerned. Some philosophers might disagree, but they have the burden of proof. Note also that this argument does not exclude the use of robotic pets or similar artefacts, which function and appear as agents indeed, but do not take the *role* of the care giver; rather, they are recipient of care. This is a different problem, which has been discussed elsewhere – including by the author.

Second, even without explicitly considering the role of technology, current health care is highly professionalized, is often experienced as a burden, seems to have an emphasis on formal forms of expertise rather than know-how and craftsmanship, is usually done in an organizational context in which there is a high degree of division of labour, and is often discussed in financial-economic terms alone.

This development must be understood as part of the cultural-material process and experience that is usually named “modernity”, which has its brighter and its darker sides. Contemporary health care as “modern” health care means, for instance, that care giving work is divided into small units, is calculated, is professionalized, formalized and regulated. As Marx, Weber, and other classic theorists of modernity have pointed out, this inevitably leads to objectification (or reification) and alienation. For health care work, this means that care has become “labour” which involves an employment relation (with professionalization, disciplining, formalization of the work, management etc.) and a relation between care giver and care receiver in which the receiver appears to the care giver as an *object* (a thing rather than a human person, a subject) and which makes care into a commodity, a *product* or a *service*. Patients and other vulnerable people are managed and processed. This degrades not only the care receiver, it also alienates the care giver from her work and from the care receiver. The care receiver encounters only a ... “robot” care giver, a “robot nurse” or “robot doctor” who does only her small part of labour in the health care machine. In so far as this happens in contemporary health care, that is, in so far as contemporary health care is *modern* care, the quality of care is already seriously jeopardised even without considering the role of the machine.

The machine, in this context, is usually used to *automate* the “production”. The division of labour into small units is accompanied by, or perhaps made possible or increased, by technology. In this case, the worry is that the machine is used to automate health care as part of its further modernization. As in historical labour processes, this means that human workers are replaced by machines. Then the machine indeed takes up the role of a care *agent*; then we encounter again the issue of replacement which is ethically problematic. Again, in so far as that happens, the criteria of good care are not met. Perhaps machines can be given different roles, but then those roles or functions are better not “agency” ones.

Finally, accepting vulnerability and dependency on others seems to be a precondition of human care, but in modernity we are very keen to keep our autonomy. We are so attached to it, that some of us would *prefer* “machine care”. By doing this, however, we risk to lose the humanity and dignity we were seeking to preserve.

CONCLUSION

To conclude, using machines in health care is in principle acceptable, but in so far as they function and appear as “agents” which are supposed to take over some of the essential care responsibilities identified they further threaten the fulfilment of the criteria of good care, which are already hard to meet in a modern context. The design and use of machines in medicine and health care should therefore be re-directed to avoid these problems. If we want to use machines in ethical way, we should not make artificial agents more ethical; we should tackle the problems of modern health care, and find a better role for machines in it.

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