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A Phenomenological Contribution

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By

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On the Teleological Structure of Medicine: A Phenomenological Contribution

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This dissertation has two parts, each of which contains three chapters. Part I recapitulates Pellegrino's philosophy of medicine and Part II answers Robert Veatch's critique of Pellegrino's position.

Chapter One presents Edmund Pellegrino's phenomenology of the clinical encounter: the practice of medicine comes about in response to the need for healing generated by the experience of illness; accordingly, persons who are ill (patients) and persons who profess to heal (physicians) come together for the sake of healing. Chapter Two shows that Pellegrino blends physician beneficence with patient autonomy by tracing medical morality back to the deliberations that shape the clinical encounter. Persons become patients when they seek help from physicians to answer the questions raised by illness: What is wrong? What can be done? What should be done? Physicians have the expertise required to answer the first two questions, but Pellegrino argues that physicians must come to appreciate the patient's good before they help patients determine what should be done. Chapter Three unpacks Pellegrino's complex and hierarchically structured description of the patient's good.

Chapter Four asks whether a technically competent physician can practice medicine in the manner described by Pellegrino. Robert Veatch thinks not. In a pluralist society, patients and physicians do not have common values; so they cannot deliberate together.

Chapter Five addresses Veatch's view of the patient-physician relationship. Theorized within the frame of pluralism, this relationship becomes a forum for conflict, which Veatch resolves by reducing the physician to the role of a technician who takes directions from the patient. Chapter Six draws on the work of S. Kay Toombs and Drew Leder to clarify Pellegrino's basic claim that illness establishes both the origin (*arche*) and the end (*telos*) of medicine. Not only does Veatch ignore the moral significance of illness emphasized by Pellegrino, but Veatch also denies Pellegrino's insight that medical ethics should respond to the patient's need to trust the physician. In sum, the contrast between Veatch and Pellegrino highlights Pellegrino's contribution to medical ethics. His phenomenology of the clinical encounter displays the teleological structure of medicine.

This dissertation by Jacob N. Rosen fulfills the dissertation requirement for the doctoral degree in philosophy approved by Robert Sokolowski, Ph.D., as director, and by Richard F. Hasing, Ph.D., and Edmund D. Pellegrino, M.D., as readers.

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To the memory of my mother

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Introduction

§1 Edmund Pellegrino and Robert Veatch

The goal of this dissertation is twofold: to present Edmund Pellegrino's teleological philosophy of medicine and to defend it against the objections leveled by Robert Veatch.

Since Pellegrino and Veatch are leading figures in the philosophical examination of medical ethics, the disagreement between them illustrates two basic approaches to the patient-physician relationship. Pellegrino begins with the clinical encounter itself: the meeting between a person who is ill (the patient) and a person who professes to heal (the physician) is the foundation for medical ethics. Therefore, the ethics of medicine follows from the philosophy of medicine. In other words, the philosopher discloses what medicine is in order to show how medicine should be practiced. In contrast, Veatch sees the clinical encounter as an arena for conflict, especially when patients and physicians are strangers with different moral perspectives. Consequently, the philosopher's job is to prevent and to resolve conflict by determining who has the authority to make medical decisions and to determine whether that authority can be limited. In brief, Veatch's approach to medical ethics is shaped by the problem of pluralism whereas Pellegrino's approach to medical ethics is shaped by the Socratic question: what is medicine?

Given this stark contrast, much could be learned about philosophical medical ethics by comparing their positions.¹ However, this dissertation has a different objective. Part

¹ See Virginia Ashby Sharpe, "How the Liberal Ideal Fails as a Foundation for Medical Ethics, or Medical Ethics 'In a Different Voice,'" (Ph.D. diss., Georgetown University, 1991). In another dissertation, Dan Davis presents Pellegrino's theory of clinical judgment

one shows how the teleological structure of medicine articulated by Pellegrino follows from his phenomenology of the clinical encounter. Part two defends Pellegrino's position against Veatch's objection and shows how Pellegrino responds to the problems Veatch worries about as he considers the patient-physician relationship within a pluralist society. In sum, this dissertation presents and defends a teleological theory of what medicine is and how medicine should be practiced. To achieve this twofold objective, it focuses on phenomenological contributions to the philosophy of medicine.

§2 Themes of the Dissertation

This defense of Pellegrino's teleological position goes against the grain of mainstream bioethics because most contemporary philosophers do not think teleologically. In short, they do not determine what something is by articulating the good for the sake of which it exists. However, this is precisely what Pellegrino does when he poses the Socratic question: What is medicine? Pellegrino answers this question by showing that the practice of medicine comes about for the sake of the patient: the work of healing is the work of attaining the patient's good. According to Pellegrino, the patient's good is a complex whole that includes, among other goods, physiological function, embodied agency, and inherent dignity. Ultimately, the patient's good is informed by an

as an instance of *phronesis*. See Davis, "*Phronesis* and the Physician: A Defense of the Practical Paradigm of Clinical Rationality," (Ph. D., diss., Georgetown University, 1996). Both Sharpe and Davis discuss Pellegrino's teleology and Davis discusses Pellegrino's phenomenology of the clinical encounter as well. However, Sharpe and Davis do not thematize the close connection between Pellegrino's phenomenology and teleology by showing that the patient's experience of illness establishes the origin and the end of medicine. Nor do they defend Pellegrino's teleological phenomenology against the objections made by Veatch.

understanding (whether articulated distinctly or apprehended vaguely) of what it means to be human and why being human is good.

Illness disrupts or threatens the different elements of the patient's good and physicians and medicine exist in order to restore or sustain them. In short, illness generates a need for healing to which physicians and medicine respond. Moreover, medicine responds to this need through the agency of physicians because they have made a profession to heal: physicians publicly declare that they have the knowledge, skill, and experience required to help patients heal and patients seek out physicians precisely because the latter have professed (publicly promised) to heal. Put differently, physicians make the medical power to heal available to patients; were it not for the work of physicians, medicine could not benefit persons who are ill and in need of healing.

There are several reasons why Pellegrino's teleological account of medicine has few adherents. First, claims on behalf of professional beneficence are greeted with skepticism because the practice of medicine has not been unproblematically beneficial; indeed, purportedly beneficial actions have often produced harmful results.² Consequently, contemporary medical ethics is principally distinguished by the assertion of patient autonomy as a bulwark; autonomy is invoked to protect patients from physicians who claim that their professional expertise extends to knowing what is best for their patients. There can be no doubt that the assertion of professional beneficence established a

² The history of medicine provides many examples of harms caused by purportedly beneficial acts, from routine bloodletting to unilateral decisions about whether life-sustaining treatments should be used.

pattern of paternalism that is no longer acceptable.³ Accordingly, one goal of this dissertation is to show that Pellegrino's teleology is consistent with patient autonomy. As will be seen, Pellegrino's claim that the end (*telos*) of the clinical encounter is a right and *good* healing action calls on patients to be agents because patients, not physicians, should determine the goodness of treatment.

Second, the assertion of teleology in contemporary debates about ethics is met with a specific objection: namely, that teleology is inappropriate in a pluralist context because teleological accounts only make sense from within a particular moral community. However, pluralist societies are comprised by different moral communities; so persons who belong to different moral communities cannot share a teleological understanding of any human activity, including medicine. Therefore, another goal of this dissertation will be to show that Pellegrino's teleological phenomenology of the clinical encounter works within the context of pluralism precisely because it defines healing in terms of the patient's good. Since illness disrupts the patient's life, he or she must affirm that the likely outcome of any treatment is worthwhile (in light of the associated risks of unintended consequences, i.e., "side-effects," and the probability of success, i.e., that the intended effect will be achieved).

Third, Pellegrino's teleological theory of medicine presupposes that physicians are healers. However, within the biomedical model, physicians treat their patients as bodies as they use their medical power to alter physiological processes or anatomical structures. Therefore, if healing involves more than curing bodily ailments and requires physicians to

³ I set aside the question of whether paternalism was ever acceptable let alone justified.

know their patients as persons, then physicians are not healers; nor are they competent to be healers. This objection presents an especially difficult challenge to Pellegrino's theory because it raises the question of whether physicians are healers or technicians. Moreover, from an empirical perspective, the question cannot be resolved; indeed, there may be sufficient empirical evidence to warrant the conclusion that physicians are technicians, not healers.

However, this challenge misconstrues the significance of Pellegrino's theory. His thesis that healing is the end of medicine calls for physicians to heal their patients and, if they fall short of this end, his theory is not vitiated. Were the assertion of moral ends contradicted by our failures to achieve them, then civil disobedience would not be able to illuminate our failures as moral agents. While Pellegrino's theory is not a call for civil disobedience, it is a reminder to all of us of what the practice of medicine ought to be. Consequently, the argument that his teleology should be set aside as impractical would silence an important voice in medical ethics. The end of healing needs to be articulated to remind physicians that they should focus on the patient as a person precisely because the medicine exist for the sake of persons who are ill. In sum, physicians should remember that they treat bodies to heal persons. Moreover, if they forget this truth about the nature of medicine, then patients will not be able to trust their physicians and it will become very difficult, if not impossible, for physicians to help their patients answer all of the questions raised by the experience of illness. What is wrong? What can be done? What should be done? Accordingly, the overarching goal of this dissertation is to show that Pellegrino's

teleological theory of medicine promotes the trust that is required for the clinical encounter to be a healing relationship.

§3 Plan of the Dissertation

The dissertation is divided into two parts, each of which consists of three chapters. Part one sets out Pellegrino's teleological theory of medicine. Chapter 1 presents the foundation of his theory: the phenomenology of the clinical encounter. Pellegrino discloses three universal features that make medicine what it is: the fact (or experience) of illness; the act of profession; and the act of medicine. Accordingly, chapter 1 presents Pellegrino's description of each feature and shows that his phenomenology of the clinical encounter displays the teleological structure of medicine. Put simply: patients seek help from physicians to answer the questions raised by the experience of illness.

Chapter 2 shows that Pellegrino's philosophy of medicine differs from the traditional assertion of medical beneficence in two important (and interrelated) ways. First, Pellegrino establishes the philosophical foundation for the physician's obligation to benefit his or her patients. Second, Pellegrino distinguishes beneficence from paternalism and condemns the latter because, for many patients, the end of healing cannot be achieved if patients do not exercise their agency within the clinical encounter. Chapter 2 also argues that the language of agency makes more sense in the clinical encounter than does the language of autonomy.

Chapter 3 presents Pellegrino's theory of the patient's fourfold good. The discussion takes up each level in turn, beginning with the least important level and ending

with the most important level: (1) the bodily or medical good; (2) the personal goods targeted by the patient's desires and choices; (3) the generic human goods of agency, integrity, and dignity; and (4) the ultimate good that informs the patient's understanding of what it means to be human and why being human is good. This chapter clarifies why Pellegrino insists that the clinical encounter culminates in a right and good healing action. The rightness of the action refers to the bodily or medical good whereas the goodness of the action refers to the more important levels of the patient's good.

The defense of Pellegrino's position against the objections leveled by Veatch spans the three chapters of part two. Chapter 4 is the pivotal chapter. It introduces the work of another physician, Franz J. Ingelfinger, to provide some insight into Veatch's position and to clarify the disagreement between Veatch and Pellegrino. Ingelfinger, an accomplished researcher in the field of gastroenterology, served as editor of the *New England Journal of Medicine* from 1967 until 1977, crucial years in the development of bioethics, especially for philosophers who began to take medical ethics seriously.⁴ Ingelfinger is important because he illustrates two kinds of ethical problems that become the focus for philosophers such as Veatch. First, there are the ethical problems that arise when physicians think of medicine as a set of technical skills for fixing physiological and anatomical problems. Second, there is the traditional identification of beneficence with paternalism. Thus

⁴ See Pellegrino, "From Medical Ethics to a Moral Philosophy of Medicine," in *The Story of Bioethics: From Seminal Works to Contemporary Explorations*, eds. Jennifer K. Walter and Eran P. Klein (Washington, DC: Georgetown University Press, 2003); Veatch, "The Birth of Bioethics: Autobiographical Reflections of a Patient Person," *Cambridge Quarterly of Healthcare Ethics* 11 (2002): 344-52. See also David J. Rothman, *Strangers at the Bedside: A History of how Law and Bioethics Transformed Medical Decisionmaking* (New York: Basic Books, 1991).

Ingelfinger provides a foil for understanding Veatch's philosophical work in medical ethics: Veatch is responding to physicians such as Ingelfinger. At the same time, Ingelfinger illustrates the vagueness of traditional medical morality so he also provides a foil for understanding Pellegrino's project of providing a philosophical foundation for (and clarification of) medical morality.

Chapter 5 examines the position Veatch stakes out in his new book, *Patient, Heal Thyself!*⁵ In particular, I consider his understanding of how the patient-physician relationship should be structured when it is a meeting between moral strangers, i.e., persons who do not share the same moral outlook. I refer to the position Veatch develops as the "principal-agent" model of the patient-physician relationship.⁶ In chapter 5, I also present Veatch's fundamental objection to Pellegrino's teleology. Veatch denies Pellegrino's claim that the starting place for thinking about medical ethics is the patient's experience of illness. According to Veatch, the fact of illness has no such ethical significance.

Chapter 6 responds to Veatch's understanding of the patient-physician relationship by drawing on the work of two phenomenologists. S. Kay Toombs corroborates Pellegrino's claim that the fact of illness is ethically significant because she shows that

⁵ Veatch, *Physician, Heal Thyself! How the New Medicine Puts the Patient in Charge* (New York: Oxford University Press, 2009). Hereinafter cited as *PHT*.

⁶ It would be more accurate to call Veatch's proposal the "master-servant" model of the patient-physician relationship because Veatch argues that the patient should be in charge in a manner that more closely resembles the way masters control servants than the way principals control agents. However, I continue to refer to principals and agents because, in chapter 6, I show that Pellegrino's teleological phenomenology of the clinical encounter clarifies the sense in which patients and physicians relate to each other as principals and agents do: both relationships facilitate mutual deliberation between persons in need of help and the professionals who have the expertise to provide the help that is needed.

illness affects the patient by alienating the body from the self, and the self from the world.

Drew Leder shows that Veatch's concerns about physicians can be traced back to the way in which physicians are trained to think of their patients' bodies: as if they were complex mechanisms, rather than the living body that constitutes human beings as agents in the world. Chapter 6 also shows why it is important to consider Veatch's perspective on the patient-physician relationship. He raises the central question in the clinical encounter between patients and physicians. Can patients trust physicians? Veatch concludes that trust is impossible whereas Pellegrino argues that trust cannot be eradicated from the clinical encounter. Therefore, Veatch develops what Pellegrino calls an "ethics of distrust" whereas Pellegrino's teleological phenomenology shows that a principal objective of medical ethics is to establish the conditions of trust, not to structure the clinical encounter in a way that eliminates the possibility of trust.

In sum, this dissertation presents and defends Pellegrino's thesis: illness establishes the origin (*arche*) of medicine and the end (*telos*) of medicine. Illness gives rise to the practice of medicine because medicine comes about in order to fulfill the need for healing that comes with being ill; consequently, illness also specifies that healing is the end of medicine. Moreover, when healing is properly understood as restoring or sustaining the patient's complex good, then the end of healing calls upon patients and physicians to deliberate together so that they can adequately answer the questions that confront persons who are ill and prompts the ill to seek help from persons who profess to heal. What is wrong? What can be done? What should be done? These three questions, highlighted by

Pellegrino's phenomenological philosophy of medicine, determine the teleological structure of medicine.

§4 Limited Scope of the Dissertation

There are two sets of texts that are not integrated into this dissertation. First, there are the books that Pellegrino wrote with David C. Thomasma.⁷ I do not deal with these texts because I want to present Pellegrino's teleological phenomenology of the clinical encounter and he has published more than enough material for me to achieve this aim without having to address questions of whether the position I present is Pellegrino's own position. Second, there are the books and essays written by Richard Zaner that have shaped my understanding of the clinical encounter and medical ethics. For the most part, I have limited my discussion of Zaner's work to the footnotes;⁸ for the focus of my dissertation is Pellegrino's phenomenology of the clinical encounter and the teleological structure it displays. I present Pellegrino's position in chapters 1-3 and defend his position in chapters 4-6. While I have integrated other phenomenological investigations of medicine into the body of the dissertation for the limited purpose of defending Pellegrino's

⁷ Two of the four books they wrote together directly address issues covered in this dissertation. Pellegrino and Thomasma, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions* (New York: Oxford University Press, 1981) and *For the Patient's Good: The Restoration of Beneficence in Health Care* (New York: Oxford University Press, 1988). However, the relevant positions expressed in both books are well stated in other essays published by Pellegrino.

⁸ In §45 below, I discuss some of the ways that Zaner's phenomenological approach to the clinical encounter differs from Pellegrino's approach. Ultimately, the differences between Pellegrino and Zaner underscore the significant contribution phenomenology can make to medical ethics.

position against the objections raised by Veatch, I have relied upon the work of Kay Toombs and Drew Leder to achieve this objective.

Part One

Presentation of Edmund Pellegrino's Teleological Theory of Medicine

Chapter 1

The Phenomenology of the Clinical Encounter

§5 The Fact of Illness

Illness is Pellegrino's starting point for both the philosophy and the ethics of medicine. "Medicine and physicians exist because humans become ill."¹ This statement asserts more than a matter of fact; it makes an ontological claim about the origin of medicine. It also reflects Pellegrino's classical orientation as a philosopher. Medicine comes into being for a single reason: people get sick; they become ill.² As the ontological origin of medicine, illness causes medicine to be and, since classical philosophy articulates the causes of things, his philosophy of medicine articulates illness.

Pellegrino writes: "The person who becomes a patient suffers what is nothing less than an ontological assault."³ This very strong claim grounds his philosophy of medicine in the personal experience of illness. It is necessary, therefore, to show what Pellegrino means by an ontological assault.

¹ Pellegrino, "Toward a Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness," *Journal of Medicine and Philosophy* 4 (1979): 44. Hereinafter cited as "Reconstruction."

² I do not distinguish illness and being ill from sickness and being sick. Both pairs refer to the disruption of health as it is experienced by the person whose health has been disrupted. I also use the term 'malady' to refer to a disruption of health. Whenever I use one of these expressions I could add the disjunction 'or injury' ('or being injured') without altering my thesis; just as I could add the disjunction 'or surrogate' when I refer to the patient making a decision. For the sake of brevity, I do not.

³ Pellegrino, "Reconstruction," 44.

In our usual state, we see ourselves identified with our bodies, facing the world and acting on it in essential unity. In illness the body is interposed between us and reality—it impedes our choices and actions and is no longer fully responsive. The body stands opposite to the self. Instead of serving us, we must serve it. It intrudes on our existence rather than enhancing or enriching it.⁴

Illness disrupts the integration of body and self we experience when we feel whole, “that state in which Galen said we are unimpaired in doing things we wish to do.”⁵ Since the body no longer responds to our wishes when we are ill, Pellegrino is right to say that it “intrudes on our experience.” Indeed, the body comes to the fore as an impediment to our projects. In this sense, illness is an ontological assault: it attacks the integrity of healthy experience. As such, illness is “a disorganization of patient’s whole world.”⁶

⁴ Ibid.

⁵ Pellegrino, “The Healing Relationship: The Architectonics of Clinical Medicine,” in *The Clinical Encounter: The Moral Fabric of the Patient-Physician Relationship*, ed. Earl E. Shelp (Dordrecht: D. Reidel Publishing Company, 1983), 163. In its original context, Pellegrino’s reference to wholeness and Galen shows the extent to which he traces medicine back to the experience of illness:

What the sick person seeks is restoration to his or her definition of wholeness, that state in which Galen said we are unimpaired in doing the things we wish to do. This is as realistic a definition of health as we are likely to get. It depends as much on the patient’s assessment as the physician’s. If full restoration is not possible, then amelioration of suffering, adaptation, or coping with chronic or fatal illness become the ends of the healing relationship. (“The Healing Relationship,” 163)

One should not underestimate the extent to which Pellegrino’s teleological theory of medicine empowers the patient precisely because it grounds the practice of medicine in the patient’s need for healing as that need is experienced by the patient.

⁶ Pellegrino, “Medicine, Philosophy, and Man’s Infirmary,” in *Humanism and the Physician* (Knoxville, TN: University of Tennessee Press), 64. This essay originally appeared in *Conditio Humana: Erwin W. Straus on his 75th Birthday*, eds. Walter Ritter von Baeyer and Richard M. Griffith (Berlin and New York: Springer Verlag, 1966), 272-84. Looking back, in 2003, Pellegrino wrote: “my contact with Professor Straus led me to my first effort to link philosophy and medicine.” Pellegrino, “From Medical Ethics to a Moral Philosophy of Medicine” in *The Story of Bioethics: From Seminal Works to Contemporary Explorations*, eds. Jennifer K. Walter and Eran P. Klein (Washington, DC: Georgetown University Press, 2003), 6. Although Pellegrino refers to disease rather than illness in 1966, he obviously links medicine and philosophy by reflecting on how the

Since Pellegrino stresses the patient's experience of illness, he attends to its multiple consequences, especially on how we experience and understand ourselves.

[I]llness erodes the image we have fashioned of ourselves over the years. That image harmonizes our deficiencies and our strong points; we carefully and laboriously protect and refurbish it; we delicately balance it against the external exigencies of human life. Illness forces a reappraisal and that poses a threat to the old image; it opens up all the old anxieties and imposes new ones—often including the real threat of death or drastic alterations in lifestyle.⁷

Our self-image is, as this passage makes clear, who we understand ourselves to be. It is, then, our very self that illness calls into question. Can I continue to be the person I am? Can I fulfill my aspirations? If the answer to either question is no, then new questions arise. How much will my life change? Who will I become? What will I be? Behind these questions lurks another. Will I continue to be at all? Or does this illness announce my death? These questions make plain that the blows delivered by illness constitute an ontological assault. Illness singles me out and threatens my existence. Who and what I am cannot be taken for granted.

To be “sick” is literally a statement of *dis-ease*—a loss of well-being characterized by a constellation of changes in Life-world and lived body. . . . Immediate and

disruption of health raises questions about the meaning of being human. Consider the paragraph as a whole:

Disease is itself a disorganization of a patient's whole world. Its meaning to a man is related to how he views himself and the world. What a man believes of himself forms his personality and even the kind of disease he may have. The nature of disease, the ontologic definition of medicine, the comprehensive understanding of the psychosomatic unity, and its disorganization in disease are all matters about which the clinician can be illuminated by contact with the philosophers of man. (*Humanism and the Physician*, 64)

This passage reveals much about Pellegrino: he has long recognized that medicine involves philosophical anthropology; he was an early champion of developing a humanities curriculum for medical students; and he has consistently advocated a holistic understanding of medicine.

⁷ Pellegrino, “Reconstruction,” 44.

future plans are put on hold, or if pursued, they are approached warily and fearfully, with uncertainty that they will be fulfilled as anticipated. . . . Sickness puts the whole fabric of the sick person's life-world at risk. . . . As the perceptions of sickness expand and strengthen there arises a loss of existential freedom with respect to the lived body. . . . It becomes a potential or actual enemy of the self, shattering the unity of the awareness of self. . . . Alienation of the body from the self, a true ontological disassociation occurs. The person altered by illness asks if he is the same person who became ill. He does not know if he will ever be again that person.⁸

Illness discloses our vulnerability. The life we enjoy is not permanent. No matter how much we seem to be in control, illness undermines that control and, when serious,

⁸ Pellegrino, "Philosophy of Medicine and Medical Ethics: A Phenomenological Perspective," in *Handbook of Bioethics: Taking Stock of the Field from a Philosophical Perspective*, ed. George Khushf (Dordrecht: Kluwer Academic Publishers, 2004), 193. Husserl introduces the term *Lebenswelt* (life-world) in *Die Krisis der europaeischen Wissenschaften und die transzendente Phaenomenologie: Eine Einleitung in die phaenomenologische Philosophie*, hrsg. Walter Beemel, Husserliana 6 (The Hague: Martinus Nijhoff, 1954). *The Crisis of European Sciences and Transcendental Phenomenology: An Introduction to Phenomenological Philosophy*, trans. David Carr (Evanston: Northwestern University Press, 1970). The life-world is the comprehensive horizon within which subjective experience (life) unfolds. As such, the life-world is correlative to the subject, for it is the all-embracing context within which his or her life takes shape. However, there are not many different life-worlds, one for each subject. Instead, each subjective life happens within the life-world and everything he or she experiences is experienced from his or her unique perspective. Accordingly, the life-world embraces a multiplicity of perspectives and each perspective finds its place within the selfsame life-world. See Klaus Held, "Husserl's Phenomenology of the Life-World" in *The New Husserl: A Critical Reader*, ed. Donn Welton (Bloomington & Indianapolis: Indiana University Press, 2003), 32-62, especially 57-61; Dan Zahavi, *Husserl's Phenomenology* (Stanford: Stanford University Press, 2003), 125-33.

Thus Pellegrino needs to be corrected insofar as he implies that the each individual has his or her own life-world. Were this the case, then we would not experience each other as persons in the same world. I believe Pellegrino would accept this correction because he gets his definition of the life-world from Alfred Schutz: "that province of reality which the wide awake and normal adult simply takes for granted in common sense." "Phenomenological Perspective" 188, quoting Alfred Schultz and Thomas Luckman, *The Structures of the Life-World*, trans. Richard M. Zaner and H. Tristram Engelhardt, Jr. (Evanston: Northwestern University Press, 1973), 3. Since the natural attitude refers to the pre-philosophical belief in the reality of the world and the objects within it, it would seem strange indeed to say that each person dwells in an individual life-world.

illness radically alters our life. Even if the alteration is only temporary, it reminds us that we are vulnerable precisely because we are animate organisms, living bodies. While some may be lucky enough to live without serious or chronic illness, none can avoid the death foreshadowed by the disintegrations brought on by illness. Most will face serious illness at some point and many will endure chronic illness for long periods.

Since illness means losing the unimpaired use of our bodies to act as we wish, Pellegrino says that “being ill is . . . a state of diminished humanity.”⁹ His explanation brings out the vulnerability that comes with being ill. “The patient loses most of the freedoms which we regard as specifically human. His body is no longer the instrument of his will, and he cannot pursue the ends he has defined for his life. The patient is further impeded by pain, disability, or malaise.”¹⁰ Hence “illness takes from us those things we cherish as most human—our freedom to act in pursuit of aims we ourselves define; to make rational, free, and informed choices; and to do so from a position we have defined as our own.”¹¹

Not only does illness make us recognize that human life is perishable; when illness imperils us, we must rely upon others to recover. The patient, as Pellegrino points out,

lacks the knowledge and the skills necessary to cure himself or gain relief of pain and suffering. In many illnesses, the patient is not even free to reject medicine, as in severe trauma or other overwhelming acute emergencies. Voluntarily or not, the patient is forced to place himself under the power of another person, the health

⁹ Pellegrino, “Moral Agency and Professional Ethics: Some Notes on Transformation of the Physician-Patient Encounter,” in *Philosophical Medical Ethics: Its Nature and Significance*, eds. Stuart F. Spicker and H. Tristram Engelhardt, Jr. (Dordrecht: D. Reidel Publishing Company, 1977), 218. Pellegrino also speaks of illness as a state of wounded or damaged humanity.

¹⁰ Ibid.

¹¹ Ibid., 218-9.

professional, who has the knowledge and the skills which can heal—but also harm. This involuntary need grounds the axiom of vulnerability from which follows the obligation of the physician.¹²

Illness gives rise to medicine precisely because it generates a need for healing.

Without the help of a person who has the knowledge and skill required to make the ill person whole again, the ill person will continue to suffer the ontological assault delivered by illness. The alienation of the body from the self prevents the patient from pursuing many projects woven into the fabric of his or her life. This discontinuity alienates the patient from the world. Not only is the wholeness, taken for granted when healthy, disrupted by illness, but the very possibility of returning to the life enjoyed before the onset of illness becomes a question. Thus illness undermines both the sense of self and the sense of independence enjoyed before the onset of illness.

In this way, illness makes one uniquely and profoundly vulnerable. To illustrate this point, Pellegrino contrasts being ill with other vulnerable states:

The prisoner is deprived of freedom and civil rights; the poor and the socially outcast are constrained even in the most mundane matters of life; none of us is totally “free”; we must all conform to some set of social conventions. But in none of these situations is our capacity to deal with our vulnerability so impaired as in illness. We feel, usually, that we can cope with almost all of the other states of vulnerability if we have our “health.” After all, we perceive health as a means toward freedom and other primary values. We ask only to be released from prison, given a job or money, and if we are healthy, we can rebuild our humanity and the integrity of our person. In illness, none of these things will help. Our essential mechanisms for coping with all other exigencies are compromised; we face the loss of life itself, or we are suddenly asked to live a life which appears not worth living.¹³

¹² Pellegrino, “Reconstruction,” 44-5.

¹³ Ibid., 45.

Pellegrino should not be misunderstood. He is not saying that being ill is necessarily worse than being in prison, being destitute, or being an outcast. Clearly, many would prefer illness to any of these conditions. However, many might prefer illness only if it could be known in advance that the illness was not serious, disabling or life-threatening; for we presuppose health as a good that, on the one hand, permits us to live our lives as we would like and, on the other hand, allows us to deal with adversity when we are not able to live as we would like. Consequently, we lose our basic power to deal with life when we are ill. "There is, therefore, a special dimension of anguish in illness."¹⁴ Moreover, this anguish increases with the severity of the ontological assault. The more the unity of body and self is disrupted, the harder it is to cope with our lives; in turn, as coping becomes more difficult, the need for healing becomes more pressing.

In sum, illness affects us distinctively: by alienating the self from body, illness alienates us from our own lives. Consequently, illness raises a profound question for the person who is ill: what does it mean to be who I am? Moreover, this question cannot be satisfactorily answered when we are ill precisely because illness undermines our self-understanding as it disrupts the wholeness we experience when we are healthy. At the very least, if illness is serious enough to require medical attention, it takes control of our lives precisely because we fear, often rightly, though sometimes wrongly, that unless we take action to restore our health, we will no longer be able to live as we wish or we will no longer be able to live at all. In short, illness generates a need for healing: to become whole

¹⁴ Ibid.

again. Medicine, in general, responds to this need; in particular, it is *this* physician, actualizing his or her medical power, who responds to *this* patient's need for healing.¹⁵

§6 The Act of Profession

Physicians take responsibility for healing their patients by exercising the knowledge and skill required to meet their patients' need to be healed. When they do so, they are acting as physicians and, by doing so, they make good on their profession to heal. According to Pellegrino, physicians set themselves apart from others by publicly declaring that they are devoted to healing the ill. His presentation of this act of profession reveals much about how he understands medicine and medical ethics. He begins as follows:

In the presence of a patient in the peculiar state of vulnerable humanity which is illness, the health professional makes a "profession." He or she "declares aloud" that he has special knowledge and skills, that he can heal, or help, and that he will do so in the patient's interest, not his own.¹⁶

Pellegrino makes several points. First, and foremost, the presence of the patient is primary. Without the patient, there is no profession because the profession arises in response to the patient's need for health. Second, "the peculiar state of vulnerable humanity which is illness" refers to the unique way in which illness compels us to confront our perishability. Illness threatens the patient's life and lifestyle because it amounts to an

¹⁵ There is more to 'medical power' than the armamentarium physicians have at their disposal to treat patients. It is the potency of physicians to work in, with and through the body for the sake of healing. This characterization draws on the "simplified definition of medicine" given by Pellegrino and David C. Thomasma: "a relation of mutual consent to effect individualized well-being by working in, with, and through the body." Pellegrino and Thomasma, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions* (New York: Oxford University Press, 1981), 80.

¹⁶ Pellegrino, "Reconstruction," 46.

ontological assault on the patient's existence as a person. Third, the profession is an activity. The physician not only declares to the patient that he or she has the knowledge and skill required for healing but also that this medical power will be *put to work* for the sake of healing the patient.

Thus, by professing medicine, the physician adopts the good of the patient as the end of medical practice. "The word *profession* comes from the Latin word *profiteri*, which means to declare aloud. But how do we declare aloud? When you come to a physician, his question is, How can I help you? Implied in that question is his promise, the promise to help . . . to heal, to restore the balance."¹⁷ By virtue of the act of profession, physicians dispose themselves to help those who call upon them with a need for healing. "Implicit in the act of profession are two things. The first implication is that the physician possesses the necessary knowledge—that he is competent. The second is that he will use that competence in the patient's interest and not his own, for the patient's good."¹⁸

Pellegrino makes another important point. Not only is the profession of medicine enacted in the clinical encounter, but its enactment initiates the practice of medicine. Indeed, the profession of medicine and the initiation of the practice for the sake of this person who is ill are one and the same act: for the physician and the patient are brought together to restore the healthy condition the patient enjoyed before the onset of illness. When the profession of medicine is understood in this way, as an activity for the sake of patients, it can be distinguished from any association formed to advance the interests of

¹⁷ Pellegrino, "Toward a Reconstruction of Medical Morality," *American Journal of Bioethics* 6 (2006): 67. I distinguish this essay from the original version published in 1979 by specifying the date in the short form as follows: "Reconstruction" (2006).

¹⁸ Ibid.

healthcare professionals. As Pellegrino points out, entering the profession of medicine cannot be reduced to

simply becoming a member of a defined group with a common education, standards of performance, and a common ethic. These are all secondary conditions of the central act of profession, which is an active, conscious declaration, voluntarily entered into and signifying willingness to assume the obligations necessary to make the declaration authentic.¹⁹

By virtue of their profession, physicians assume the obligations necessary to make good on their profession. They must, as the saying goes, “put their money where their mouth is.” Since they declare their devotion to healing, physicians must take responsibility for healing their patients. Were they to act otherwise, their profession would be a lie. Moreover, it does not matter why they have devoted themselves to the end of healing. Each time the profession is enacted in the clinical encounter, it responds to the needs felt by the person who claims the attention of the physician. Furthermore, the act of profession, whether explicit or implicit, tends toward the same reassuring result: “The expectation is thus induced in the ill person that the declaration will be true and authentic, that the professional’s knowledge and skill are genuine, and that the professional’s concern for the patient’s interests will be truly exercised.”²⁰

The profession of medicine not only responds to the patient’s need for healing, it requires the patient to entrust him- or herself to the physician.

In making this profession, the physician also invites *trust*—in his knowledge, his competence and his character. The physician invites this trust and makes his promise of competence in the presence of another human person who is . . . vulnerable, dependent, anxious and eminently exploitable should the physician be a vicious and not a virtuous person. The patient, for his part, is forced to trust

¹⁹ Pellegrino, “Reconstruction,” 46.

²⁰ Ibid.

the physician even if he wishes not to do so. At least he must submit even if he does not trust – if he wishes to be healed by *this* doctor.²¹

The moral demands of medicine exceed the obligations that attach to promises precisely because the physician and the patient do not meet as equals. “The professional-client relationship is not simply a contract between equals in which each party can negotiate his own interest, since one party is not free *not* to negotiate.”²² On the contrary, “the professional holds the balance of power.”²³ The patient does not know what is wrong or what is required to heal. The physician professes to have this knowledge. This “inequality of power poses special obligations on the person who professes.”²⁴ Indeed, physicians are the fiduciaries of their patients because physicians stand in a special relationship of trust with patients.²⁵ The strict obligations that attach to the fiduciary relationship flow directly from the physician’s profession to heal patients who must, because they are ill, trust that the physician (1) is competent and (2) will exercise that competence for the patient’s good.

²¹ Pellegrino, “Phenomenological Perspective,” 196.

²² Pellegrino, “Reconstruction,” 46.

²³ *Ibid.*, 46.

²⁴ *Ibid.* See also Richard M. Zaner, “The Phenomenon of Trust and the Patient-Physician Relationship,” in *Ethics, Trust, and the Professions: Philosophical and Cultural Aspects*, eds. Edmund D. Pellegrino, Robert M. Veatch, and John P. Langan (Washington, DC: Georgetown University Press, 1991), 45-64. Hereinafter cited as *ET&P*.

²⁵ In addition to Zaner cited above, see also Robert Sokolowski, “The Fiduciary Relationship and the Nature of the Professions,” in *ET&P*, 23-39 and Pellegrino, “Trust and Distrust in Professional Ethics,” in *ET&P*, 69-85.

§7 The Act of Medicine

The fact of illness and the act of profession bring the patient and the physician together. However, medicine is only realized when a clinical decision results in therapeutic action. “This culmination in a right and good healing action is what constitutes medicine *qua* medicine.”²⁶ Since this act, the act of medicine, aims at what is both right and good for this patient, what Pellegrino means by “right” and “good” must be discussed.²⁷ He uses these terms

specifically in relationship to the moment of clinical decision. “Right” refers to a decision that is technically correct, that squares with empirical and scientific fact, adjusted to the particularities of *this patient*. It is derived objectively by the physician. “Good” refers to what this patient perceives as worthwhile and valued in his life. It is personally derived. Physicians ordinarily see a “good” decision as covering both aspects, but patients, in fact, may not. It is to account for both domains—the physician’s and the patient’s—that the distinction is made.²⁸

This passage captures much of Pellegrino’s project. The act of medicine unites the physician’s knowledge and skill in respect to healing with the patient’s need to be healed. The act is right insofar as the diagnosis is correct and the selected treatment is indicated by the diagnosis and the patient’s medical history. These objective determinations are based on the physical exam, medical history, clinical evidence and empirical research.²⁹

²⁶ Pellegrino, “Reconstruction,” 47.

²⁷ The present discussion is brief. When I discuss different moments within the healing process in chapter 2, the distinction between the rightness and goodness of a healing action will be explored in more detail. This difference will become even clearer when I discuss Pellegrino’s theory of the patient’s fourfold good in chapter 3.

²⁸ Pellegrino, “The Healing Relationship,” 170, n.6.

²⁹ A qualification is necessary. The diagnosis, while derived from more or less objective evidence and capable of objective confirmation, involves a considerable amount of interpretation. Pellegrino knows this well. See Pellegrino, “The Anatomy of Clinical Judgment: Some Notes on Right Reason and Right Action,” in *Clinical Judgment: A Critical Appraisal*, eds. H. Tristram Engelhardt, Jr., Stuart F. Spicker, and Bernard Towers

However, the action is not good unless it is desired and chosen by the patient. This means the act of medicine must be the treatment considered most likely to restore the wholeness the patient enjoyed prior to the onset of illness, on the one hand, without, on the other hand, requiring the patient to run risks that he or she finds excessive relative to the anticipated benefits. In this passage, Pellegrino also acknowledges that physicians tend (or have tended) to think that medically indicated treatments are good. At best, this tendency overlooks the moral agency of patients; at worst, it harms patients by failing to recognize them as persons. By limiting the physician's judgment in respect to the goodness of medically indicated treatment(s), Pellegrino makes room for patients to exercise their moral agency.³⁰

The distinction between the right and the good does not, however, mean that physicians and patients arrive at their conclusions independently of each other. The clinical encounter is structured by questions that flow from the experience of illness. "A patient in need who consults a physician wants to know what is wrong, what can be done about it, and what should be done."³¹ These questions can only be answered through a

(Dordrecht: Kluwer Academic Publishers, 1979), 169-94; and Pellegrino, "Value Desiderata in the Logical Structuring of Computer Diagnosis," in *The Ethics of Diagnosis*, eds. Jose Luis Piset and Diego Gracia (Dordrecht: Kluwer Academic Publishers, 1992), 173-95.

³⁰ As will be discussed in chapter 3, Pellegrino distinguishes a fourfold hierarchy of goods desired by the patient: (1) the medical good or restoration of physiological function; (2) the patient's perception of the good as expressed in his or her preferences, projects or plans; (3) goods such as agency, integrity and dignity which belong generically to humans; and (4) the spiritual or existential convictions which ultimately inform the patient's life. The physician is an expert concerning the medical good and a healing action is *right* insofar as it serves the good at this level. However, it is *good* only if it serves the patient's higher order goods. Therefore, the physician and the patient must exercise their agency together.

³¹ Pellegrino, "Reconstruction," 47.

shared inquiry. Physicians must examine their patients and take medical histories in order to answer the first two questions. Since this process yields possible actions only, the clinical encounter cannot be completed until the final question is answered. The physician cannot provide the answer, although he or she can recommend an action, because the likely result of the action must conform to the patient's values. However, the patient cannot make this decision alone because he or she cannot figure out what should be done without understanding—as fully as possible—what is wrong and what can be done. In other words, the patient must appreciate the likely outcomes of his or her condition in the absence of treatment as well as the likely results of the various possible treatments in order to determine which alternative is best. This means that patients and physicians must deliberate together.

The upshot of their mutual deliberation is the act of medicine: a right and good healing action. The act is the end of the clinical encounter. “What the physician and the patient seek together is a judicious decision, one which optimizes as many benefits and minimizes as many risks as the situation will allow. . . . The end is, therefore, not a general statement of the probabilities, but a particular statement of what a particular patient should do.”³² Moreover, the clinical encounter is not complete until action is taken because the “end of the medical encounter, and the process of clinical judgment through which it is achieved . . . is restoration and healing—some corrective, remedial, or preventative action is directed at what the patient and the doctor and the patient perceive as a diminution of the

³² Pellegrino, “Anatomy,” 172-3.

patient's wholeness.”³³ The act of medicine responds to the patient's need for healing by answering the patient's most urgent question: what should be done is that which best restores the wholeness the patient enjoyed prior to the onset of illness.

This determination cannot be made until the physician helps the patient answer the first two questions: What is wrong? What can be done? These questions are answered by methods of inquiry the physician is uniquely qualified to carry out. Physical examination, medical history, laboratory tests and diagnostic imagery facilitate diagnosis. In turn, diagnosis determines what can be done. Accordingly, the reasoning called for by the first two questions largely follows the physician's training and experience as a clinician. In contrast, the reasoning required to determine what should be done “is mainly dialectical, ethical, and rhetorical.”³⁴ Consequently, the agency of the patient becomes more important as the clinical encounter moves toward resolution and “the physician has a special moral obligation to assure and facilitate the patient's moral agency, especially in light of the patient's special vulnerability.”³⁵

Pellegrino develops this point as follows:

To assure a fully participatory moral agency, the physician must repair to the extent possible the wounded humanity and state of inequality of the sick person. He does so only in part by curing, or containing, illness or relieving pain and anxiety. These must be complemented by disclosure of the information necessary for valid choice and genuine consent and by guarding against manipulation of choice and consent to accommodate . . . the physician's personal or social philosophy of the good life.

A first requirement, therefore, is to remedy the patient's information deficit as completely as possible. Information must be clear and understandable and in the patient's language. He must know the nature of his illness, its prognosis, the alternative modes of treatment, their probable effectiveness, cost, discomfort, side

³³ Ibid., 172.

³⁴ Ibid., 181.

³⁵ Pellegrino, “Reconstruction,” 49.

effects, and the quality of life they may yield. Disclosure must include degrees of ignorance as well as knowledge and the physician's own limitations.³⁶

By helping the patient understand what is happening now and what is likely to happen in the future, the physician communicates more than a technical expertise. The physician begins the process of healing by helping the patient think through the meaning of the ontological assault that is the experience of illness. Put differently, the physician cares for the patient by creating the conditions for "a morally valid consent which is the vehicle for expression of the patient's moral agency."³⁷ The physician's knowledge and skill should not, therefore, be conceived as a narrow mastery concerning the biological processes of illness. It is, instead, the art of healing persons whose sense of wholeness has been disrupted or threatened by illness.

According to Pellegrino, the restoration of the patient's agency is a crucial element in the art of healing.

More is required than the minimal conditions of a legally valid consent, which is after all, guarantee against the grosser violations of the patient's right to decide. A morally valid consent moves closer to the realization of both senses of the word "con-sent" (Latin: *consentire*), to feel and to know something together. Patient and physician, therefore, must each feel he knows and understands the available facts, and each must feel he is truly part of the decision making.³⁸

By insisting on consent, Pellegrino protects patients from physicians who tend to exceed their moral authority, but this is not why he insists upon it. Consent is necessary because, without it, medicine could not be realized in a right and good healing action. In other words, medicine could not attain its end if the patient did not consent to treatment. In the

³⁶ Ibid., 49-50.

³⁷ Ibid., 50.

³⁸ Ibid., 50.

paradigmatic case, the clinical encounter finds completion as “a state of feeling and knowing together” converges on a right and good healing action. Thus Pellegrino’s phenomenology of medicine discloses a healing relationship that

places the actual locus of decision making somewhere between physician and patient, and not really with one or the other. As in any relationship between humans, medical or otherwise, obtaining consent requires persuasion, a mutual accommodation of wills. It is extremely difficult to set limits on the degree to which manipulation of consent is morally permissible. It is important . . . to indicate that the physician must be alert to those subtle choices of words, nuances of emphasis, or body language which tip the patient’s consent in the direction of what the physician feels is “good.”³⁹

That the patient and physician come together for the sake of healing means they work toward the same end: the patient’s good. In particular, they deliberate together until a right and good healing action is chosen. Their deliberation is shaped by the three questions raised by the patient’s experience of illness. What is wrong? What can be done? What should be done? That there is a division of labor does not mean they inquire independently of each other. Indeed, the task of healing requires them to work together so that the patient can, in the course of the clinical encounter, recover as fully as possible his or her agency.

§8 Universality

The fact of illness, the act of profession, and the act of medicine are not simply the features of clinical encounter in a particular culture. These phenomena are common to practices that aim at healing the ill, whenever and wherever they take place.

³⁹ Ibid., 50-51.

As long as humans are mortal, become ill, and are altered existentially by illness and disease, they will need help, healing, caring, and curing. The relationship may be mediated and modulated by culture, technology, or spiritual belief, but its fundamental human grounding will not disappear.⁴⁰

That grounding is the fact of illness. It is a universal truth that humans become ill. It is equally true that there are healers in every culture. These persons declare that they have the knowledge and skill required to heal those made vulnerable, dependent, or anxious by illness. This means that the experience of illness is met in every culture by a profession to heal.

The social and cultural definitions of health and illness may vary but the need for healing is a constant. It is in that constant fact that we should seek our organizing principle—the universal fact that humans become ill, and in that state seek and need help, healing, and cure. However the cultural milieu may differ, this fact is common to all medical systems.⁴¹

The fact of illness and the profession to heal are universal phenomena.⁴² However, medicine is not realized until an action (or set of actions) specifically intended to heal takes place. This action—the act of medicine—addresses the person who is ill. In fact, the act of medicine targets the person as a patient, i.e., as one who bears the burden of illness. A person becomes a patient because of these burdens.

What these burdens are, how they are understood, and what can be done about them are *not* universal features of medicine. They are local determinations, made according to the norms at work in particular healing relationships. Pellegrino recognizes

⁴⁰ Pellegrino, “From Medical Ethics,” 8.

⁴¹ Pellegrino, “The Healing Relationship,” 162.

⁴² Robert A. Hahn, a leading medical anthropologist begins his work, *Sickness and Healing: An Anthropological Perspective* (New Haven and London: Yale University Press, 1995), with the following statement: “In all epochs and everywhere, sickness and healing are primal human concerns” (1).

this enormous variability but, as a phenomenologist, he seeks out that which remains the same throughout all the variations:

What is unchanging and indeed what cannot change—the special nature of the human experience of being ill and of being healed. The social roles of physicians and patients are defined differently in different times and places. But the unchanging phenomenon—the encounter of one who is ill and seeking assistance from another who professes to heal to heal or help in healing—is common to all places and times.⁴³

Persons who are ill need to be healed. Persons who profess to heal respond to these needs. Their encounter culminates in an action specifically intended to heal *this* person. The fact of illness, the act of profession and the act of medicine are the essential features of the clinical encounter. As such, they are the philosophical foundation for medical ethics Pellegrino uncovers as he considers the phenomenon of medicine as it is exemplified in the clinical encounter. Thus Pellegrino's

phenomenological orientation . . . differs from the usual derivations of the ethics of medicine from the applications of existing moral philosophies to medical practice. It departs from the many current alternative ethical theories like narrative, casuistry, caring and principlism. Each of these, however, grasps some aspect of the life-world of doctor and patient. None is by itself sufficient as a philosophy or ethic of the clinical encounter. By bracketing these theories at the outset, the phenomenological orientation offers an alternative which may come closer to the thing in itself; namely, what medicine is as a human experience and a moral enterprise.⁴⁴

Pellegrino sets aside the presuppositions that come along with other theoretical approaches to medical ethics so that he can describe the phenomenon of the clinical encounter as it is lived by the doctor and the patient. By doing so, he discovers that the human experiences that shape the clinical encounter also display its teleological structure.

⁴³ Pellegrino, "Being Ill and Being Healed," *Bulletin of the New York Academy of Medicine* 57 (1981): 70.

⁴⁴ Pellegrino, "Phenomenological Perspective," 199-200.

The person who is ill comes to the attention of a person who professes to heal and their meeting is completed by a right and good healing action.

Chapter 2

From the Patient as an Agent to the Patient's Good

§9 Background: Tradition and Innovation

The internal morality of medicine advanced by Pellegrino is both novel and traditional. It is novel in the sense that it does not uncritically accept the “mixture of high ideals, common sense, and practical wisdom” that, according to Pellegrino, characterizes the Hippocratic ethic.¹ Not only does this approach lack philosophical rigor, it has come to be viewed with suspicion, on grounds that Pellegrino makes plain. “The good physician emerges as an authoritative and competent practitioner, devoted to his patient’s well-being. He is the benevolent but sole arbiter who knows what is best for the patient and makes all decisions for him.”² According to this paternalistic ethos, good physicians unilaterally decide what should be done. This proposition must be rejected, especially in pluralist societies; otherwise, good physicians are bad agents. This contradiction raises the question that has shaped Pellegrino’s philosophical project: Can the Hippocratic tradition be

¹ Pellegrino, “The Hippocratic Ethic Revisited,” in *Humanism and the Physician*, 97. Pellegrino does not distinguish the Hippocratic ethic from traditional medical morality since the ethic that emerges from the Hippocratic corpus “long sufficed to guide the physician in his service to patient and community” and “every subsequent medical code is essentially a footnote to the Hippocratic precepts” (95). The Hippocratic ethic is not, however, a philosophically sophisticated approach to the moral issues that arise in the practice of medicine. “A few principles of genuine ethics are often repeated and intermingled with etiquette and homespun advice of all sorts” (97). That this eclectic and didactic approach continues to appeal to the practicing physician can be seen in Edward C. Rosenow’s essays. “The Challenge of Becoming a Distinguished Clinician,” *Mayo Clinic Proceedings* 74 (1999): 635-7; “Recertifying in the Art of Medicine: What I Would Tell Young Physicians,” *Mayo Clinic Proceedings* 75 (2000): 865-8. Rosenow’s essays also show that traditional medical morality needs to be examined philosophically.

² Ibid.

justified?³ However, the challenge for Pellegrino is neither to justify the Hippocratic tradition in its entirety nor to reject it completely as Robert Veatch urges.⁴ Pellegrino seeks to distinguish the moral insight communicated by the Hippocratic tradition from the paternalistic practices it has fostered. As he puts it, “[t]he reverence we rightly accord the Hippocratic precepts must not obscure the need for a critical examination.”⁵ Although this critical examination is novel, it permits Pellegrino to preserve the insight of the Hippocratic ethic. Therefore, his philosophy is also traditional.

The opening of Pellegrino’s 1978 essay, “Ethics and the Moral Center of the Medical Enterprise,”⁶ illustrates how he blends the traditional with the novel. He writes:

Medicine is at heart a moral enterprise. All its efforts converge ultimately on decisions and actions which are presumed to be good for some person in need of help and healing.

This fact has been acknowledged explicitly for two millennia in the professional moral codes of eastern and western medicine. Whether or not they subscribe to these codes, all physicians implicitly assume an obligation to respect certain normative moral guidelines in the care of their patients.⁷

³ Pellegrino opens “Reconstruction” by posing the following questions:

Is a commonly accepted code of professional morality possible, in a democratic, morally pluralistic society? Are there philosophically justifiable obligations that bind all who profess medicine, or more generally, all who profess to heal? Can obligations be derived that are prior to, and independent of, the particular positions physicians or patient may take on the specific medical moral dilemmas of the day? In short, is it possible to reconstruct a professional morality more suited to contemporary requirements than the Hippocratic ethic? (32).

To a large extent, these questions gave rise to his philosophy of medicine and continue to inform his articulation of what medicine is.

⁴ In part two, I show that Veatch’s anti-Hippocratic orientation leads to his rejection of Pellegrino’s reconstruction of medical morality.

⁵ Pellegrino, “The Hippocratic Ethic,” 95.

⁶ Edmund D. Pellegrino, “Ethics and the Moral Center of the Medical Enterprise,” *Bulletin of the New York Academy of Medicine* (July-August 1978): 625-40. Hereinafter cited as “Moral Center”.

⁷ *Ibid.*, 625.

The first paragraph affirms the teleological structure of medicine: it aims at the patient's good. It also distills the phenomenological form articulated in Chapter 1. The fact of illness generates a need for healing to which the act of profession responds. Accordingly, physicians and patients meet for the sake of healing and the act of medicine completes their clinical encounter because it benefits the patient through a right and good healing action. The centrality of teleology and beneficence suggests that Pellegrino is a traditionalist. The second paragraph confirms this suggestion. Medicine is a moral enterprise precisely because its teleological structure obligates physicians to benefit their patients.

Nevertheless, Pellegrino recognizes that medicine will cease to be moral if physicians continue to assume that the goodness of their decisions is guaranteed by the internal morality of medicine.⁸ Accordingly, Pellegrino rouses physicians from what might be called their moral slumber. "What has not been so clear until very recently—and what puzzles many physicians today—is that medicine must . . . be an *ethical* enterprise. That is to say, the physician's actions must have some rational justification beyond simple conformity to one or another ancient or modern professional code, however admirable."⁹ This statement reflects the novelty of Pellegrino's position. Physicians can rely upon neither their competent medical judgment nor the traditional mores of physicians to justify

⁸ That medicine has an internal morality does not mean that a decision is good because it was made by a physician. However, the fact that physician's make bad decisions does not vitiate the internal morality of medicine. The internal morality provides the norms for evaluating medical decisions. Evaluation involves a complex inquiry framed by the following question. Is the likely outcome of decision beneficial to the patient and has the patient affirmed this benefit as desirable when weighed against the foreseeable burdens of the decision?

⁹ Pellegrino, "Moral Center," 625-6.

their decisions; for they cannot presume to know what is best for their patients. “Such a paternalistic construing of the physician-patient relation is increasingly untenable and even immoral.”¹⁰ Physicians have no moral authority to make decisions unilaterally and Pellegrino condemns traditional medical ethics when the “physician is assumed to be the patient’s moral agent and no notice is taken of the possibility of conflict between the physician’s and the patient’s value systems.”¹¹

There are, as Pellegrino points out, “many urgent reasons [why] patients . . . wish to exercise their own moral agency.”¹² To support this proposition, he cites an essay by Alasdair MacIntyre¹³ but he does not mention his commentary on this essay.¹⁴ Both essays, Pellegrino explains, address “the transfer of moral authority from physician to patients” but “MacIntyre argues by the *via negativa*.” In contrast, Pellegrino states: “I shall argue for a similar conclusion by the *via positiva*, because I believe that a new foundation for professional medical ethics is required, one that is founded in the situation of being ill, and not in the socio-historical facts of medicine as a privileged profession.”¹⁵ Here Pellegrino breaks with traditional claim that the practice of medicine uniquely qualifies physicians to decide what is best for their patients. This break follows from his starting point. Pellegrino begins with the fact of illness, not the fact noted by MacIntyre,

¹⁰ Ibid., 630.

¹¹ Ibid.

¹² Ibid.

¹³ Alisdair MacIntyre, “Patients as Agents,” in *Philosophical Medical Ethics: Its Nature and Significance*, eds. Stuart F. Spicker and H. Tristram Engelhardt, Jr. (Dordrecht: D. Reidel Publishing Company, 1977), 197-212. Pellegrino cites this essay in “Moral Center,” 639, n.5.

¹⁴ Pellegrino, “Moral Agency.” I drew upon this essay in chapter 1. See above, §5.

¹⁵ Pellegrino, “Moral Agency,” 213.

and central to much subsequent work in bioethics, that “[w]e are increasingly moral strangers to each other.”¹⁶ Instead, Pellegrino argues that physicians must attend to the agency of their patients in order to respond adequately to the experience of illness that makes them patients in the first place. Accordingly, Pellegrino says patients want to exercise their own agency for reasons unrelated to whether physicians and patients are strangers, acquaintances, or friends. Patients, Pellegrino observes,

are better educated and can understand the alternatives in medical decisions better than ever before, and legal opinions in democratic societies assure the individual of the right to accept or deny treatment. Moreover, the capabilities of modern medicine now extend to preventing, prolonging, or discontinuing life at will as well as modifying generation, genetics, and behavior—offering possibilities of intrusion into man’s most personal and intimate existence. Even in the more mundane medical encounters, striking the balance of efficacy against harm, expense, and discomfort requires the most careful assessment of what is worthwhile or of value to the patient.¹⁷

In short, patients want to exercise their agency because medicine shapes their lives in profound ways: at the “most personal and intimate” levels. Not only should patients be

¹⁶ MacIntyre, “Patients as Agents,” 209. The thesis of moral strangers is most closely associated with the work of H. Tristram Engelhardt, Jr., who rejects the possibility of a “content-full secular moral vision, which is canonical for all persons.” *The Foundation of Bioethics*, 2nd ed. (New York: Oxford University Press, 1996), 9. The absence of such a morality is

the fundamental catastrophe of contemporary secular culture and frames the context of contemporary bioethics. One encounters moral strangers, people with whom one does not share sufficient moral principles or enough of a common moral vision to be able to resolve moral controversies through sound rational argument or an appeal to moral authority. When one attempts rationally to resolve such controversies, the discussions go on and on without a final conclusion (8).

Pellegrino’s teleological theory of medicine offers an alternative to the sense that the clinical encounter is just another arena for conflict within a pluralist society. He does not deny the fact of pluralism; instead, he articulates the patient’s good in a way that justifies beneficence. See Virginia Ashby Sharpe, “How the Liberal Ideal Fails as a Foundation for Medical Ethics or Medical Ethics “In a Different Voice”” (Ph.D. diss., Georgetown University, 1991).

¹⁷ Pellegrino, “Moral Center,” 630.

able to make these decisions for themselves; they are capable of understanding their situation well enough to share in the deliberative process that ends in the act of medicine. As Pellegrino points out, the physician should not even make ordinary decisions unilaterally. What patients value must be considered in all but emergency situations for it is the patient who bears the burdens of illness, needs to be healed, and whose life is altered by the act of medicine. Accordingly, physicians must tend to the balance their patients strike between the burdens and benefits of a proposed treatment. In other words, looking after patients means attending to their needs and letting them decide whether a treatment is beneficial and, if so, whether the expected benefit exceeds the burdens.¹⁸

Of course, Pellegrino understands why bioethicists take the *via negativa*. Consider his condemnation of paternalism:

If moral paternalism were ever justified, even in simpler times, it had to be on the basis of some commonly shared set of values. But if there is a moral characteristic of our times it is pluralism—not just between societies, as has always been the case, but within societies and even between individuals in the same family. Each physician represents only one set of the divergent views we hold today about the value of life, health, or happiness.¹⁹

¹⁸ Pellegrino reformulates the golden rule in a way that captures the physician's devotion to the patient's needs as they are understood by the patient. He begins with a straightforward transposition of the golden rule to the clinical setting. Then he provides a necessary correction.

For the physician to say simply that he would treat the patient as he would himself or a member of his family is morally unsound. This misinterpretation of the golden rule would only reopen the possibility of overriding the patient's wishes. The golden rule in medical decisions is to be observed rather differently: We [professed healers] should so act that we accord the patient the same opportunity to express or actualize his own view of what he considers worthwhile as would desire for ourselves. (Pellegrino, "Reconstruction," 51-2)

¹⁹ Pellegrino, "Moral Center," 630.

Pellegrino does not suggest that paternalism has ever been justified. His point is that a necessary (but insufficient) condition to justify paternalism would be that physicians and patients share the values that inform medical decisions. Pluralism precludes this condition; so paternalism cannot be justified. Nevertheless, medicine has been practiced paternalistically for generations and, in response, many apply philosophical theories of ethics to the clinical encounter in order to protect patients from their physicians. This approach seems to be appropriate given the custom of paternalism, the history of abuse in medical research, and the personal violation that occurs when the physician overrides, rather than restores, the patient's agency.

Pellegrino responds to the problem of paternalism differently because he understands healing differently. To heal is to make the person whole again. Consequently, the physician is called upon to treat the patient as an agent, not simply as a body. When healing is understood in bodily terms alone, the patient no longer shows up as a person who is ill and needs to be healed: instead, the patient presents a bodily problem to be fixed through the instruments available in the physician's armamentarium.

Thus Pellegrino goes against the grain in two ways: not only does he condemn the paternalistic ethos common to the practice he joined more than 60 years ago; he also condemns the tendency to reduce patients to their bodily functions. Neither aspect of medicine helps the person who is ill when he or she needs the care of a person who professes to heal.²⁰ Instead, both keep the physician from making good on his or her

²⁰ A qualification is needed: Pellegrino condemns physicians who treat their patients as bodies rather than persons. He does not condemn the biological understanding of how medical treatment works.

profession to heal and, in this way, they undermine the trust that is essential to the healing relationship.

§10 Agency instead of Autonomy

The assertion that patients have no grounds to trust their physicians leads to the assertion of patient autonomy as the basic principle of medical ethics. Pellegrino's teleological theory of medicine and ethics of beneficence provides an alternative account. An important step toward establishing this alternative is to highlight agency rather than autonomy in order to recognize that clinical medicine benefits the patient by helping him or her exercise the power to act and choose. Autonomy is not finely grained enough to capture the most important question about the nature of agency in the clinical encounter. What goods does clinical medicine seek to bring about and how can these goods be achieved? The concern with patient autonomy raises the question of who decides what should be done rather than the question of how patients and physicians can best determine what should be done. This oversight is significant because agents become patients when they cannot determine what should be done without the help of their physicians. Since patients need the help of their physicians to answer this crucial question, a theory of medical ethics needs to show how patients and physicians can deliberate together. Accordingly, my discussion of Pellegrino's teleological theory will be framed in terms of agency rather than autonomy.

There are several more reasons why references to agency fit the medical context better than references to autonomy. First, being an agent contrasts with being a patient as

acting differs from being acted upon. Thus, when I refer to the patient as an agent, I underscore the limitation of the traditional view: it regards the patient as the bearer of illness and the recipient of the physician's healing actions. While being affected by illness or injury gives rise to a need to be acted upon by the physician, being a patient does not exhaust the being of the person who is ill and needs to be healed. Indeed, healing in the fullest possible sense requires the patient to take action in the clinical encounter in order to recover his or her power to act in the world. Second, autonomy contrasts with heteronomy so it sets up a different opposition: one either rules oneself or one is ruled by another.²¹ Since paternalism harms patients by subjecting them to heteronomy, autonomy has been asserted to protect patients. However, the agency of patients need not be opposed to the agency of physicians. In fact, the clinical encounter is a meeting between two moral

²¹ It should be pointed out that what is meant by autonomy in bioethics departs dramatically from Kant's deontology since, for Kant, heteronomy includes being ruled by one's own inclinations. Thus doing what one wants would not be autonomous at all. Kant starkly and irreconcilably opposes duty and inclination. For example, he says that the actions of persons who, "without any further motive of vanity or self-interest, . . . find an inner pleasure in spreading joy around them and can rejoice in the satisfaction of others as their own work" have "no true moral worth" but are "on a level with such actions as arise from other inclinations, e.g., the inclination for honor, which if fortunately directed to what is in fact beneficial and accords with duty and is thus honorable, deserve praise and encouragement, but not esteem; for its maxim lacks the moral content of an action done not from inclination but from duty." Immanuel Kant, *Grounding for the Metaphysics of Morals*, trans. James. W. Ellington, 3rd ed. (Indianapolis: Hackett Publishing Company, Inc., 1993), 11. He summarizes this opposition in the following passage: "For the will stands . . . at a crossroads between its a priori principle, which is formal, and its a posteriori incentive, which is material; and since it must be determined by something, it must be determined by the formal principle of volition, if the action is done from duty." Ibid., 13. Hence the will is autonomous only when it is determined exclusively by its formal principle; otherwise, it is determined (at least in part) by material incentives (the inclinations) and, consequently, heteronomous.

agents who can deliberate together. Moreover, when they do so, the upshot is a right and good healing action.

Third, the language of agency is closely related to the experience of illness and the need for healing. Since agency means acting or exerting power, illness can be understood as a disruption of agency. Moreover, the agent is the one who acts or exerts power; so illness can be understood as an ontological assault on the agent. Autonomy does not comport with the experience of illness as well as agency because, in the clinical encounter, agency tends to be blended as patients and physicians deliberate together. The clinical encounter is not a situation in which one either rules oneself or one does not. Fourth, the ill person does experience a loss of agency and, as a consequence, becomes a patient in two senses: (a) the person suffers a loss or disruption of agency and, consequently, (b) he or she needs the agency of another, namely the physician, who works as a healer in and through the patient's body. That healing requires the agency of another does not, however, mean the patient is no longer an agent. Indeed, healing requires patients and physicians to exercise their agency together. Finally, it is not clear whether the patient can be autonomous if he or she needs the agency of another. In fact, his or her need to rely upon the physician presents what seems to be a straightforward instance of heteronomy.

Autonomy as a boon

Pellegrino acknowledges that the application of the principle of autonomy to the clinical encounter has produced "the most radical reorientation in the long history of the Hippocratic tradition. As a result, the physician-patient relationship has become more

honest, open, and respectful of the dignity of patients.”²² He traces the emergence of this principle of medical ethics to “the modern idea of participatory democracy” and “the socio-political forces that coalesced in the mid-1960s.”²³ Then he draws the following conclusion:

These forces converged to engender both mistrust of the physician’s traditional paternalism and a demand for self-determination and informed consent in medical relationships. “Autonomy” has become the watchword that symbolizes the moral and legal claim of patients to make their decisions without constraint or coercion, however beneficent the physician’s intention might be.²⁴

That autonomy and beneficence need not be in conflict is one of Pellegrino’s basic claims and, as will be seen below, it prompts him to question whether autonomy should be posited as the central principle of medical ethics. Before I turn to his criticism of autonomy, however, I want to present his understanding of what autonomy is.

In “Autonomy and Integrity,” Pellegrino defines autonomy as

a capacity for self-rule, a quality inherent in rational beings enables them to make reasoned choices and take actions based on a personal assessment of future possibilities weighed in terms of their own value systems. In this view, autonomy is a capacity that flows from the fact that humans can think and feel and make judgments about what they deem to be good.²⁵

Pellegrino then points out that

the capacity for self-rule is so deeply embedded in what it means to be a human being that it constitutes a moral claim, a claim which generates a duty of respect in other persons. This claim is expressed as the principle of autonomy: i.e., so act in

²² Pellegrino, “The Relationship of Autonomy and Integrity in Medical Ethics,” *Bulletin of the Pan American Health Organization* 24 (1990): 361. In this context, I interpret Pellegrino’s reference to the Hippocratic tradition as a reference to the history of medical ethics, i.e., the tradition of reflecting on the morality of medical practice.

²³ Pellegrino, “Autonomy and Integrity,” 363.

²⁴ Ibid.

²⁵ Ibid., 362.

relationships with others that their capacity for autonomy (and thus their moral claim) can be exercised as fully as circumstances will permit.²⁶

As this passage makes clear, Pellegrino welcomes the transformation of the clinical encounter brought about under the banner of autonomy and he describes the “widely accepted medical decision-making paradigm” it has engendered as follows:

Competent patients have the moral and legal right to make their own decisions, and these decisions take precedence over those of the doctor or the family. When patients are [not] competent, . . . their rights of decision are transferred to a valid surrogate or some anticipatory statement by the patient (such as a living will, medical directive, or durable power of attorney), or in the absence of these to a legally appointed guardian.²⁷

Finally, the assertion of patient autonomy finds expression in the

doctrine of informed consent that has become the central requirement of morally valid medical decision-making. For consent to fulfill the claims of human persons to self-governance, it must be based on sufficient information to make a reasoned choice and must be free of coercion or deception. The procedures surrounding informed consent are designed to facilitate the capacity of rational beings to make judgments of what they consider best rather than what the physician or any other person might consider best for them.²⁸

Clearly, Pellegrino does not “question . . . the importance of the socio-political, legal, and moral emphasis on autonomy in protecting the patient’s right of self-determination.”²⁹

Indeed, he has long championed this right; more than thirty-five years ago, he pointed out that it is “[s]o fundamental . . . in a democratic society that to limit it, even in ordinary medical transactions, is to propagate an injustice.”³⁰

²⁶ Ibid.

²⁷ Ibid., 364.

²⁸ Ibid.

²⁹ Ibid.

³⁰ Pellegrino, “Toward an Expanded Medical Ethics: The Hippocratic Ethic Revisited,” in *Hippocrates Revisited: A Search for Meaning*, ed. Roger J. Bulger (New York: MEDCOM

Autonomy as a problem

Nonetheless, Pellegrino issues a caution: “certain limitations to the concept of autonomy . . . may impede the fullest expressions of the respect for persons which autonomy is supposed to enhance.”³¹ He identifies three problematic tendencies. First, autonomy tends to be interpreted in a legalistic manner and, consequently, leads “to fulfillment only of what is specifically prescribed.”³² Thus autonomy establishes a legal minimum rather than a moral maximum. This tendency obscures the end of medicine and the morally demanding height at which the clinical encounter should aim. Indeed, the focus on autonomy

fosters the all-too-frequent view of the physician-patient relationship as a contract rather than a fiduciary relationship or a covenant. The fiction is encouraged that a contract is possible in a relationship in which one party is ill, vulnerable, and exploitable while the other holds the needed knowledge and power. In this contractual view, the procedures for making a valid informed consent, important as they are, come to take the place of the substantive moral issue itself.³³

Since Pellegrino does not identify the substantive moral issue at stake, I am guided by his interpretation of consent in the clinical encounter. As shown in Chapter 1, consent completes the clinical encounter in the sense that a state of feeling and knowing together converges on a right and good healing action. Therefore, when Pellegrino makes consent a necessity for the ethical practice of medicine, he advocates something other than the formal disclosure of risks and the signed authorization of treatment that memorializes the agreement patients and physicians make with each other. He calls upon physicians and

Press, 1973), 136. Presumably, it would be an injustice in other societies as well, though it may not be recognized as such.

³¹ Pellegrino, “Autonomy and Integrity,” 364.

³² Ibid., 365.

³³ Ibid., 365.

patients to deliberate together in a way that “places the actual locus of decision making somewhere between physician and patient, and not really with one or the other.”³⁴

According to Pellegrino, consent is mandated by the end of medicine: a person who is ill and a person who professes to heal decide *together* what should be done.

This culminating act frames the moral issue. It can be expressed narrowly, as a conditional: if the patient understands (a) what is wrong, (b) what can be done (including nothing), (c) the likely outcomes and (d) the foreseeable risks associated with each alternative, then the patient can strike the balance between benefits and burdens as he or she thinks best. Only then is it clear that the patient affirms the goodness of the selected treatment and chooses to undergo the risks associated with it. Formalized exchanges do not promote such personal decisions because they do not foster the kind of intimate inquiry in which the patient’s personal need for healing can be appreciated by those who profess to heal. When clinical medicine fails to address the patient as a person in this way, treatment will tend towards technical correctness and the personal need for healing will generally be ignored. When reduced to the physiological result of medically indicated actions, the end of medicine, healing, is compromised: it is realized incompletely, at best. The moral issue can, therefore, be framed broadly. If the clinical encounter is not shaped in a way that encourages (a) the patient to disclose his or her personal need for healing and (b) the physician’s knowledgeable registration of this disclosure, then medicine will tend to fall short of its end and no measure taken to protect the patient’s autonomy will bring about the

³⁴ Pellegrino, “Reconstruction,” 50-1.

conditions in which this personal need can be addressed. Obviously, this would prevent physicians from making good on their profession to heal.

Second, Pellegrino claims that the “emphasis on self-determination . . . minimizes the physician’s obligations of beneficence and effacement of self-interest.”³⁵ This sets up a false dichotomy between patient autonomy, on the one hand, and physician beneficence, on the other hand. Also, when “viewed as a legal right or even a moral claim,” autonomy “can severely circumscribe the range of discretionary decisions—those unanticipated choices the clinical situation may force on the physician.”³⁶ The use of advance directives illustrates this difficulty: “six pages of detailed instruction on how the physician should manage life-sustaining and other treatments,” Pellegrino worries, “could easily lead to a paralysis of decision of decision-making injurious to the patient.”³⁷ The problem, according to Pellegrino, is that “[w]hen patients are unable to spell out everything in advance, the physician may spend more time trying to figure out what the patient wishes than deciding what is in the patient’s best interest.”³⁸ While this observation raises questions about paternalism or the opposition between beneficence and autonomy, I postpone my discussion of this issue until part two. For now, it is sufficient to note that the

³⁵ Pellegrino, “Autonomy and Integrity,” 365.

³⁶ Ibid.

³⁷ Ibid.

³⁸ Ibid. In a recent conversation, Pellegrino provided a different example. Suppose, during a colonoscopy, the physician discovers a polyp that appears to be malignant but is located in a spot where there may be an increased risk of a perforation. What should the physician do? Pellegrino does not raise the question in order to answer it but rather to illustrate that there is some discretionary space within which the physician exercises his or her judgment.

emphasis on patient autonomy can obscure the agency of physicians.³⁹ Put differently, the emphasis on autonomy may tend to efface the agency rather than the self-interest of the physician.

Third and last, Pellegrino points out that the stress put on individual self-determination stands opposed to the obligations that bind people together into the communities that make a good human life possible:

The prevailing emphasis on autonomy generates a cult of moral privatism, and individualism insensitive to the fact that humans are members of moral community. When autonomy is absolutized, each person is a moral atom who asserts his or her rights independently and even against the claims of the social entity to which he or she belongs. Conflicts between the rights of its individual members raise serious questions of economic and social justice that demand a better balance between autonomy and the common good than now prevails.⁴⁰

For the most part, I consider the excessive concern with autonomy insofar as it shifts attention away from the important issue of how the mutual deliberation of physicians and patients can be realized. This difficult question becomes especially urgent when the clinical encounter is understood as a meeting between strangers. Then moral atomism seems appropriate to the pluralist context because the foundation of trust needed for a shared inquiry cannot be established. In this dissertation, I hope to uncover the foundation for trust and to show how this foundation permits clinical medicine to fulfill its end. Accordingly, I do not address the question of how the wishes of individual patients can be balanced against the commonweal.

³⁹ It is worth noting that many persons who look to alternative or complementary practices when they need to be healed do so because they find that the practitioners pay more attention to them as persons or they find such approaches to be more meaningful to them as persons. In any case, they do not seem to complain that these practices are paternalistic even though the treatment decisions tend to be made unilaterally.

⁴⁰ Pellegrino, "Autonomy and Integrity," 365.

In sum, the question of whether patients and physicians can deliberate together is best explored when it is framed in terms of agency rather than autonomy precisely because it addresses the meaning of consent. Can patients and physicians know and feel together what should be done? If this question cannot be answered affirmatively, then Pellegrino's teleological account of medicine as a blending of agency fails. In what follows, I attempt to provide an affirmative answer. The first step requires recognizing that the power to act and choose can be shared. Actions and choices are not exclusively individual determinations. Indeed, the assertion that self-determination is an individual achievement involves an abstraction from the intersubjective context of personal life. This is not to deny our individuality. Instead, it is to situate our lives as agents within the broader social or cultural context in which we come to be the persons that we are. In short, we do not become the persons that we are free from the influences of others.⁴¹ Thus when an individual exercises his or her power to act or choose, he or she is not, properly speaking, acting alone. Instead, the agent is at work in a way that has been profoundly shaped by the agency of many, many others. This means that the agency of the individual is, in a fundamental sense, already blended with the agency of others.⁴²

⁴¹ Indeed, our personal lives are shaped by countless others: whether known to us or not, these influences cut across the generations of past, present and even future persons and they make themselves known through customs or traditions as well as the many other ways human beings have developed to transmit the knowledge and practices that shape our many different communities.

⁴² Martin Heidegger develops this insight into the everyday existence of human beings when he describes the "They" (*das Man*) as well as the state-of-mind or attunement (*Befindlichkeit*) that discloses the "They" in its everydayness. *Being and Time*, trans. John Macquarrie and Edward Robinson (New York: Harper and Row, 1962), sections 27, 35-8. Heidegger is not, of course, the first philosopher to explore this theme. It can be traced back to Plato's allegory of the cave, if not to some of the Pre-Socratic fragments.

§11 The Patient's Good Introduced

Pellegrino's presentation of medicine's teleological structure permits him to embrace the agency of patients without contradicting the internal morality he defends because he attends to the patient's need for healing when he articulates the patient's good. The insight that medicine benefits the patient by responding to his or her need for healing guides Pellegrino's defense of the internal morality of medicine. Thus Pellegrino rejects the traditional understanding of beneficence as a form of paternalism while he preserves the traditional claim that medicine exist for the sake of the patient. In this section, I introduce his teleological account of medicine with a brief summary of the patient's fourfold good. In the following section, I consider how he differentiates moments within the teleological structure of medicine. Then, in Chapter 3, I explore the four levels of the patient's good in more detail.

Pellegrino stresses the teleological nature of ethics. Every ethical theory begins with a simple imperative: "Do good and avoid evil."

This is the ancient dictum of *synderesis*, and, implicitly or explicitly, the indispensable transcendental ground for any system of ethics. This is because the good is the end or *telos* of moral science. . . . One may locate the good in many places – in natural law (Aristotle and Aquinas), in the will (Kant), in the affect (Hume), or intuition (Moore). But no ethics can avoid the concept of the good, since, without the good as *telos*, the word "ought" is without direction, and morality, itself, dissolves in the acid of skepticism.⁴³

The point is simple: without the obligation to do good and avoid evil, ethics makes no sense. There can be no obligations without identifiable goods for the sake of which one acts and there can be no prohibitions unless such goods can be diminished or violated by

⁴³ Pellegrino, "The 'Telos' of Medicine," 21.

our actions. Given the claim that ethics is founded upon and oriented by the good, Pellegrino places himself squarely within the Aristotelian tradition: “Every art and every inquiry, and likewise every action and choice, seems to aim at some good, and hence it has been beautifully said that the good is that at which all things aim.”⁴⁴ Aristotle does not assert that every action is good; but rather that every action is for the sake of something the actor desires as good. In other words, we act to realize the goods we believe make life worth living.⁴⁵ What these goods are and how they are best realized is, of course, hotly debated. Nevertheless, our lives are oriented by some understanding of the good in respect to which actions and agents are evaluated.⁴⁶ Since moral judgments are senseless absent such an orientation, Pellegrino suggests that skepticism about teleology is morally corrosive.

⁴⁴ *NE.I.1.1094a1-2.*

⁴⁵ Although we can wish for goods we cannot bring about through our own actions, our lives as moral agents are shaped by that for the sake of which we wish. As Aristotle observes, we wish for ends and, when we have the power to realize those ends through our own actions, we deliberate about the means to do so. *NE.III.4-5.*

⁴⁶ Charles Taylor makes a similar point in *Sources of the Self* (Cambridge: Harvard University Press, 1989). In the first two chapters, he argues that being a self requires understanding one’s own life in teleological terms. He states this quite clearly in the following passage.

The issue of our condition can never be exhausted for us by what we *are*, because we are always also changing and *becoming*. It is only slowly that we grow through infancy and childhood to be autonomous agents who have something like our own place relative to the good at all. And even then, that place is constantly challenged by the new events of our lives, as well as constantly under potential revision, as we experience more and mature. So the issue for us has to be not only who we *are*, but where we’re *going*; and though the first may be a matter of more or less, the latter is a question of towards or away from, an issue of yes or no. That is why an absolute question always frames our relative ones. Since we cannot be indifferent to our place relative to the good, and since this place is something that must always change and become, the issue of the direction of our lives must arise for us (46-7).

This teleological understanding frames Pellegrino's approach to medical ethics and informs his reconstruction of the Hippocratic ethic. Thus his innovation preserves, rather than undermines, the end of medicine. It is the good of the patient.

Medical ethics has its own construal of *synderesis* in the first moral precept of the Hippocratic Oath. Here it states:

I will follow that system or regimen which, according to my ability and judgment, I consider for the benefit of my patient and abstain from whatever is deleterious and mischievous. . . . (Francis Adams's translation)

All the moral precepts of the Oath, the other deontological books of the Corpus, and the entire subsequent history of medical ethics are elaborations of this first principle. This medical *principium primum* enjoins upon doctors the primary duty of acting to benefit the patient, in a word, always to act for the patient's good. The patient's good is, therefore, the end of medicine, that to which medicine, by its nature, tends and that which gives it definition.⁴⁷

That medical morality follows from the teleological structure of medicine is no new thesis. For generations, physicians have believed that their training as physicians uniquely qualifies them to determine the best treatment. This claim presupposes that end of healing cannot be grasped without the specialized knowledge physicians possess. The increasing power to cure patients gives rise to an additional presupposition: namely, that knowledge of the human body and the means for restoring its functions when they have been disrupted is sufficient to heal. In this way, healing comes to be understood as something physicians do and, consequently, the patient is not recognized as an agent in his or her own healing process. This flaw is exacerbated when healing is identified with curing: on the one hand, when cure is possible, the end of healing would make it imperative and the patient would cease to be an agent; on the other hand, when cure is not possible, the patient could not be

⁴⁷ Pellegrino, "The 'Telos' of Medicine," 21.

healed and physicians would abandon patients in need of healing. Pellegrino rejects these paternalistic presuppositions.

Since he recognizes that the patient's need for healing is shaped by the experience of illness, Pellegrino knows that healing requires the agency of the patient, not just the agency of the physician. Thus healing happens when patients and physicians work together. Pellegrino also knows that the need for healing is often felt most keenly when the patient cannot be cured. To develop a renewed sense of wholeness, the patient must adapt to the limitations imposed by illness and, to achieve this end, the patient needs the physician's help. Therefore, the work of healing cannot be limited to the restoration of physiological function without undermining the agency of patients and abandoning those patients who cannot be cured. In short, the goods achieved by medicine exceed the restoration of physiological function. Indeed, such restoration, when possible, is a means for achieving as completely as possible the patient's good.

Pellegrino divides the patient's good into four levels: (1) the biomedical or bodily good, which is optimal physiological function; (2) the patient's particular personal good, which is defined by his or her preferences, plans, and projects and constitutes a particular understanding of the good life; (3) the generic human goods the patient enjoys precisely because he or she is human, such as agency, integrity, and dignity; and (4) the patient's ultimate or spiritual good, which are those objects of belief or conviction that the patient is unwilling to compromise because he or she believes they are essential to a good human life.

§12 Teleology and Healing

Pellegrino's teleological account of medicine involves more than his account of the patient's fourfold good. It also involves his understanding of health as well as the distinctions he makes concerning the end of medicine. Pellegrino traces his definition of health back to Galen: "that state in which Galen said we are unimpaired in doing the things we wish to do. This is as realistic a definition of health as we are likely to get."⁴⁸

I draw several conclusions from this statement. First, Pellegrino interprets health in terms of agency, defined as the power or ability to act. Therefore, health refers to the person because the ability to act determines whether one is healthy or unhealthy: when healthy, a person can do what he or she wishes; when unhealthy, this ability is impaired. Second, health refers to the body in the derivative sense that good physiological function facilitates agency and poor function impedes it. Were physiological function not related to the organism's ability to act as whole, it would make no sense to distinguish a healthy body from an unhealthy one. Indeed, what sets good physiological function apart from poor or bad function is the different effect each has on the organism as a whole: the former permits it to do what it needs to do in order to keep on being what it is whereas the latter impedes this work.⁴⁹ Third, this means that health should be understood in terms of what

⁴⁸ Pellegrino, "The Healing Relationship," 163.

⁴⁹ This articulation owes much to Joe Sachs' translation of *entelecheia* as "being-at-work-staying-itself" and many discussions with Alan Rubenstein about what it means to be alive or dead. In the introduction to his translation of *De Anima*, Sachs writes:

The understanding of the form of anything as its being-at-work-staying-itself is a fundamental explanatory structure, and it is clear that life falls under it. For anything, from plants on up, that grows into a mature form, and maintains an organized body by appropriating from its surroundings, to be at all is to keep on being what it is by being and staying at work; the cessation of such activity is

humans need to do in order to keep on being human. For human beings, then, health goes well beyond the physiological functions necessary for survival: it also includes the activities pursued as part of a good human life. As Galen writes, “that condition in which we do not suffer pain, and are not impeded in the activities of life, we call health.”⁵⁰ Obviously, the activities of life are culturally shaped and vary widely, but this is beside the point since Pellegrino defines health as being “unimpaired in doing the things we wish to do.”⁵¹

Naturally, Pellegrino’s definition of health informs his presentation of healing as the end of medicine. It also prompts him to draw distinctions within the teleological structure of medicine. He says that, “in clinical medicine, the good of the patient is the end, *primus inter pares*.”⁵² If the patient’s good is the end of medicine in the primary sense because it is first among equals, what are the other ends against which the patient’s good stand out? Pellegrino provides an answer in his contribution to *Human Dignity and Bioethics: Essays Commissioned by the President’s Council on Bioethics*:

The ends of medicine are focused on the good of the patient as a human person. Medicine’s ends are ultimate, intermediate, and proximate. Ultimately, medicine aims to restore health; its intermediate aim is to cure, ameliorate, or prevent illness. Most proximately, it is to make a right and good healing decision, for a particular patient in a particular clinical encounter.⁵³

death, and a dead oak tree, though it is still something, is no longer an oak tree. [Joe Sachs, “Introduction,” *Aristotle’s On the Soul and Memory and Recollection*, trans. by Joe Sachs (Santa Fe: Green Lion Press, 2001), 9.]

⁵⁰ Galen, *A Translation of Galen’s Hygiene (De sanitate tuenda)*, trans. by Robert Montraville Greene (Springfield, Ill.: Thomas Books, 1951) 15. Galen makes this statement in Book I, “The Art of Preserving Health, Chapter 5, “Conditions and Constitutions.”

⁵¹ Pellegrino, “The Healing Relationship,” 163.

⁵² Pellegrino, “The ‘Telos’ of Medicine,” 23.

⁵³ Pellegrino, “The Lived Experience of Human Dignity,” 530.

To illustrate these distinctions, consider a case of streptococcal pharyngitis (strep throat). I wake up with a sore throat and I am apprehensive about eating breakfast since it is painful to swallow. In addition, I am acutely aware of the saliva collecting in my mouth and the seemingly constant need to swallow makes me uncomfortable. As illnesses go, this is not bad: I am not worried and the symptoms are manageable. However, I need to see a doctor because I cannot make the diagnosis myself nor can I write the prescription. The clinical encounter is brief and uncomplicated because the inquiry is minimal and little deliberation is needed: a throat culture confirms the diagnosis and I want to begin treatment with the appropriate antibiotic as soon as possible. I fill my prescription and, within 24 hours, my throat is no longer sore.⁵⁴ This progression clarifies the distinctions Pellegrino makes. I leave the doctor's office with a treatment plan: the antibiotics and the instructions about when and how to take them. This is the *proximate* end of medicine: the inquiry that brought me to the doctor concludes when the doctor and I agree about what should be done. However, there is more to healing: the requirements of the treatment plan must be fulfilled so that their intended effect can be realized. The intended effect of the treatment plan is the *intermediate* end of medicine. In this case, it is the curative work of the antibiotics. In turn, the *ultimate* end of medicine is more than the cure of a bacterial infection: it is the restoration of my health. In other words, it is waking up without a sore

⁵⁴ Alternatively, the infection could persist in a more virulent form, in which case I would return to my doctor's office and we would decide on a different course of action. So as not to contribute to the problem of virulent, antibiotic resistant bacteria, I need to take the full course of antibiotics, usually over ten days.

throat, eating and drinking without apprehension or discomfort, and going through the day without noticing or worrying about swallowing.

The treatment of streptococcal pharyngitis illustrates the easiest case. Painless treatment resolves the bodily problem so completely that I feel the same immediately after treatment as I did before the onset of illness. There is no need for convalescence, recuperation, or rehabilitation: I simply pick up where I left off. Obviously, this is not case for many conditions. Setting aside the frequently anxious and difficult deliberations that end with a treatment plan, there is, quite often, no picking up where one left off, even when the selected treatment perfectly achieves the intended result.⁵⁵ This means that the selected treatment (proximate end) points beyond its intended bodily effects (intermediate end) to the restoration of health (the ultimate end). In other words, the proximate and intermediate ends of medicine are means to achieving the ultimate end of medicine. They are, therefore, instrumental goods transcended by the ultimate end they target, namely the restoration of health.⁵⁶

Pellegrino's distinctions should not be construed to imply that medicine has three separate ends. Instead, they should be understood to mark different moments in the healing process. The proximate end of medicine is the decision that answers the patient's questions. What is wrong? What can be done? What should be done? This decision specifies an action (or set of actions) and its intended physiological effect is the intermediate end of medicine. By itself, this physiological effect does not restore the

⁵⁵ Consider dialysis or joint-replacement surgery: even when there are no complications and the patient enjoys the expected benefit, treatment changes his or her life dramatically.

⁵⁶ I set aside for another time the question of whether and to what extent the ultimate end immanently shapes the proximate and intermediate ends.

patient's health precisely because health is more than physiological function; being healthy means being without pain and unimpaired in doing the things we wish to do. Thus health is experienced as a kind of wholeness: it is the unity or integration of body, self, and world we experience when we are able to do what we want, without pain or impediment. Pellegrino describes illness as an ontological assault because it disrupts this sense of wholeness and, as it turns out, the difference between curing and healing turns on this sense of wholeness. When lost physiological functions cannot be restored, there can be no cure. However, it is always possible to heal the person who is ill by helping him or her find a renewed sense of wholeness; so when the underlying condition cannot be cured, healing requires helping the patient change his or her lifestyle in a way that accommodates the physiological limits illness imposes and medical treatment cannot alter.⁵⁷ It will become clearer as this presentation of medicine's teleological structure proceeds that the end of healing, the ultimate end of medicine, always involves the renewal or recovery of wholeness.⁵⁸

Let me conclude by relating the three moments of the healing process to the four levels of the patient's good. When Pellegrino articulates these levels, he shows what being whole means for a human being. The unity of bodily, personal, human and spiritual goods in a single, human life is the patient's good and, therefore, this fourfold good is the end of

⁵⁷ Medicine is limited in two pertinent ways: either there is no effective treatment for the particular malady or any possible treatment involves risks the patient finds unacceptable.

⁵⁸ Both health and healing can be traced back to the Indo-European root *kailo*, which *The American Heritage Dictionary of the English Language* defines as follows: "Whole, uninjured, of good omen." "Kailo," "Appendix I: Indo-European Roots", 4th ed. (Boston: Houghton Mifflin, 2000), <http://www.bartleby.com/61/roots/IE198.html> (accessed April 29, 2008).

medicine. Obviously, there is considerable disagreement about what these goods are.

As a healing practice, however, medicine focuses on the patient's understanding of these goods because it is their unity in the context of his or her life that is disrupted or threatened by the experience of illness. Thus healing means the restoration of disrupted goods, if possible, and the preservation of threatened goods, which is always possible. While physiological functions and agency are goods that can be disrupted or even lost permanently, generic human goods such as integrity and dignity cannot be lost.⁵⁹

Consequently, physicians can always heal their patients by preserving their dignity and integrity, as well as honoring their spiritual values. To summarize, the healing process has various moments: the treatment decision or proximate end of medicine; the physiological effect of treatment or intermediate end of medicine; and the restoration of health or ultimate end of medicine. Whether they happen all at once, or in succession, or even independently of each other as when a treatment decision is made but not implemented, each aims at the good of the patient. Shared decision-making, physiological interventions intended to restore organic functions, and recovering or renewing wholeness are different ways in which medicine aims at the patient's good. Accordingly, the good of the patient stands out: *primus inter pares*.

⁵⁹ I distinguish the integrity and dignity that belongs to a person because he or she is a human being from the integrity or dignity ascribed (rightly or wrongly) to some persons because of their character. The latter senses of these goods follows from the exercise of agency whereas the former is independent of agency.

Chapter 3

The Patient's Fourfold Good

§13 Unpacking the Teleological Structure of Medicine

In this chapter, I examine Pellegrino's account of the patient's good. As introduced in Chapter 2, the patient's good has four levels: (1) the bodily or medical good; (2) the personal good or the good as it is projected by the patient's preferences and plans; (3) the generic human goods of agency, integrity, and dignity; and (4) the ultimate or spiritual good, which is the patient's good of last resort. For the most part, I rely on four essays. My examination of the patient's bodily, personal, and ultimate goods draws on a pair of essays: "Moral Choice, the Good of the Patient, and the Patient's Good" and "The 'Telos' of Medicine and the Good of the Patient." My examination of integrity and dignity draws on "The Relationship of Autonomy and Integrity in Medical Ethics" and "The Lived Experience of Human Dignity," respectively.¹ This examination brings out the complexity in Pellegrino's teleological account of medicine and, in addition, shows Pellegrino's remarkably sensitive account of what it means to heal the patient. The end of medicine is to make the patient whole again: what this means will become clearer as I articulate the levels of the patient's good.

¹ Pellegrino, "Moral Choice, the Good of the Patient, and the Patient's Good," in *Ethics and Critical Care Medicine*, eds. John C. Moskop and Loretta Kopelman, 117-38; "The 'Telos' of Medicine and the Good of the Patient" in *Clinical Bioethics: A Search for the Foundations*, ed. Corrado Viafora (Dordrecht: Springer, 2005), 21-32; "The Relationship of Autonomy and Integrity in Medical Ethics," *Bulletin of the Pan American Health Organization* 24 (1990): 361-71; and "The Lived Experience of Human Dignity," in *The President's Council on Bioethics, Human Dignity and Bioethics: Essays Commissioned by the President's Council on Bioethics* (Washington, DC: 2008), 513-39.

§14 The Patient's Medical Good

According to Pellegrino, the medical good is the level of the patient's good that "relates most directly to the art of medicine, that part which is uniquely medical."²

Pellegrino provides a brief explanation in "The 'Telos' of Medicine". He writes:

The medical good aims at the return of physiological function of mind and body, the relief of pain and suffering, by medication, surgical interventions, psychotherapy, *etc.* At this level, the patient's good depends on the right use of the physician's knowledge and skill, those which are intrinsically part of the medical *tekne*.³

Pellegrino's emphasis on the technical dimension of medicine is appropriate for two reasons. First, it captures the distinctive feature of medicine as it is taught in medical schools and typically practiced in offices, clinics, and hospitals throughout the United States and much of the world. Second, the ethical dilemmas generated by this powerful form of medicine have given rise to bioethics.⁴

Pellegrino's discussion of the medical good in "Moral Choice" captures the problematic quality of modern medical power in a section of the essay entitled,

² Pellegrino, "The 'Telos' of Medicine," 25.

³ *Ibid.*, 25-6.

⁴ The diagnostic machinery and therapeutic armamentarium typical of medical practice in the United States displays a seemingly unlimited technological sophistication and the use of this technology has created many of bioethics' original questions. Consider, for example, dialysis, organ transplantation and brain death as well as the various questions raised by critical care medicine and the ICU. Of course, medicine has always had a technical dimension, but it was not until medical techniques were grounded in the laboratory sciences that what has come to be called 'biomedicine' emerged and displaced other healing practices. Biomedicine is "clinical medicine based on the principles of the natural sciences (biology, biochemistry, etc.)." *Dorland's Pocket Medical Dictionary*, 27th ed. (Philadelphia: Elsevier Saunders, 2004), s.v. "biomedicine."

“Biomedical or Techno-medical Good: What Medicine Can Achieve Technically.”⁵

The subsequent discussion specifies the working definition stated in his title.

Biomedical or techno-medical good encompasses the effects of medical interventions on the natural history of the disease being treated. It is the good that can be achieved by the application of expert technical medical knowledge—cure, containment of disease, prevention, amelioration of symptoms, or prolongation of life. It is directly related to the physician’s technical competence; it is the first step in fulfillment of his or her promise to help. Biomedical good is the *instrumental* good the patient seeks from the physician. It is also a good internal to medicine—part of its claim to be a special kind of human activity. It is the good that results from the physician’s craftsmanship—his capacity to make the technically correct decision and to carry it out safely, competently, and with minimal discomfort to the patient. Biomedical or techno-medical good is usually subsumed under the phrase “medically indicated.”⁶

Four points call for emphasis. First, the medical good results from an act which specifically targets the bodily disruption as it is understood by the physician. Second, the achievement of this good is not an end in itself. It is also a means for achieving what medicine promises to do: to restore the personal good particular to the patient and to preserve the higher human and spiritual goods. Third, medicine is set apart from other activities precisely because it is able to achieve this instrumental good. Fourth, the patient has the right to refuse medical treatment because, as an instrumental good, the medical good is desirable only insofar as it promotes the patient’s higher order goods. Moreover, the physician has an obligation to make sure the patient understands what can be done so that he or she can answer the question: what should be done? In sum, the achievement of the medical good by itself does not fulfill the physician’s profession to heal. That the

⁵ Pellegrino, “Moral Choice,” 121.

⁶ Ibid.

clinical encounter culminates in a right and good healing action does not mean that it aims at the medical good alone.

The medical good, which Pellegrino describes as “the effects of medical interventions on the natural history of the disease being treated” insofar as they aim at “cure, containment of disease, amelioration of symptoms, or prolongation of life” seems to be the same as the intermediate end of medicine, which is “to cure, ameliorate, or prevent illness.”⁷ The medical good is, of course, good, but it is an instrumental good: the physiological effects intended by a right and good healing action point beyond themselves to the good of the person whose body is being affected. Were the medical good identified as the ultimate end of medicine, there would be no need to treat the patient as a person. However, as Pellegrino points out,

[t]here always is an unfortunate tendency for physicians to equate biomedical or techno-medical good with the whole of the patient’s good. Techno-medical good does not exhaust the good the physician is obliged to do. It is an essential but not a sufficient component of good medicine. Two ethical errors may result from the conflation of techno-medical good with the good of the patient.

The first error is to make the patient a victim of the medical imperative to insist that if a procedure offers any physiological or therapeutic benefit it must be done. On this view, ethical medicine is limited to technically right interventions. Ethical quandaries are thus ignored since the only good acknowledged is medical good in its narrowest sense, and this is ascertained by scientific means and not by ethical discourse or analysis.

The second error is to confuse the physician’s judgment of the tolerability of the quality of life that would ensue from a treatment with the medical indications for that treatment. On this view, if treatment of a defective infant results in a life without “meaningful relationships,” then it is not indicated and should not be done. This is an unjustifiable extension of medical judgment beyond its legitimate limits. Whether a life is worth living is a value decision only the patient who must live that

⁷ Pellegrino, “The Lived Experience of Human Dignity,” 530. While Pellegrino does not identify the medical good and the intermediate end of medicine, the similarity is remarkable.

life can decide. Moreover, it is not a matter determinable by the capabilities of medicine *qua* medicine.⁸

In this passage, Pellegrino identifies the problem of paternalism. It has two forms. Either the physician overrides the patient's agency by refusing to recognize that the medical good is limited by the patient's higher order goods; or the physician mistakenly believes his or her judgment about those higher order goods concerns the medical good and, consequently, substitutes his or her judgment for that of the patient. In both cases, the physician decides what should be done, despite being obligated to help the patient make this decision. Thus the physician harms, rather than helps, the patient. Indeed, the physician undermines rather than preserves the generic human good of agency. To a large extent, I defend Pellegrino by showing that he avoids these paternalistic harms without compromising the teleological structure of the clinical encounter. Pellegrino fulfills this twofold aim because he understands that the clinical encounter is a shared inquiry: patient and physician deliberate together for the sake of healing. Their first step is to determine the medical good, i.e., the likely results of medical interventions. However, they must also consider whether this good is limited by the patient's higher goods and, if so, to what extent; for

the medical good must be brought into proper relationship with the other levels of the patient's good. Otherwise, it may become harmful. What is medically "good" simply on the grounds of physiological effectiveness may not be "good," if it violates higher levels of good, like the patient's good as he perceives that good.⁹

In sum, the medical good must be understood as the end targeted by medically indicated (technically correct) therapy. It is the bodily result that makes a healing action

⁸ Pellegrino, "Moral Choice," 121.

⁹ Pellegrino, "The 'Telos' of Medicine," 26.

right. However, this result does not, by itself, make the healing action *good*. For a right healing action to be good, that which makes it right must be an instrument of that which makes it good: the medical good must serve the patient's personal, human, and spiritual goods. Put differently, to implement a medically indicated treatment for its own sake is to substitute the intermediate end of medicine for its ultimate end and, consequently, to risk seriously harming the patient as this substitution fails to appreciate what the patient wants and needs: to feel whole again.

§15 The Patient's Personal Good

According to Pellegrino, "[a] biomedically or techno-medically good treatment is not automatically good from the patient's point of view."¹⁰ This insight is one of Pellegrino's most significant contributions to the philosophy of medicine because it permits him to defend the teleological structure of medicine without advocating paternalism. Pellegrino insists that medical treatment

must be examined in the context of the patient's life situation and his or her value system. To be good in the fuller sense, the choice must square with what the patient thinks worthwhile given the circumstances and alternatives his illness forces upon him. . . .

. . . Our concern must be for the person who is to live the life that illness imposes, not what we think of the quality of that life.¹¹

If the clinical encounter had no end other than the medical good, there would be no need for patients to exercise their agency. Physicians would simply make their diagnosis and prescribe the treatment most likely to restore physiological function as completely as

¹⁰ Pellegrino, "Moral Choice," 123.

¹¹ *Ibid.*, 123-4.

possible. This paternalistic pattern is wrong because the end of the clinical encounter is the good of the patient. Furthermore, this end is not served if the likely and foreseeable result of medically indicated treatment does not conform to the patient's understanding of the good life. Pellegrino could not be clearer on this point:

The medical good serves the many, complex facets of what the patient perceives as his own good. Here, we are concerned with the patient's personal preferences, choices, and values, and the kind of life he wants to live, the balance he strikes between the benefit and burdens of proposed intervention. These qualities and values are unique for each patient and cannot be defined by the physician, the family or anyone else. . . . To serve the general good of the patient, the medical good must be placed within the context of *this* patient's life-plans.¹²

That the patient's plans and preferences limit the medical good means that the physician cannot know what is best for the patient. Therefore, mutual deliberation is required:

Patient interest . . . is necessarily subjective and relative, since it is rooted in *the patient's view* of what is in his own best interests at this time, and in this circumstance. We [physicians] cannot know what that is until we ask the patient. This view does not deny the possibility that some objects of interest will be bad or injurious—it requires only that they have been freely chosen by this patient.¹³

Medical treatment calls for the patient's consent because the goodness of the medical act cannot be known unless it is affirmed by the patient. In short, the physician cannot make good on his or her profession to heal unless he or she consults with the patient.¹⁴

¹² Pellegrino, "The 'Telos' of Medicine," 26.

¹³ Pellegrino, "Moral Choice," 124.

¹⁴ Technical competence is an insufficient basis for determining what should be done: "in the complex anatomy of clinical judgment, competence is a necessary, but not sufficient condition of a moral medical transaction and an authentic act of profession. Competence must itself be shaped by the end of the medical act—a right and good healing action for a particular patient." Pellegrino, "Reconstruction," 49.

Pellegrino's acknowledgement that the patient may choose something "bad or injurious," does not alter his understanding of the physician's obligation to the patient.

It is no revelation that we may know the good, but do not do not infallibly choose it. Because someone has chosen something as good does not make it good intrinsically or instrumentally. To accept the patient's definition of his own best interests does not necessitate that the doctor agree nor is he bound morally to promote those interests. What the physician must do is to give the most serious weight to the patient's judgment of his own interest in making decisions. Indeed, that judgment must be accorded primacy, since it arises from the operation of an even more fundamental good—the human capacity to choose.¹⁵

The physician's judgment about what is or is not a desirable result of treatment is an insufficient basis for determining what should be done for the same reason that the physician's competence to determine what are or are not medically indicated treatments cannot, by itself, determine what should be done: what is best for the patient is for the patient to decide. However, the physician's role is not limited to presenting a set of alternatives to the patient:

It is the obligation of the physician to ascertain, by the most careful method, the kind of life that might ensue from a particular treatment in a particular patient. These are matters of scientific judgment proper to medicine. They are essential in helping the patient decide if the life that ensues from treatment is worthwhile. It is he [the patient] who must judge, with the physician's help, the kind of life he wishes to lead and the risks or discomfort he is willing to bear to attain the benefits medical treatment might offer.¹⁶

The patient comes to the physician in a crisis: not only does the patient recognize illness as a turning point in his or her life; the patient also recognizes that this turning point calls for a decision. Moreover, to decide well what should be done, the patient needs to

¹⁵ Pellegrino, "Moral Choice," 124-5. In "The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective," *Fordham Urban Law Journal* 30 (2002): 221-44, Pellegrino addresses the difficult situation that arises when the physician cannot, in good conscience, provide the treatment the patient wants.

¹⁶ Pellegrino, "Moral Choice," 122.

understand what is wrong and what can be done; so, while the physician's expertise is limited to the medical good, this is precisely what the patient needs to evaluate in order to decide what should be done. Indeed, the patient needs to evaluate whether and how the medical good fits into his or her understanding of the good life. Therefore, the "physician has a special obligation to assure and facilitate the patient's moral agency."¹⁷ This obligation makes consent meaningful:

More is required than the minimal conditions of a legally valid consent, which is after all, guarantee against the grosser violations of the patient's right to decide. A morally valid consent moves closer to the realization of both senses of the word "con-sent" (Latin: *consentire*), to feel and to know something together. Patient and physician, therefore, must each feel he knows and understands the available facts, and each must feel he is truly part of the decision making.¹⁸

Consent, as Pellegrino describes it, cannot happen unless the physician shares his or her expertise with the patient in a way that permits the patient to be an agent. When the clinical encounter falls short of this aim, it fails the patient. Moreover, since medically indicated treatment cannot be good if it does not serve the patient's good as he or she perceives it, the need for consent "places the actual locus of decision making somewhere between physician and patient, and not really with one or the other."¹⁹

The shift from the patient's medical good to his or her particular personal good is not a movement beyond the ends of medicine. Instead, it is a shift from the narrowly physical aspect of healing to the fundamentally personal nature of healing. That the physician treats the body to heal the person follows from the definition of health Pellegrino takes from Galen. The physician works to restore the patient's capacity to engage in life's

¹⁷ Pellegrino, "Reconstruction, 49.

¹⁸ Ibid., 50.

¹⁹ Ibid., 50-51.

activities because this is what health is: the exercise of agency without pain or other psychophysical impediments. That medicine works directly on the physical sources of these pains and impediments does not mean that medicine focuses on them exclusively. Medicine heals when clinical practice is shaped by the patient's agency; for the restoration of health is the restoration of agency. Therefore, the shift from the patient's medical good to his or her particular personal good shows how the teleological structure of medicine protects the same interest informed consent is meant to protect. When health is understood as the power to engage in life's activities without pain or psychophysical impediment, it becomes clear that medicine is directed to the patient as an agent. Thus Pellegrino's teleological account of medicine does the same work that is done by the demand for informed consent without, however, appealing to an external moral theory.

§16 The Generic Human Good of Agency

If the shift from the patient's medical good to his or her particular personal good protects the patient as an agent, why does Pellegrino go beyond the level of the patient's particular personal good to the generic human good of agency? After all, one stays close to the concrete experience of illness as it is lived when one focuses on the personal good as it is defined, in particular, by the patient's plans and preferences. In contrast, the move to agency as such is an abstraction. Agency does not exist by itself as agents cannot be separated from their actions, plans, and preferences. Moreover, illness disrupts concretely the life of this agent in particular: it interferes with his or her actions, thwarts his or her

plans, and defies his or her preferences. When the agent cannot cope with this disruption by him- or herself, the need for healing comes to the fore. Medicine responds to this need.

That the agent becomes a patient in order to continue being an agent reveals much of why Pellegrino addresses agency as a generic human good. Persons who are ill seek the restoration of their agency. While their particular plans and preferences are important, they recognize that agency is an indispensable part of a good human life. In other words, a human life without agency would seem radically incomplete. Indeed, much of what makes life worthwhile would be missing.²⁰ The generic human good of agency is the very power to act: to shape one's own life according to what one believes is best or most important. Illness threatens this power and medicine seeks to restore it.

Although illness shows up against the background of the patient's particular personal good, Pellegrino addresses the power of agency itself, as it shows up in the clinical encounter. In "Moral Choice," he focuses on "the operation of the capacity to use reason to *make* choices, and to communicate those choices through speech."²¹ This statement captures what agents do and, as Pellegrino articulates this capacity, he points beyond the patient's particular personal good to agency as a generic human good:

One cherished and distinctive feature of human existence is the capacity to establish a life plan, and to select from a variety of goods those things that are

²⁰ Pellegrino acknowledges the appropriateness of quality of life decisions so long as they are made by the patient. Such quality of life judgments, when appropriately informed and competently made, give rise to refusals of treatment and should be respected. In contrast, he objects to making decisions based on judgments about the quality of another person's life. Edmund D. Pellegrino, "Decisions to Withdraw Life-Sustaining Treatment: A Moral Algorithm," *JAMA* 283 (February 23, 2000): 1066.

²¹ Pellegrino, "Moral Choice," 125.

preferred for reasons that are unique and personal. Humans may not reason wisely, prudently or correctly, but the freedom to do so is a good without which it is impossible for the mentally competent person to live a good life.²²

Treatment should conform to the patient's understanding of the good life because, to do otherwise, would violate the goodness of agency the patient enjoys as a human being:

If we are not to violate the humanity of the patient in medical decisions, so long as the patient is competent, we must allow him to make his own choices. We cannot override these choices even if they run counter to what we think is good for the patient. To manipulate the patient's consent, to deceive or misinform him, even to do what we think is good is to violate his good as a human being.²³

It is true that neither the physician's sense of what is best for the patient nor the physician's evaluation of what the patient thinks is best can override what the patient thinks is best; but not because the patient *knows* what is best.

The question whether the patient's judgment is mistaken misses the point.

Competent patients are agents and should be treated as such. To do otherwise is to deny this basic feature of a good human life. This means that the generic human good of agency grounds the physician's respect for the patient's personal choices. Accordingly, the physician does not defer to the patient's particular personal good because the patient knows what the good human life is. Instead, the physician recognizes that the healing process should be oriented by the patient's particular personal good because agency is itself a generic human good physicians are obligated to preserve. Therefore, it would be harmful to override the patient's "capacity to use reason to *make* choices, and to communicate those choices through speech."²⁴ Indeed, much of the patient's need for

²² Ibid.

²³ Ibid., 125-6.

²⁴ Ibid., 125.

healing stems directly from the negative impact illness has on his or her agency. In response, the physician has a complex obligation: to preserve the patient's agency by deliberating with him or her about what should be done to restore the personal good that was enjoyed before the onset of illness. If this end cannot be achieved, the physician must help the patient adjust to the limits illness has imposed; in this way, the physician preserves the good of agency even though the particulars have changed. In sum, the physician takes care of the patient as an agent by asking the patient to be an agent.

§17 From Restoration to Preservation

So far I have discussed three of the goods served by medicine: the patient's medical good, his or her particular personal good, and the generic human good of agency. All three goods are subject to disruption. Consequently, medicine works to restore them. Indeed, if it were impossible to restore them, then medicine would not exist. The body would either heal itself or it would not, and there would be no reason to seek out another person for the sake of healing. Happily, it is possible to restore many of the physiological functions disrupted by illness but this power is not unlimited. Some functions cannot be restored and, sometimes, the loss of function brings about the loss of life. While a person is now more likely to survive the loss of many different physiological functions, but these losses disrupt personal plans.²⁵ Since this disruption changes the person's possibilities, the loss of physiological function disrupts the personal good particular to the affected individual:

²⁵ Consider, for example, respirators, pacemakers, dialysis, or the pharmaceutical regulation of blood pressure. This list could be greatly expanded, though not infinitely. The intensive care unit (ICU) now makes it possible to survive the simultaneous loss of multiple functions.

his or her preferences and plans cannot be realized. These changes at the level of the personal good reflect changes at the level of the generic good of agency precisely because illness limits the power to act and choose. Consider, for example, an automobile accident that results in paralysis, a chronic illness such as multiple sclerosis, or dementia. In each of these cases, the disruption of physiological functions affects the person not only in reference to his or her particular personal good, but as an agent, in general. Thus medicine is not concerned with the disruption of physiological functions alone. Indeed, its concern with physiological processes is instrumental: the aim of medical intervention is to restore the generic good of agency in the way that facilitates fulfillment at the level of the patient's personal goods. In short, medicine treats the body to heal the person.

That there is more to the art of healing than the restoration of these three goods is suggested by the examples concerning the generic good of agency. Although paralysis, multiple sclerosis and dementia affect different persons differently, there is a sense in which a person remains an agent so long as he or she has the power to act or choose. Thus it might make more sense to describe medicine as working to preserve agency at the generic level and restore it at the level of the personal good. I do not do so for two reasons. First, agency can be lost. In certain vegetative states, for example, agency is permanently lost. The temporary loss of agency happens more frequently since there are a variety of maladies that can bring about a temporary loss of consciousness or, for that matter, a temporary loss of competence. Second, the disruption of agency is part of the experience of illness. Indeed, we would not go to the doctor if illness did not impair our ability to do what we want. Nevertheless, the intuition that some goods are restored while

others are preserved does hold true, but not necessarily in respect to agency.²⁶ The goods preserved by medicine are the other generic human goods: integrity and dignity. I will discuss them in turn. Then I will take up the spiritual good: this ultimate level of the patient's good is the good of last resort.

§18 The Generic Human Good of Integrity

According to Pellegrino, there are two senses in which integrity is significant for medical ethics: one refers to the integrity of the person whereas the other refers to the person of integrity. He sorts them out as follows:

In the first sense, integrity is a moral claim which belongs to every human simply by virtue of being human. In the second sense, integrity is a virtue, a moral *habitus* acquired by constant practice in our relation with others. Integrity belongs to all persons as humans, but not all are persons of integrity.²⁷

While both have “important ethical implications in medical ethics,” only one is a generic human good.²⁸ Accordingly, I focus on the integrity of the person, *not* the person of integrity. Integrity is a good enjoyed by every human being precisely because he or she is human and it is a good that is well served by medicine because, as will be seen, integrity and health are closely related.

Pellegrino brings out what the integrity of the person means by going back to its etymological origin: “integrity is from the Latin *integer*, and it means wholeness,

²⁶ I am willing to concede that in some instances medicine preserves rather than restores agency.

²⁷ Pellegrino, “Autonomy and Integrity,” 366.

²⁸ The person of integrity has no greater need for healing than the scoundrel and, while the distinction between them is important, it is irrelevant to the profession to heal because the physician has the same obligation to both.

completeness, or unimpaired unity.”²⁹ There is, then, a straightforward connection to the root sense of health since both mean being whole. Moreover, the kinds of things that can be healthy are, for the most part, the kinds of things that have integrity. Indeed, they are precisely those beings that Aristotle identified as entities or substances. Living beings are, for Aristotle, the paradigmatic instance of being because each one is the unity of material and form, potentiality and actuality. Moreover, each endures as a unity only insofar as it is at work maintaining itself as a whole. Hence the wholeness or unity of living beings is not static. In a fundamental sense, maintaining wholeness is the ceaseless work of completion.³⁰ Living beings continue being what they are through a constant exchange with what they are not. Indeed, being alive is the work of integrating what is other into one’s own being. To stay alive, I must eat and breathe, rebuild cells and tissues, eliminate wastes, etc. So long as I am alive, the exchange never stops.

Pellegrino addresses the connection between integrity and health, but in more concrete terms, as is appropriate to his philosophical interest in the goods served by medicine and by healing as the end of medicine.

By the integrity of the person we mean the right ordering of the parts to the whole, the balance and harmony between the various dimensions of human existence necessary for the well-functioning of the whole human organism. The integrity of the person is expressed in a balanced relationship between the bodily, psychosocial, and intellectual elements of his or her life. No one element is out of proportion to the others. Each takes the lead when the good of the whole requires it. Each yields to the other in the interest of the whole. Integrity in this sense is synonymous with health. Disease amounts to disintegration, a rupture of the unity

²⁹ Pellegrino, “Autonomy and Integrity,” 365.

³⁰ Hans Jonas’ discussion of metabolism articulates this point quite well. See “Biological Foundations of Individuality,” in Hans Jonas, *Philosophical Essays: From Ancient Creed to Technological Man* (Engelwood Cliffs, NJ: Prentice-Hall, Inc., 1974), 185-205.

of the person. This rupture may occur in one or more of three spheres, each with its own ethical implications: the corporeal, the psychological, and the axiological.³¹

Before I turn to the ruptures or disintegrations Pellegrino references, I should note that the loss of integrity, in the sense of biological wholeness, ends the life of the organism; for when the living being can no longer maintain its unity, it ceases to be an organism and becomes a corpse. This follows from the fact that the wholeness or completeness an organism enjoys is not a static form: it is a continually renewed achievement. This ongoing being-at-work³² called for by being alive extends throughout the different levels Pellegrino mentions. Not only does he define the integrity of the person as “the right ordering of the parts to whole” but as “the balance and harmony between the various dimensions of human existence.” The latter phrase makes clear that part-whole integrity is not rigid or fixed because the wholeness or completeness of a person is not fabricated: it arises naturally through organic processes and is maintained through constant changes, conscious and otherwise, that permit the person to live in accordance with his or her understanding of the good life. This fluid or dynamic process

³¹ Pellegrino, “Autonomy and Integrity,” 366.

³² “Being-at-work” is a neologism employed by Joe Sachs to translate *energeia* because it articulates Aristotle’s interest so well. Sachs writes:

Aristotle is interested in the way the world sorts itself out, and this is visible in anything that keeps on being the same while constantly undergoing change. . . . For such a being, to be at all depends on its keeping on being what it is. Aristotle sums up this way of being in his phrase *to ti ēn einai*, for what this sort of thing is cannot be given by some arbitrary classification of it, but as what it keeps on being in order to be at all. Its very being is activity, *energeia*, and because it is a wholeness of identity achieved in and through being-at-work, Aristotle invents as a name for it the word *entelecheia*, being-at-work-staying-itself. (Joe Sachs, introduction to *Aristotle’s On the Soul and Memory and Recollection*, trans. Joe Sachs (Santa Fe: Green Lion Press, 2001), 8-9.)

See note 49 to chapter 2 for Sachs’ discussion of being-at-work-staying-itself.

pervades personal life and, as Pellegrino points out, it can be ruptured at the corporeal, psychological, and axiological levels.

Corporeal integrity

Pellegrino takes up corporeal or bodily integrity first. It “implies a physiologically well-functioning organism, a body that can serve the aims and purposes of the person efficiently and effectively with a minimum of discomfort or disability.”³³ After positing this functional definition of a healthy body, Pellegrino describes illness:

With physical illness, corporeal unity is shattered. The body (or one of its organs) becomes the focus of attention and loses some or all of its capacity for work, play, or human relationships. There may even be loss of an organ or a function. The functional integrity of the whole organism is disrupted by a sick organ, organ system, or metabolic mechanism.³⁴

While illness involves an experience of lost health, the unity of the ill person endures, even though it is impaired. Were corporeal unity truly shattered, death would follow *quickly*.³⁵

³³ Pellegrino, “Autonomy and Integrity,” 366.

³⁴ Ibid.

³⁵ The claim that death would quickly follow the loss of spontaneous somatic integration is basic to much of the debate over the neurological determination of death (“brain death”). At issue is whether the destruction of whole brain (both hemispheres and the brain stem) reliably identifies death of the organism. The literature generated by this controversy is extensive, but well represented in essays by a few authors. James L. Bernat defends the neurological determination of death. “The Biophilosophical Basis of Whole-Brain Death,” *Social Philosophy and Policy* 19 (2002): 324-42; “The Whole-Brain Concept of Death Remains Optimum Public Policy,” *The Journal of Law, Medicine, and Ethics* 34 (2006): 35-43. D. Alan Shewmon argues that the property of somatic integration cannot be localized and can continue after the neurological criteria for brain death have been satisfied; so “brain death” is not death. “The Brain and Somatic Integration: Insights into the Standard Biological Rationale for Equating ‘Brain Death’ with Death,” *The Journal of Medicine and Philosophy* 26 (2001): 456-78. Hans Jonas argues that the boundary between life and death is inherently vague so it is wrong to act as if these conditions were separated by a bright line; instead, we must be cautious and treat a person as living if there

Therefore, medicine does not restore corporeal integrity so much as it works to preserve it against the threat of complete disintegration. In other words, illness may result in partial disintegration, but there is a difference in kind between partial and complete disintegration. The former is compatible with life whereas the latter is not. This means that even the critically ill person enjoys corporeal integrity so long as he or she is alive and this integrity is complete so long as it is present because a living being is a whole or it is not alive.

Thus partial disintegration is not so much disintegration as it is a loss of resiliency or an increase in fragility. Accordingly, the more serious the illness, the graver the threat of disintegration, because corporeal integrity, while complete, is more fragile, more susceptible to loss, i.e., the body is more prone to complete disintegration. Therefore, it makes sense to describe integrity along a continuum between the extremes of resiliency and fragility. A person can live at either end, or anywhere in the middle. However, the most resilient heal most easily whereas the most fragile heal with the greatest difficulty; for the part-whole structure that permits something fragile to be what it is has the least tolerance for change whereas the part-whole structure that permits something resilient to be what it is has the greatest tolerance for change. Finally, since being alive involves changing constantly, a person becomes increasingly fragile and, subsequently, more

is any doubt as to whether he or she is dead. "Against the Stream," in *Philosophical Essays: From Ancient Creed to Technological Man* (Englewood Cliffs, NJ: Prentice-Hall, 1974), 132-40. Although the partisans in this debate do not question the identification of death with the loss of spontaneous somatic integration, there are some who distinguish the death of the person from the death of the organism and, on the basis of this distinction, argue that the whole-brain standard should be rejected because it preserves organic life even though the person has died. See John P. Lizza, *Persons, Humanity, and the Definition of Death* (Baltimore: The Johns Hopkins University Press, 2006).

susceptible to disintegration as he or she loses resiliency, i.e., the power to tolerate change and continue to be.³⁶

Psychological integrity

Pellegrino defines psychological integrity as “the unity of the self in its relationship to the body.”³⁷ As seen in Chapter 1, the effect of illness on the experience of this unity prompts Pellegrino to claim that illness is an ontological assault. His treatment of psychological integrity builds on this point.

When illness afflicts a part of the body, we feel alienated from that part, we stand in some sense away from the offending body, and we sometimes reject it and resent it as an enemy. The image we have fashioned of our self-identity relative to our bodily integrity is threatened. We all live with a unique balance we have struck over the years between our hopes and aspirations and the limitations imposed by our physiological, psychological, or physical shortcomings. Serious illness forces a confrontation between that image and the impact of disability, pain, and death. It confronts us with the possibility of a substantially altered self-image or even non-

³⁶ The suggestion that integrity exists on a continuum between fragility and resiliency is my own and is meant to account for the fluid or dynamic quality of integrity while defending the claim that the generic human good of integrity cannot be lost. Integrity, Pellegrino writes, “is an attribute of possessed by all humans—competent or not, adult or not, conscious or not. It does not admit of degrees, nor can it be lost. Hence integrity is not something we have but it is a part of our being.” Pellegrino, “Autonomy and Integrity,” 369. If Pellegrino’s claim that integrity does not admit of degrees means that either there is wholeness or there is not wholeness, I would agree. However, if he means that part-whole structures cannot be distinguished according to their tolerance for change, then I disagree.

³⁷ Pellegrino, “Autonomy and Integrity,” 366. Since I bring out the teleological structure of medicine by focusing on physical illness, the need for healing it generates, and medicine as the distinctive human response to this need, I do not address what Pellegrino calls mental or emotional illness even though it is an important topic that deserves much attention. As Pellegrino notes, “anxieties, obsessions, compulsions, illusions” and the like distort “the balance and unity of the person” and thereby “interfere with that person’s well-functioning as much as the rupture of corporeal unity.” “Autonomy and Integrity,” 366.

existence. A new image, new points of balance, and a new definition of what constitutes health must be established if we are to become “whole” again.³⁸

The unique balance to which Pellegrino refers is a relatively stable and familiar pattern whereby we maintain our sense of who we are. It is the self-image we have formed over the course of our lives as we integrate our strengths and weaknesses, aspirations and limitations, accomplishments and disappointments, etc. Our self-image, then, is not a static picture, but rather a dynamic whole, embracing the various parts of our lives and holding them together. So it is through our self-image that we experience ourselves as wholes. However, the sense of wholeness born from and maintained by this experience is vulnerable because it is founded upon the integration of body and self; so, when illness alienates the body from the self, the pattern or rhythm of life is interrupted and the familiar self-image or identity is threatened or lost. Hence illness is a common threat to psychological integrity: as it alienates the self from the body, illness threatens our self-image, disrupts our plans, and announces, or least intimates, our mortality.

Thus illness threatens both psychological and corporeal integrity precisely because it foretells the inevitable disintegration of wholeness, identity, or unity. At some point, the power to recover our balance will fail and we will cease to be the living human beings that we are. Until that point comes, however, each and every human being has integrity by virtue of the wholeness that comes with being human. Moreover, integrity is threatened rather than disrupted by illness because illness does not destroy integrity. Even when made fragile by illness, integrity remains. Nevertheless, we can feel as if our integrity has been lost when we face serious illness and, in this sense, illness disrupts integrity.

³⁸ Ibid.

We feel as if our integrity is lost because it is so closely connected to agency.

When illness disrupts the plans through which we project ourselves into the future, our agency is certainly disrupted and, in this way, the connection between corporeal integrity and agency is disclosed. Since agency depends upon the living body, the loss of physiological function restricts our power as agents and limits the personal goods that can be realized through our own actions. These losses may or may not be restored, depending upon the state of the art in medicine and our willingness to undergo the risks associated with the available therapies. While physiological function, personal goods, and agency are *lost*, corporeal integrity becomes more *fragile*. Put differently, illness exacerbates the natural process whereby corporeal integrity becomes fragile over time until, at some point, somatic integration can no longer be maintained spontaneously and, absent intensive care, the person dies.³⁹ The disruption of agency discloses the fragility of the living body at the level of corporeal integrity. In contrast, the disruption of agency discloses the fragility of the self-image at the level of psychological integrity. If our self-image is closely tied to the pattern of our agency, i.e., our lifestyle, then our self-image is especially fragile because it cannot be maintained when agency is disrupted or lost. In this way, illness severely threatens psychological integrity. This need not be the case: the sense we have of

³⁹ The ICU is a mixed blessing. On the one hand, it is necessary and practically unquestionable because it saves lives. On the other hand, it sometimes preserves life when it would be better to let the person die. The difficulty, of course, is to distinguish appropriate uses of intensive care from inappropriate uses. Pellegrino addresses this question in terms of futility. "Decisions at the End of Life: The Use and Abuse of the Concept of Futility," in *The Dignity of the Dying Person*, eds. Juan De Dios Vial Correa and Elio Sgreccia (Vatican City: Libreria Editrice Vaticana, 2000), 219-41, "Futility in Medical Decisions: The Word and the Concept," *HEC Forum* 17 (2005): 308-18. See also "Decisions to Withdraw Life-Sustaining Treatment: A Moral Algorithm," *JAMA* 238 (2000): 1065-7.

ourselves as living wholes can become more resilient if we learn to adapt to the changes brought about by illness.

The connection between agency and integrity helps to differentiate corporeal integrity from psychological integrity. Resilience is necessarily restricted at the level of corporeal integrity because we are perishable. Not only do we die, but as we grow older, the body loses the power to heal itself. In short, corporeal integrity tends towards fragility. In contrast, it is possible to become increasingly resilient at the level of psychological integrity. One might even say that there is considerable wisdom in developing such resilience since agency and corporeal integrity are perishable goods. In other words, resilience involves the enjoyment of more lasting goods and suggests greater maturity. Hence psychological integrity is independent of corporeal integrity in the sense that the resilience of the former is not limited by the fragility of the latter. This does not mean that psychological integrity is separable from corporeal integrity. This is an absurd hypothesis: it makes no sense to speak of the human self in the absence of a living human body because the self does not exist separate and apart from the body.

However, there can be corporeal integrity without psychological integrity in permanent vegetative states, for example, when consciousness has been permanently lost.⁴⁰ Such cases are extremely rare and, while they cannot be dismissed, they do not

⁴⁰ For this reason, Robert Veatch has long argued that it should be possible to declare the death of a human being who has permanently lost the capacity for consciousness. His most recent treatment of this topic is "The Death of Whole-Brain Death: The Plague of the Disaggregators, Somaticists, and Mentalists," *The Journal of Medicine and Philosophy* 30 (2005): 353-78. There are, of course, others who support the same position but, unlike Veatch, base their argument on the difference between the death of the person and the death of the organism. See Lizza cited in note 35 above.

undermine the claim that corporeal integrity and psychological integrity can be abstracted from each other because they concern different senses of wholeness. Nor does the fact that psychological integrity can be lost in extremely rare cases mean that psychological integrity is restored rather than preserved or sustained by medical care.⁴¹ Instead, it means that the medical power to sustain corporeal integrity exceeds the power to sustain psychological integrity. Finally, the fact that corporeal integrity can be present when psychological integrity is absent discloses the complexity of medical care and raises the question of whether medical power is used wisely.⁴²

Axiological integrity

There is, however, another level beyond corporeal and psychological integrity.

Axiological integrity refers to

the intactness of the values we cherish and espouse. Each of us is in a real sense defined by the particular configuration of values we have chosen as our own. In illness these values may be in conflict with those of the physician, our families, or society. Our conception of healing reflects our personal assessment of what constitutes well-functioning. This is as much a value-determined conception as it is a physical or psychological one. In order for us to be cured or treated, our most cherished values must also become the subject of the physician's scrutiny and

⁴¹ I distinguish between restoration and preservation because some of the patient's goods are disrupted by illness and may (or may not) be restored by medical treatment. For example, good emergency medicine and effective rehabilitation after an automobile accident may (or may not) restore many disrupted physiological functions. In turn, the power to realize many personal goods may (or may not) be restored. So both medical and personal goods are subject to disruption and loss across the course of a lifetime, as is, consequently, the generic human good of agency. However, the generic human goods of integrity and dignity are not disrupted by illness. Instead, they are threatened by illness and the practice of medicine aims to preserve or sustain them.

⁴² Pellegrino's articulation of futility addresses this question. See the sources cited in note 39 above.

possible manipulation. Thus our values are at risk of challenge or damage in the medical transaction.⁴³

Appropriately, axiological integrity integrates the different aspects of the patient's good. The patient values bodily health not just for its own sake, but in order to realize the goals projected by his or her preferences or plans. These goals, together with other personal interests, shape the patient's personal good and, because they express the patient's values, they belong to his or her axiological integrity. Lastly, the patient values the generic good of agency because it permits him or her to pursue a good life. Thus axiological integrity incorporates, within the meaning of a single life, the bodily or medical good, the particular personal good, and the generic human good of agency. In short, axiological integrity refers the physician to the patient as a person. The patient is a person whose life has been shaped by choices, actions, omissions, hopes, fears, ambitions, disappointments, friends, family, and much, much more. His or her values are woven through this unfolding whole and since these values orient him or her in the world, this axiological orientation is intimately tied to who this person is, how he or she understands him- or herself, or is understood by others. Thus axiological integrity is the whole of what a person values; as such, it is nothing less than the entirety of the bonds that connect the person to the world, to other persons, and to the complex unity formed by the body and the self. When the person is ill, this whole—axiological integrity—is at stake.

Pellegrino speaks to this vulnerability when he points out the possible conflicts within the clinical encounter. He pays special attention to the possibility of conflict with the physician because no other person has more control over how the patient will be treated

⁴³ Pellegrino, "Autonomy and Integrity," 366-7.

and, if that treatment is to serve the patient's axiological integrity, then the patient's values must be made known to the physician. This means that the patient must expose him- or herself to the physician in order to be healed. This exposure includes the patient's cherished values, especially the ones that are most threatened. These values in particular "must also become the subject of the physician's scrutiny and possible manipulation" precisely because they are more likely to be lost if they remain hidden. Pellegrino recognizes the paradox involved: healing requires the exposure of valued goods even though their exposure puts them at risk. In fact, this exposure is a violation necessitated by the appeal to the physician for help. In order for healing to happen,

the person must to some degree be violated. The physician lays hand on the patient, peers into every orifice, inquires into the details of the patient's social relationships and psychological responses. This is a licit invasion of integrity to which the patient gives assent. But consent cannot obviate the exposure of integrity to serious risk attendant upon medical treatment.⁴⁴

The physician is permitted these liberties for the sake of healing, to make the patient whole again. Accordingly, the physician is bound to serve the good of the patient. Hence the obligations of the physician can be traced back to the patient's experience of illness, now understood as a threat to the patient's integrity. As Pellegrino notes, the "potential for the tripartite disintegration of the person, which is part of being ill, creates obligations for the physician—who is bound by covenant to heal and help."⁴⁵ The physician must preserve the integrity of the patient precisely because it is threatened by illness and gives rise to the need for healing to which the physician responds. This obligation binds the physician: he or she cannot make good on the profession to heal if the good of integrity is not preserved.

⁴⁴ Ibid., 367.

⁴⁵ Ibid.

This generically human good is threatened rather than disrupted since it is the wholeness that belongs to a human being as a human being. Accordingly, there can be no healing if this wholeness is lost because, without it, there is no human being.⁴⁶ Put differently, fidelity to healing as the end of medicine requires the physician to keep the integrity of the patient intact.

The difference between restoring physiological functions, the personal good, and agency, on the one hand, and sustaining integrity, on the other hand, does not alter the meaning of healing: “to make whole again, that is, to reestablish the wholeness that constitutes a healthy existence.”⁴⁷ However, it does take note of the changes brought about by illness and healing. The moments of being well, being ill, and being healed are both the same and different. Physiological functions, preferences, plans, and goals change as does the power to take action and make choices. The wholeness that incorporates these changes stays the same. The patient’s integrity endures in the sense that it is the identity or unity that runs through the manifold of moments that constitute a person’s life. Illness threatens this integrity because each human is subject to disintegration. Frequently, a person feels these threats as a loss because many of the goods he or she values are subject

⁴⁶ This statement requires clarification since there can be corporeal integrity where there is no psychological integrity as is the case, for example, when someone has permanently lost consciousness. That axiological integrity can be present even when psychological integrity is absent is illustrated by the controversy over whether Terry Schiavo should continue to receive artificial nutrition and hydration. The question litigated by the courts was whether there was sufficient evidence to establish that she would have refused medical treatment.

⁴⁷ Pellegrino, “Autonomy and Integrity,” 367.

to disruption and can, in fact, be lost. Nevertheless, the wholeness that belongs to a person as a human being is not lost as long as the person is alive.⁴⁸

Concluding remarks on integrity

I need to make four more points about Pellegrino's articulation of integrity as one of the patient's generic human goods. The first concerns Pellegrino's remark that "restoration of the integrity of the person is the moral basis of the physician-patient relationship."⁴⁹ Although the patient may experience integrity as being lost and then restored, the physician preserves the patient's integrity throughout the changes brought on by illness in such a way that the patient who has been healed is able to recognize the enduring wholeness of his or her life. Thus healing promotes resiliency, with the following qualification: whereas corporeal integrity is made fragile by illness, healing brings about greater resilience at the level of psychological and axiological integrity. Hence Pellegrino's remark is followed by the statement that "any morally authentic doctor-patient relationship must by definition be 'holistic.'"⁵⁰ This is true because healing preserves wholeness and provides the patient with the opportunity to experience a more profound sense of wholeness.⁵¹

⁴⁸ I do not take up the question of whether there is any sense in which this wholeness transcends death.

⁴⁹ Pellegrino, "Autonomy and Integrity," 367.

⁵⁰ Ibid.

⁵¹ Sally Gadow shows that illness can transform the relationship between the body and self in a way that enriches their complex unity. "Body and Self: A Dialectic," *The Journal of Medicine and Philosophy* 5 (1980): 172-85, reprinted in *The Humanity of the Ill: Phenomenological Perspectives*, ed. Victor Kestenbaum (Knoxville: University of Tennessee Press, 1982), 86-100.

Second, Pellegrino relates the good of integrity to the end of the clinical encounter when he notes that a clinical decision that preserves integrity is a decision that has integrity.

The principle of respect for integrity can and does ameliorate some deficiencies of the principle of autonomy. For one thing, respect for integrity is inconsistent with the minimalistic view of some physicians—namely, that autonomy is reducible to a right to refuse treatment. In order to truly respect the integrity of the person, we must strive to give integrity to his or her decision as well, to respect a wholeness that places that decision within the history and the background of the patient’s life. A particular decision can never stand isolated from the whole narrative of the patient’s life, the drama he or she has lived and is living, and the way he or she perceives self, family, and community in relation to the decision in question. All of these particulars must enter into the final choice if that choice is to have integrity in itself and be the act or decision of a whole or complete person.⁵²

This passage goes a long way toward making the point at which his essay aims: integrity “encompasses a more fundamental and richer safeguard for the dignity of patient and physician than current interpretations of the principle of autonomy.”⁵³

The third point is a stronger claim. Whereas we may or may not have autonomy, integrity belongs to the being of the human. “It is an attribute of possessed by all humans—competent or not, adult or not, conscious or not. It does not admit of degrees, nor can it be lost. Hence integrity is not something we have but it is a part of our being.”⁵⁴ Of course, when we have the power to make choices and take action, that power, whether it is called agency or autonomy, must be respected because it is integrated into our lives as an especially important good. Thus respect for integrity includes respect for autonomy: it serves the patient’s particular personal understanding of the good life and the generic

⁵² Pellegrino, “Autonomy and Integrity,” 369.

⁵³ Ibid., 361-2.

⁵⁴ Ibid., 369.

human good of agency. However, respect for integrity is a more comprehensive principle because it attends to the wholeness of the patient's life as a human being in need of healing. Moreover, respect for integrity recognizes that illness is a crisis. Since the person who is ill needs to know what is wrong, what can be done, and what should be done, he or she becomes a patient in need of help. In particular, the patient needs help answering these three questions.

Finally, the observation that medicine is ultimately a deliberative inquiry is one of Pellegrino's chief insights and he brings it to bear in the following remark.

Respect for the integrity of persons . . . moves the patient's decision from the level of simple assent or dissent to the level of consent—because it implies mutual and consensual arrival at a decision by the doctor and patient acting together. In this view, respect for the integrity of persons requires a positive effort to get not just a decision that is autonomous by external criteria but one that represents the common ground of knowing and feeling that exists between the doctor and the patient. It is not a case of the patient assenting or dissenting as an isolated entity, but of the doctor and patient consenting—that is, acting together, with each respecting the integrity of the other's person.⁵⁵

Hence Pellegrino's investigation of integrity concludes with the foregoing discussion of informed consent as mutual deliberation and the following formulation for morally defensible decision-making:

The decision should not be made by the physician in the place of the patient, nor by the patient in isolation from the physician or the community. . . . The morally optimal condition is one in which the decision arises between doctor and patient. That is, the physician should make the decision for, and with, the patient—the “for” signifying not “in place of” but “in the interests of” the patient. This formulation preserves . . . the moral claim to autonomy, and the deeper claim to the integrity of persons.⁵⁶

⁵⁵ Ibid., 369-70.

⁵⁶ Ibid., 371. It would be a gross misunderstanding to think that Pellegrino's statement about the physician making the decision means that the physician is, in fact, the decision-maker. As has been pointed out repeatedly and in this passage, Pellegrino insists that the

§19 The Generic Human Good of Dignity

Dignity, the last of the generic human goods articulated by Pellegrino, is the most elusive. Fortunately, I do not need to resolve the debates about what dignity means and whether it is significant for medical ethics.⁵⁷ My task is much more limited: to show what Pellegrino means by dignity and why it is significant for his theory of medical ethics.

Two senses of dignity

Pellegrino makes an important distinction between two senses of dignity. The first sense is the intrinsic or inherent worth that belongs to every human being precisely because he or she is human. The second sense is not intrinsic, but attributed or imputed to a person.⁵⁸ Intrinsic dignity does not change and cannot be lost whereas attributed dignity

patient and the physician should make the decision together so that the clinical encounter ends in a right and good healing action. Nevertheless, the physician does write the order in the patient's chart or write the prescription. In this sense, the physician makes the decision: he or she has the authority to bring about certain healing actions, namely those that are intended to heal the patient. As Pellegrino writes, "the physician must write the orders that are carried out by others. The physician cannot avoid the fact that she is the focal point through which harm and benefit of a clinical decision will flow in the majority of cases." "Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship," *Journal of Contemporary Health Law and Policy* 10 (1994): 52. It would, however, be an abuse of this authority to make decisions unilaterally: ethical decisions are the upshot of mutual deliberation.

⁵⁷ See The President's Council on Bioethics, *Human Dignity and Bioethics: Essays Commissioned by the President's Council on Bioethics* (Washington, DC, 2008).

⁵⁸ Daniel Sulmasy describes attributed dignity as "that worth or value that human beings confer upon others by acts of attribution. The act of conferring this worth may be accomplished individually or communally, but it always involves a choice. Attributed dignity is . . . a conventional form of value." Daniel Sulmasy, "Dignity and Bioethics: History, Theory, and Selected Applications" in The President's Council on Bioethics, *Human Dignity and Bioethics*, 473. In addition to being a physician, Sulmasy is a philosopher. He earned his Ph.D. at Georgetown University, where Pellegrino directed his dissertation. The two worked together for many years at Georgetown's Center for Clinical

changes and can be lost. To avoid confusing these two senses of dignity, I will refer to attributed dignity as *esteem*, since I think self-esteem as well as the esteem of others expresses the attribution of value basic to the second sense of dignity.⁵⁹ Thus I will use dignity to refer exclusively to a human being's intrinsic worth. This distinction sharpens the critical point: every human being possess an immutable and inalienable worth, while esteem comes and goes. Pellegrino expresses the difference as follows:

intrinsic human dignity is . . . the inherent worth present in all humans simply by virtue of their being human. Intrinsic dignity cannot be gained or lost, expanded or diminished. It is independent of human opinions about a person's worth. It is the inherent grounding of the moral entitlements of every human being to respect for one's person, one's rights, and one's equal treatment under the law in a just political order.

Extrinsic or imputed dignity . . . is the assessment of worth or status humans assign to each other or to themselves. It is based on external measures of worth or value as perceived in a person's behavior, social status, appearance, etc. It sums up certain perceived attributes judged admirable or condemnable by other persons, by culture, by political or social criteria, by fashion, or by membership in certain groups. Imputed dignity can be gained or lost simply by one's own self-judgment or by the judgment of others. It can be taken away or granted by law or social convention or by one's opinion of one's own worth in comparison with others.⁶⁰

Pellegrino's exploration of the lived experience of human dignity is framed by a key insight:

What is most significant for our understanding of our own or another's dignity is that we experience them only in community with others. Assessment of my own dignity is disclosed in the personal encounter with another. The experience of dignity is inescapably a phenomenon of intersubjectivity. Only in the encounter with others do we gain knowledge of how we value each other and ourselves.⁶¹

Bioethics. Sulmasy was Co-Director of the Center for a year before he became the Director from July 1996 through the June of 1998.

⁵⁹ One does not attribute intrinsic dignity to persons; one recognizes their intrinsic dignity.

⁶⁰ Pellegrino, "The Lived Experience of Human Dignity," 517-8.

⁶¹ *Ibid.*, 521.

Our encounters with each other motivate us to evaluate ourselves and others. This means, as Pellegrino points out, that dignity and esteem come to our attention in the context of our relationships with each other. Even if some reflections on our own worth seem to be private, they are typically motivated by an experience with others. Thus dignity and esteem are easily confused. They seem to be the same because they share the same intersubjective foundation and both present the worth of human beings. Moreover, we rarely have reason to tease dignity apart from esteem so we conflate them, without acknowledging the difference between the inherent and immutable worth that belongs to every human being and the diversity of opinions we have about particular persons, including ourselves.

Why, then, do we distinguish between esteem and dignity? Why do we recognize that there is a worth that belongs to being human that cannot be altered by the contingent circumstances of our particular lives? These contingencies permit us to make all kinds of discriminations. However, some discriminations wrongfully violate the fundamentally equal and inalienable worth of individuals *qua* human being. What the basis of this equal worth is and when it can be appropriately invoked are debatable questions beyond the scope of this dissertation. That dignity is asserted as an intrinsic worth possessed by every human being and appreciated as a bar to actions that disregard this worth suffice to establish that dignity is experienced as a generic human good.

The assertion of dignity as the intrinsic and equal worth shared by every human being also discloses the occasion for the distinction between esteem and dignity:

Humans become most acutely aware of their own dignity and that of others when it is threatened by the acts and opinions of their fellow humans or by the

circumstances of one's life, work, social, political or community life, or by the way one reacts to the exigencies of these encounters.⁶²

We recognize the difference between esteem and dignity when we suffer or witness wrongs that compel us to recognize the intrinsic worth that exists whether esteem is present or absent. Esteem, we know, is a matter of opinion, so we learn to deal with its variability. We also know that different persons and communities have different attitudes about the particular details that distinguish one person from another. In contrast, dignity goes to a dimension of being human that is shared by every human being. This universal dimension of human existence—whatever it is—should command the respect of every human for every other human.

When that respect is absent, the individual is reduced to the particular, contingent, details of his or her life in the sense that he or she becomes subject to the judgments these particulars provoke, without the protection that our common humanity should afford. It is this casting out beyond the pale of protection that distinguishes dignity from esteem. Dignity asserts the universal basis of human worth to protect persons against particular judgments that deny their equal, intrinsic, and inalienable worth. In this way, the assertion of dignity in response to a wrong differentiates the dignity that comes with being human from the particulars referenced by esteem (or lack thereof). “All too often,” Pellegrino writes, “dignity, like many of the more precious but intangible phenomena of human life,

⁶² Ibid.

is taken for granted. Only when it is threatened, demeaned, or wrenched forcibly from us do we understand how inseparable our dignity is from our humanity.”⁶³

Dignity and the clinical encounter

Medicine, as Pellegrino knows well, is frequently practiced in a way that threatens the patient’s dignity and, consequently, dignity comes to the fore as one of the patient’s generic human goods medicine is supposed to serve. However, dignity is like no other good because it is the intrinsic worth that belongs to the patient as a human being. Accordingly, no other good can serve as a proxy for dignity.⁶⁴ So, when discussing dignity in the context of the clinical encounter, it is necessary to deal with the intersubjective context in which dignity and esteem are experienced as well as the way in

⁶³ Ibid., 515. One could object that dignity cannot be “wrenched forcibly from us” if it is truly intrinsic, inalienable and immutable. Sadly, history provides many examples that clarify this usage:

a multitude of human beings have experienced the degradation of the human spirit that follows from the systematic deprivation of human dignity. To illustrate, one need only mention the Holocaust, slavery, genocide and ethnic cleansings, and the political murders of massive numbers of dissidents by the ideological tyrannies of Maosim, National Socialism, and Stalinism. To the victims, the resulting indignities were the cause of horrific suffering. To the rest of us, their sufferings were so crushingly obvious that to ignore them would have undermined—and in some cases did undermine—our own dignity as well (515).

That dignity is intrinsic and inalienable does not mean it is recognized or respected and, when there is neither recognition nor respect, one is deprived of the immunities (protections or rights) that come with respect for dignity. This loss of immunity, I submit, is what Pellegrino means when he speaks of dignity being wrenched away or otherwise lost. The point is not that those who suffer indignities have no dignity but rather that they are treated as if they had no dignity.

⁶⁴ Thus Pellegrino strongly disagrees with Ruth Macklin, who argues that dignity protects no interest that isn’t already protected by the principle of autonomy. “Dignity is a Useless Concept,” *BMJ* 327 (2003): 1419-20.

which they are experienced together in order to understand how medicine preserves the generic human good of dignity.

When Pellegrino wrote that “[t]he experience of dignity is inescapably a phenomenon of intersubjectivity,”⁶⁵ he did not distinguish between intrinsic and attributed dignity. This was no oversight; both arise in our relations with each other so both are intersubjective, as is the clinical encounter. As “a confrontation, a face-to-face encounter between someone who professes to heal and someone in need of healing,” the clinical encounter “is a phenomenon of intersubjectivity” and, consequently, “a locus for the experience of human dignity and its loss.”⁶⁶ At this point, it is not clear whether Pellegrino means dignity, esteem, or both. While one might assume that the qualification *human* signals intrinsic worth rather than esteem, the attention he pays to questions that worry the patient suggests that he intends both insofar as the patient experiences them without differentiating between them. In healing relationships,

there are always the silent questions: [1] How will my plight be perceived? [2] Has my vulnerability diminished the respect I deserve as a fellow human being? [3] Is my need for help perceived as a manifestation of a physiological or psychological weakness? [4] Does that perception erode my dignity in the eyes of the one whose help I need?⁶⁷

That these questions are posed silently speaks to the problem of trust. We worry about the judgments of those who profess to heal us precisely because we have entrusted ourselves to their care. These worries underscore the sense of vulnerability that comes with being ill: what is at stake is not something we possess, but our very being. Who and

⁶⁵ Pellegrino, “The Lived Experience of Human Dignity,” 521.

⁶⁶ Ibid., 522.

⁶⁷ Ibid.

what we are is imperiled by illness. In this vulnerable condition, we frequently do not know how the healers to whom we entrust ourselves feel about us or even whether they respect us as human beings. As these silent questions concern both dignity (2, 4) and esteem (1, 3), they show that patients feel vulnerable as persons not only because illness is an ontological assault, but because patients frequently do not know whether the physicians to whom they have entrusted themselves are worthy of that trust. Thus being vulnerable involves more than being uncertain about the prospect of being healed. The person who is ill is also uncertain as to whether he or she will be treated respectfully (dignity) and with solicitude (esteem).

More will be said about vulnerability in part two. The point I want to make now is that patients do not distinguish between dignity and esteem because they experience them together, as the following passage shows:

The experiences of threats to and loss of dignity are well known to hospital patients. They begin with the haughty receptionist, continue with the admitting clerk and the interrogation about insurance, and are followed by lying on the gurney waiting in the hall for the x-ray technician. Being the “next case” does little to reassure us. There are subtle variations in the list of cumulative assaults on one’s sense of dignity. I have heard the litany from my own patients, and know it from personal experience. It takes a stronger perception of one’s inherent dignity than most of us possess not to feel humiliated.⁶⁸

The regular and systematic absence of esteem for the patient as a person undermines self-esteem and raises questions about dignity. Given the humiliating routines, patients may wonder whether, in addition to their health, they have lost their dignity. “In times of suffering, disfigurement, or certainty of death, patients often lose their confidence in their

⁶⁸ Ibid., 524.

own worth or dignity.”⁶⁹ In other words, the occasions when patients feel the loss of esteem, often prompt them to wonder whether they have lost their dignity as well. As Pellegrino observes, there are very few persons who have such a strong sense of dignity that they do not experience the loss of esteem as a threat to dignity.⁷⁰

Pellegrino makes special reference to the dying and the chronically ill when he considers how the loss of esteem affects the experience of dignity.⁷¹

Most patients survive . . . routine humiliations, but there are many occasions when the experience entails deeper repercussions and, hence, greater moral significance. Chronic illness, mental illness, dying, and death are occasions when the patient’s perception of loss of his or her dignity is deep enough and persistent enough to be, itself, an additional source of suffering. This suffering is often more distressing than the pains, discomfort, or disability caused by the disease itself.⁷²

If the purview of medicine is restricted to the disruption and restoration of physiological functions, then the suffering caused by threats to dignity would not concern physicians.

But, since this suffering generates a need for healing in patients, all who profess to heal are obligated to preserve the patient’s dignity and, when possible, to restore his or her self-esteem. That physicians fail to satisfy this obligation has, as Pellegrino points out, especially serious consequences for dying or chronically ill persons.

⁶⁹ Ibid., 523.

⁷⁰ Perhaps only the most arrogant could experience their dignity as invulnerable. It is not clear whether they could hold on to their sense of dignity if, for example, they had to endure the rigors of aggressive chemotherapy or their lives were altered by Parkinson’s disease or multiple sclerosis.

⁷¹ This should not be surprising. When medicine is understood as a technique of physiological intervention, healing tends to be reduced to curing and the incurable are treated as if they cannot be healed. In this way, the profession to heal becomes meaningless when it comes to the dying and the chronically ill. This moral failure speaks to the need to revive the teleological understanding of medicine.

⁷² Pellegrino, “The Lived Experience of Human Dignity,” 524-5. Despite its importance, I do not discuss mental illness in my dissertation.

Cumulative assaults on the dignity of the dying are often the reason for a desperate request for euthanasia or assisted suicide as well as for the prevalence of clinical depression among dying patients.⁷³

As disease becomes chronic and unrelenting and progresses to foreseeable death, the experience of indignity becomes more insistent. It becomes ever harder to believe in one's underlying inherent dignity. It is difficult to controvert the ravages of a long illness—emaciation, loss of appetite, inability to care for one's most personal needs, overwhelming weakness and fatigue, and the deterioration of physiognomy and affect. Those realities powerfully force the conclusion of personal unworthiness of the patient.⁷⁴

The responsibility of physicians

According to Pellegrino, “[t]he preservation of human dignity and the prevention of indignity are obligations built into the ends of medicine” precisely because “[t]he ends of medicine are focused on the good of the patient as a human person.”⁷⁵ This means that physicians

must be the unfailing advocates and defenders of patient dignity. They must be cognizant of those many times when the “system,” the “team,” or the “teaching hospital” may function to the detriment of the patient's self-esteem. Physicians are not guiltless if their staff and those around them in any way demean patients who lack education or financial means, or are elderly, or easily confused, or experience language barriers, etc. The therapeutic process begins when a patient in need calls the doctor's office or is admitted to the hospital.⁷⁶

To live up to this responsibility, physicians must be engaged on at least three levels. First, as members of the profession, they have a responsibility for the institutional structures of medical practice. Second, as educators, they influence the attitudes and habits of the physicians they train. Third, as clinicians, they affect patients directly. Pellegrino's broad

⁷³ Ibid., 525.

⁷⁴ Ibid., 527.

⁷⁵ Ibid., 530.

⁷⁶ Ibid., 531.

conception of the physician's responsibility to the patient follows from his teleology.

He reminds physicians that medicine exists to respond to the patient's need for healing so, to make good on their profession to heal, physicians must do everything they can to protect the dignity and esteem of their patients.

The vulnerabilities engendered by illness should not be exacerbated when the patient, in his or her quest for to be healed, appeals to others for help. Whether the injuries are the result of personal encounters or institutional structures, physicians need to take responsibility for the way medicine is practiced. Unfortunately, too many shirk this responsibility. They

distance themselves from the actions of those who act in their name on the basis of lack of time, difficulty in "getting good help," or simple insensitivity to anything not susceptible to resolution by a prescription or a procedure. More seriously, the behavior of his or her team may be a reflection of the physician's arrogance.⁷⁷

The upshot of Pellegrino's concern is clear: disrespect for the dignity of patients and insensitivity to the impact of illness on their self-esteem should not be tolerated by physicians. They

cannot ignore those many assaults on human dignity, intrinsic as well as attributed, that are taken for granted in the bureaucratic, commercialized, and impersonal places that hospitals have, all too often, become. Some of this is indeed unavoidable, given the complex nature of contemporary medical care. But physicians, administrators, and policy-makers must always ask, "What is the impact of our organization or 'system' on the care of the persons they were designed to help?" A more collective sense of shared responsibility for the "dehumanization," the "depersonalization," or the "alienation" that the sick feel in today's health and medical care institutions must fall on the physician. Physicians

⁷⁷ Ibid. Pellegrino does not elaborate on this arrogance. Presumably, he means that some physicians do not want to be bothered with anything other than the techniques of physiological intervention because they think everything else is trivial or not worthy of a physician's attention.

can exert enormous moral influence if they take their advocacy role seriously as part of their common professional ethic.⁷⁸

In short, “the devoted patient advocacy expected of the ethical physician dictates a higher degree of vigilance than is now common.”⁷⁹ The physician cannot make good on his or her profession to heal when medical care routinely threatens the patient’s dignity and undermines his or her self-esteem.

As educators, physicians function as role-models so they profoundly influence the attitudes and habits of the persons they train.

In teaching institutions, students and residents will look to their clinical teachers for guidance in protecting patient dignity. Clinical teachers must be aware that arrogance, indifference, and ineptitude can lead patients to feel alienated and undignified, reduced to lesser members of the human community. All who enter the presence of the seriously ill person become accomplices if the patient feels a loss of dignity. Unconsciously, the members of the health care team can contribute to the patient’s sense of unworthiness.⁸⁰

The explicit point of this paragraph is that physicians must be respectful of patients’ dignity and sensitive to patients’ self-esteem not just for the patients’ sake but also to foster similar attentiveness in medical students and residents. Pellegrino also makes clear that patients’ experience of dignity and esteem are shaped by their encounters with physicians because dignity and esteem are experienced in the context of a community. We understand who and what we are in terms of how we are like, and unlike, those with whom we associate and this process of identification and differentiation shapes the experience of dignity and esteem.

⁷⁸ Ibid., 532.

⁷⁹ Ibid., 531.

⁸⁰ Ibid., 533.

Pellegrino's attention to community brings out a subtle point. Physicians, and others devoted to the care of patients, are implicitly obligated to establish a sense of community that sustains the patient's dignity and supports his or her self-esteem.

Pellegrino points in this direction in the following passage:

Students and medical residents must be taught in settings in which human dignity is expressly addressed. Students will easily learn good and bad habits. Indifference, ineptitude, and arrogance are transmissible. Courses designed to teach compassion, intercultural competency, and the like may help. But, ultimately, students and residents model their attitudes about patient care on their clinical teachers' behavior. The same is true of the institutions within which they take their first steps as clinicians. The virtues of dignity-responsive care can only be learned in personal and institutional settings that sustain those virtues.⁸¹

Since patients come to physicians in order to be healed, physicians have a special responsibility to establish the unique moral community in which two or more persons form a bond for the sake of healing. Accordingly, Pellegrino calls upon physicians to be vigilant: they need to direct their attention to the settings and relationships that shape the practice of medicine so that the clinical encounter can be the kind of community that promotes healing. "Physicians can exert enormous influence if they take their advocacy role seriously as part of their common professional ethic."⁸² Indeed, if physicians act as "unfailing advocates and defenders of patient dignity,"⁸³ then medicine will be practiced and taught "in settings in which human dignity is expressly addressed." This would be "dignity-responsive care." Clearly, physicians must pay more careful attention to their responsibilities as educators and as members of the medical profession if medical care is to respond appropriately to the dignity and esteem of those who need help to heal.

⁸¹ Ibid.

⁸² Ibid., 532.

⁸³ Ibid., 531.

As clinicians, physicians know that none of the wrongs patient suffer in the name of being healed

occurs in isolation. Health professionals, friends, family, and fellow patients are all participants. Seriously ill and dying patients are acutely sensitive to the way others in their presence react to them. The visitor's look of shock on entering the patient's room, the poorly disguised pity, the slight turning away of the eyes, the ever shorter visits, the struggle to say something meaningful, the mournful countenance, the recoil from bodily contact—those reactions all sustain the patient's conviction that she or he is no longer a respected, needed, or wanted member of their community or society. These phenomena feed the patient's perception of being a burden and even an embarrassment to his family, friends, and physicians.⁸⁴

In this passage, Pellegrino identifies the subtle and various ways in which the patient loses the sense of community that preserves the sense of dignity and fosters self-esteem. When this sense of community is lost, the patient's dignity is threatened and his or her self-esteem is diminished. How others “respond to . . . the decline of their patient, friend, or family member has serious consequences for that patient's perception of his worth” precisely because this perception is intersubjective: “Those in the patient's presence are inevitably co-actors and participants in the unfolding drama. As such they incur certain ethical obligations.”⁸⁵ Since their “intended or unintended signals of body language, word, and countenance are all too often affirmations for the patient of his perceived loss of dignity,”⁸⁶ health professionals, friends and family must be on guard to avoid signaling to the patient that he or she has neither the dignity that comes with being

⁸⁴ Ibid., 527.

⁸⁵ Ibid.

⁸⁶ Ibid.

human nor the esteem of those devoted to his or her well-being.⁸⁷ Consequently, as

Pellegrino points out, a

final, and often neglected, obligation of physicians is to help family and friends to understand that the ways they respond to the patient's plight and vulnerability are important determinants of the degree to which the patient will feel alienated from the human community. All who enter the patient's presence can become complicit in the patient's loss of self-worth.⁸⁸

Pellegrino stresses the importance of community not only because he recognizes that the experience of dignity and esteem arise within a community, but, more importantly, because he understands that illness threatens community by alienating the person who is ill from his or her body, from others, and from the world. Given the suffering that results as illness threatens the very bonds that make our lives meaningful, physicians cannot make good on their profession to heal if they overlook the impact of the alienation their patients feel: "Too many lose all sense of personal worth and despair of regaining identifiable dignity."⁸⁹ In such circumstances, it is not enough to assert that dignity cannot be lost.

⁸⁷ S. Kay Toombs makes a similar point about intersubjective context of illness and self-esteem:

in illness and disability, the felt dimension of interaction with Others may exacerbate the loss of self-esteem. In the case of disability, one sees one's distorted body through the eyes of the Other and thus constitutes it in a negative fashion. This is not a culture which celebrates physical difference or dependence. People who stagger, use crutches, sit in wheelchairs, lack limbs, shake with tics or tremors, are far from the ideal. In directly experiencing the Other's responses (facial expressions, gestures, averted eyes) the person with a disordered body feels herself concretely diminished, devalued. "The Role of Empathy in Clinical Practice," *The Journal of Consciousness Studies* 8, Nos. 5-7 (2001): 253.

Although Toombs refers primarily to disability and self-esteem, her remarks generally describe the intersubjective threats to dignity and esteem experienced by persons who are ill, injured or disabled.

⁸⁸ Pellegrino, "The Lived Experience of Human Dignity," 532-3.

⁸⁹ *Ibid.*, 526. "The business mogul who suffers a massive heart attack, the truck driver who has had his first epileptic episode, the housewife and mother whose lymphoma is

Dignity must be sustained and self-esteem must be supported by the bonds physicians form with their patients by caring for them as persons. When physicians develop these bonds, they start to heal their patients by resolving the silent questions that patients bring to the clinical encounter: “How will my plight be perceived? Has my vulnerability diminished the respect I deserve as a fellow human being? Is my need for help perceived as a manifestation of a physiological or psychological weakness? Does that perception erode my dignity in the eyes of the one whose help I need?”⁹⁰ Pellegrino gives voice to these questions because they underscore the obligations physicians take up when they profess to heal the persons they encounter in the clinic: “dependent and vulnerable humans needing help must expose their fragile sense of self-worth to the gaze of others”⁹¹ so physicians must work constantly to sustain their patients’ dignity and support their self-esteem.

At each step, the physician must try to bolster the patient against a sense of unworthiness and guilt. The physician must avoid false humor, unrealistic expectations, and the temptation to avoid the ultimate questions. Somehow, the physician must be truthful and realistic and, at the same time, try to mitigate the impact of the mounting evidence of the patient’s decline. The patient must always feel worthy of the physician’s time and attention.⁹²

outpacing her chemotherapy—each suffers an ontological assault. The image they cherish of their own worth and the worth of their lives to other is forcibly shattered” (526).

⁹⁰ Ibid., 522.

⁹¹ Ibid., 529.

⁹² Ibid., 532.

§20 The Patient's Ultimate Good

Pellegrino also refers to the patient's ultimate good as the "spiritual good," which is "the good of the patient as a spiritual being."⁹³ This level of the good "gives ultimate meaning to human lives. It is that for which humans will often make the greatest sacrifices of other good things."⁹⁴ Frequently, this level reflects religious belief, but whatever the source, the ultimate or spiritual good is, as Pellegrino puts it,

the "good of last resort" . . . to which we tend to return whenever we are forced to make choices between competing goods, the one good we tend to place above others. For the religious person the highest good is accommodation to the will or law of the Creator. For the non-religious person it may be seeking the greatest pleasure, the least harm, the greatest utility, enlightened self-interest, the good of the least advantaged person in a society, the absolute autonomy of patients to choose or the survival of the species. Without arguing . . . about what that ultimate good should be, we need only accept that there is *de facto* such a good for all who attempt to make rational choices.⁹⁵

Pellegrino's teleological understanding of ethics could not be clearer. The ultimate or spiritual good "will take precedence over the other forms of patient good"⁹⁶ precisely because it is his or her final good.

For example, blood transfusion might be medically "indicated" for the Jehovah's witness, abortion of a genetically impaired fetus for a Catholic, or discontinuance of life support for an Orthodox Jew. But in these cases, the mere medical good could never be a healing act since it would violate the patient's highest good. Similarly, the Muslim, the Buddhist, the Hindu or the humanist patient has his own spiritual good which must be encompassed within a clinical decision if it is to serve the "good" of the patient.⁹⁷

⁹³ Pellegrino, "The 'Telos' of Medicine," 27.

⁹⁴ Ibid.

⁹⁵ Pellegrino, "Moral Choice," 130.

⁹⁶ Ibid.

⁹⁷ Pellegrino, "The 'Telos' of Medicine," 27.

Clearly, medically indicated acts are not healing acts when they conflict with the patient's ultimate good. However, in these same examples, it is also true that the medically indicated act conflicts with the patient's personal good as well as the generic human goods. Therefore, one might wonder what is gained by adding this level to the ethical analysis of the patient's good. If the point of such analysis is to identify conflicts within the clinical encounter, then it adds nothing new since a blood transfusion would violate the personal good, agency, axiological integrity, and dignity of the Jehovah's witness. However, Pellegrino does not articulate the levels of the patient's good to identify conflict, but rather to show (1) that healing requires more than the restoration of physiological function and (2) that healing can take place (a) when physiological function cannot be restored or (b) when the patient refuses treatments aimed at such restoration. So, when there is no cure or the indicated treatments are refused, healing means working to form a community with the patient so as to sustain his or her integrity and dignity. This work helps the patient become whole again because it serves the goods that belong to the patient as a human being *and* conforms to his or her understanding of both what it means to be human as well as why it is good to be human. This understanding may or may not be religious, but it is the bottom line: this patient's good of last resort.

In a pluralist society, it is not surprising that many of the conflicts that arise in the clinical encounter can be traced back to the disagreements about the ultimate good for human beings. Therefore, most bioethicists agree that the principle of patient autonomy takes precedence and must be used to settle conflicts in favor of the patient. Pellegrino would agree with this result since

paternalism with respect to a patient's choice of ultimate good is morally offensive. The ultimate good is the starting point of a person's moral reasoning, his first act of intellectual faith so to speak. If he or she is competent, it must be respected over medical good, and the physician's, society's, the family's, or the law's construal of ultimate good. The patient may abandon or subjugate his conception of ultimate good to his more immediate personal interests, but others may not do so.⁹⁸

In this passage, Pellegrino seems to be asserting the principle of patient autonomy since, on the one hand, he acknowledges the challenge of pluralism and, on the other hand, he identifies agency as an especially important part of being human.⁹⁹ Indeed, agency is one of three generic human goods he identifies, but he claims that it is not the highest good. According to Pellegrino, agency is not more important than integrity or dignity. Moreover, autonomy, in the sense that it is invoked to settle conflicts, is not self-orienting. Put differently, the autonomous person is not oriented as an agent by virtue of his or her autonomy but rather by the goods that he or she values.¹⁰⁰ Amongst those goods, one stands out as first or highest; it is the ultimate good for this patient. Thus Pellegrino

⁹⁸ Pellegrino, "Moral Choice," 130.

⁹⁹ Immediately after this passage, Pellegrino writes: "There has never been, nor is there likely ever to be, universal agreement on the ultimate good. Societies that wish to be homogenous in their choice of ultimate good usually do so by some form of coercion. In democratic societies it is a civic right of competent persons to choose their own belief systems." ("Moral Choice," 130)

¹⁰⁰ Kant is the only major philosopher who proposes that reason must orient itself independently of any other influence.

An absolutely good will, whose principle must be a categorical imperative, will therefore be indeterminate as regards all objects and will contain merely the form of willing; and indeed that form is autonomy. This is to say that the fitness of the maxims of every good will to make themselves universal laws is itself the only the will of every rational being imposes on itself, without needing to assume any incentive or interest as a basis. (Kant, *Grounding*, 48)

Even though respect for the law is basic to his ethical theory, respect "means merely the consciousness of the subordination of my will to a law without the mediation of other influences upon my sense." Kant, *Grounding*, 14 n.14.

writes: “To pursue a moral life we are under compulsion to act with fidelity to some ultimate source or concept of good though our choices of that source or concept may vary widely.”¹⁰¹ When medicine is understood teleologically, it is clear that this good cannot be violated. Since the ultimate good orients the patient as an agent and shapes his or her axiological integrity, any act that violates this good constitutes a profound harm to the patient, expresses a fundamental disrespect for his or her dignity, and can never be construed as a healing act.

¹⁰¹ Pellegrino, “Moral Choice,” 130.

Part Two

Defense of Edmund Pellegrino's Teleological Theory of Medicine

Chapter 4

Veatch, the Birth of Bioethics, and the Problem of the Physician *qua* Technician

§21 Background: Veatch's Anti-Hippocratic Orientation

Robert Veatch makes it quite clear that his work in biomedical ethics has been shaped by his opposition to the Hippocratic ethic.¹

The single most important intellectual event in my career in medical ethics occurred the day I realized that the Hippocratic ethic for medicine was not merely outdated and irrelevant but actually in conflict with all the dominant religious and secular moral traditions of our day. Whether one stood in any of the great modern religious traditions or in any of the camps of secular philosophy—the liberal tradition of political philosophy, Marxism, or more recent feminist or communitarian views—the Hippocratic ethic was wrong, both metaethically (epistemologically) and normatively.²

¹ Veatch has argued against the Hippocratic ethic in many essays. Robert Veatch, "Medical Ethics: Professional or Universal?" *Harvard Theological Review* 65 (1972): 531-59, "The Hippocratic Ethic: Consequentialism, Individualism, and Paternalism," in *No Rush to Judgment: Essays on Medical Ethics*, eds. David H. Smith and Linda M. Bernstein (Bloomington: The Poynter Center, 1978), 238-64, "The Hippocratic Ethic Is Dead," *The New Physician* 48 (1984): 41-2, 48. Perhaps his best known (if not most-cited) essay on this topic was co-authored with Carol Mason. Veatch and Mason, "Hippocratic vs. Judeo-Christian Medical Ethics: Principles in Conflict," *Journal of Religious Ethics* 15 (1987): 86-105. All of these essays argue that the Hippocratic ethic must be rejected because it violates basic principles of Judeo-Christian ethics or modern democratic societies. Leon Kass' careful reading of the Hippocratic Oath implicitly replies to many of Veatch's arguments. Kass, "Is There a Medical Ethic?: The Hippocratic Oath and the Sources of Ethical Medicine," in *Toward a More Natural Science: Biology and Human Affairs* (New York: The Free Press, 1985). My goal, in this dissertation, is to defend Pellegrino's teleological theory of medicine and medical ethics. Therefore, I do not enter the debate about the Hippocratic ethic, at least not directly.

² Robert Veatch, "The Birth of Bioethics: Autobiographical Reflections of a Patient Person," *Cambridge Quarterly of Healthcare Ethics* 11 (2002): 344.

Given this orientation, it should come as no surprise that Veatch objects to Pellegrino's teleological theory of medicine and medical ethics because he thinks it preserves the paternalism inherent in Hippocratic assertion of beneficence.³ Nobody objects more strenuously than Veatch to the claim that physicians, by virtue of their training or experience, have any insight into the good of their patients. Indeed, this claim is the epistemological error that prompts Veatch to condemn the Hippocratic ethic. "It seems obvious," he writes,

that it is utterly impossible for the health professional to claim expertise on determining what counts as the good for the patient. Any realistic theory of the good will include not only health, but other 'nonhealth' goods. To be an expert on determining the overall good for the patient, one would have to be an expert on balancing health against these other sometimes competing goods. Physicians surely have no such expertise. In fact, they are specialists who are uniquely committed to health. As such, they ought to be biased when it comes to balancing health and other goods.⁴

According to Veatch, the claim that physicians do have such ethical expertise expresses an epistemological prejudice and leads to the hazards Veatch identified when he realized that

the normative ethic of Hippocratic system was radically at odds with any reasonable ethical theory of the mid-twentieth century. It was blatantly paternalistic in an era when paternalism was discovered as a great moral offense; it was militantly individualistic in an era when social ethics was emerging as the only morality that could speak to an increasingly interconnected world; it was oblivious to any moral or legal rights at a time when the world was discovering fundamental claims of human beings that would stand against any appeals to calculations of benefits and harms.⁵

³ In §11 above, I discuss the passage where Pellegrino identifies the Hippocratic promise to benefit the patient as the first principle of medical ethics. See Pellegrino, "The 'Telos' of Medicine," 21.

⁴ Robert Veatch, "The Foundations of Bioethics," *Bioethics* 13 (1999): 213.

⁵ Veatch, "The Birth of Bioethics," 344.

This is an extraordinarily strong claim: the Hippocratic ethic (1) denies the agency of patients so physicians harm the persons they claim to help; (2) denies the claims of justice (by insisting that the physician focus only on the needs of the individual patient) so the medical profession harms the community where medicine is practiced in a Hippocratic manner; and (3) denies the universal rights that protect persons and communities from such harms and thereby exacerbates the wrongs perpetuated by the Hippocratic ethic. Veatch does not back down from this fiercely anti-Hippocratic stance when he recalls the experience of his original insight:

In . . . one special moment—I can’t recall the precise date, but I can recall that there was a moment of epiphany—the ethic of medical professionals that was so widely presumed that it stood as an unchallenged platitude suddenly appeared to me as not only inadequate but grossly offensive. That insight was to shape my career as a medical ethicist. It led to my doctoral dissertation, which attempted to differentiate the legitimate claim to technical expertise in medicine that physicians might make from their lack of any special standing to make normative judgments on behalf of patients.⁶

The foregoing reflections summarize Veatch’s opposition to Pellegrino’s theory. Physicians are not competent to determine the patient’s good because the patient’s good is beyond their expertise, which is confined to determining what actions will restore or promote physiological functions. Given this expertise, physicians are inclined to value the restoration or promotion of physiological functions over other goods. Therefore, physicians can help patients by exercising their medical expertise to bring about physiological changes, but physicians *cannot* help patients evaluate whether those changes are worthwhile. In short, patients must be the principal decisionmakers in the clinical encounter whereas “physicians . . . should be considered ‘secondary’ decisionmakers

⁶ Ibid.

because their decisions are necessarily secondary to the choices made by patients and family.”⁷

Veatch’s autobiographical reflections identify a revolutionary moment giving rise to the field of bioethics. “It now appears to me that two major social-cultural forces converged to produce the revolution in healthcare that was to make this the period of the new beginning for medical ethics.”⁸ Veatch dates this period as (more or less) 1967-1973⁹ and identifies the two forces as widespread and significant political challenges to traditional assertions of authority, on the one hand, and, on the other hand, the assertion of the patient’s ability (1) to understand his or her condition and (2) to make his or her own decisions about medical treatment.¹⁰ Veatch characterizes the history of biomedical ethics from the standpoint of this revolutionary generation as follows:

the history of biomedical ethics in this generation is the history of the recovery by the people of control of the ethics of decisions in the medical arena. In Western society that necessarily means an ethic rooted in both the Judeo-Christian tradition and in secular liberal political philosophy. It is an ethic that is social, committed to the rights of both patients and professionals, and anti-paternalistic. That means that it is an ethic that fundamentally rejects the Hippocratic tradition. . . . In the end, the ethic of this generation is an ethic of the lay person in the medical role.¹¹

In the course of this chapter, I will introduce Veatch’s arguments on behalf of “patient’s rights and on the lay person as epistemologically authoritative both in articulating the ethics of medicine and in making the moral choices about his or her own

⁷ Ibid., 350.

⁸ Ibid., 345.

⁹ “It is a period that I date from January 1, 1970—plus or minus 2-3 years.” Ibid.

¹⁰ Ibid. (Pellegrino provides a similar account of the conditions that gave rise to bioethics. See §9 above.)

¹¹ Ibid., 350.

care.”¹² This presentation will show why Veatch objects to Pellegrino’s teleological theory of medicine. Before I delve into Veatch’s position and his objections to Pellegrino’s teleology in part two, I also want to introduce several contrasts between Veatch and Pellegrino. I will sharpen these contrasts as I defend Pellegrino’s position.

§22 Preliminary Contrasts between Veatch and Pellegrino

Pellegrino articulated many of his most important insights during the period from 1966 to 1983;¹³ in addition, he founded *The Journal of Medicine and Philosophy* in 1976. Thus Pellegrino framed his position during the period Veatch describes as a “revolution in healthcare” and a “new beginning for medical ethics.” However, Pellegrino works to reconstruct medical morality; not to revolutionize it. His teleological theory is both innovative and traditional because it advances an *anti-paternalistic* beneficence. As will be seen, Veatch would say there can be no such thing. He might even say that ‘anti-

¹² Ibid., 346.

¹³ In 1966, “Medicine, Philosophy, and Man’s Infirmity” appeared in *Conditio Humana: Erwin Straus on his 75th Birthday*, eds. Walter Von Baeyer and Richard Griffith (Berlin: Springer Verlag, 1966), 272-84. “The Healing Relationship: The Architectonics of Clinical Medicine” appeared in 1983 in *The Clinical Encounter: The Moral Fabric of the Patient-Physician Relationship*, ed. Earl E. Shelp (Dordrecht: D. Reidel Publishing Company, 1983), 153-72. Near the end of this period, in 1981, Pellegrino and David Thomasma published the first of the four books they co-authored, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions* (New York and Oxford: Oxford University Press, 1981). However, crucial chapters of that work, insofar as it articulates the teleological structure of medicine, are based on several of Pellegrino’s earlier essays: “Ethics and the Moral Center of the Medical Enterprise,” *Bulletin of the New York Academy of Medicine* (July-August 1978): 625-40; “Toward a Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness,” *The Journal of Medicine and Philosophy* 4 (March 1979): 32-56; and “The Anatomy of Clinical Judgments: Some Notes on Right Reason and Right Action,” in *Clinical Judgment: A Critical Appraisal*, eds. H. T. Engelhardt, Jr., Stuart F. Spicker, and Bernard Towers (Dordrecht: Kluwer Academic Publishers, 1979), 169-94.

paternalistic beneficence' is an oxymoron. In any event, my task is to show that Pellegrino brings the agency of physicians and patients together in a way that realizes the end of healing. Pellegrino's achievement is not a counter-revolution. It is a positive step, but not beyond the boundaries of medicine. It is a more thorough realization of what it means to heal and to be healed. Given the continually expanding power of medicine to intervene in our lives, for good and for ill, this step is both possible and necessary. It is possible in the sense that physicians can intervene in the lives of patients in seemingly innumerable ways. It is necessary in the sense that when physicians and patients meet in the clinic, they need—*together*—to think through the question of whether possible interventions are or are not healing actions.

Thus Pellegrino does not reject the Hippocratic tradition. In "The 'Telos' of Medicine," he quotes from the Hippocratic Oath: "I will follow that system or regimen which, according to my ability and judgment, I consider for the benefit of my patient and abstain from whatever is deleterious and mischievous."¹⁴ This public declaration, Pellegrino writes approvingly, expresses the teleological structure of medicine:

All the moral precepts of the Oath, the other deontological books of the Corpus, and the entire subsequent history of medical ethics are elaborations of this first principle. This medical *principium primum* enjoins upon doctors the primary duty of acting to benefit the patient, in a word, always to act for the patient's good. The patient's good is, therefore, the end of medicine, that to which medicine, by its nature, tends and that which gives it definition.¹⁵

My defense of Pellegrino's reconstruction of medical morality against Veatch's objections should not be construed as a rejection of the anti-paternalistic *ethos* that

¹⁴ Pellegrino, "The 'Telos' of Medicine," 21.

¹⁵ Ibid.

characterizes Veatch's work. Veatch is right to assert the agency of the patient. His mistake, I will argue, is to reject the agency of the physician. Put differently, Veatch rejects the possibility that physicians and patients can deliberate together so he reduces the physician to the role of an ethically disinterested technician. As will be seen, Veatch fails to appreciate that the patient needs more than technical intervention: the patient needs help to recover the wholeness disrupted or threatened by illness.

As seen above, Veatch argues that medical morality rested upon an epistemological error until the bioethical revolution around 1970 when it became clear that physicians could not justify their claim to know what helps or harms their patients. Veatch refers to this epistemological arrogance as the problem of generalizing expertise.¹⁶ This problem or fallacy, as Veatch has called it,¹⁷ "is essentially one of confusing expertise in technical knowledge of a given scientific area with knowledge of what is morally required in that area."¹⁸ According to Veatch, medicine is practiced paternalistically when physicians commit this fallacy and, since physicians are trained to optimize physiological functions, they tend to commit this fallacy; for physicians "are specialists who are uniquely committed to health. As such, they ought to be biased when it comes to balancing health and other goods."¹⁹ Therefore, physicians tend to be paternalist: they think their training and experience qualifies them to determine what is good for the patient; but this is the problem of generalizing expertise beyond one's competence.

¹⁶ See Robert Veatch, "Generalization of Expertise," *Hastings Center Studies* 1, no. 1 (1973): 29-40.

¹⁷ Ibid., 29. See also Veatch, "The Birth of Bioethics," 349.

¹⁸ Veatch, "Generalization of Expertise," 29.

¹⁹ Veatch, "The Foundations of Bioethics," 213.

The basic question underlying my response to Veatch can be put bluntly: Are physicians as narrow-minded as he suggests? Does their expertise about how to optimize physiological function compel them to reduce the good of the patient to the level Pellegrino refers to as the “techno-medical good”? Clearly, if Veatch is right, then Pellegrino is wrong: for Pellegrino’s phenomenological teleology of the clinical encounter calls upon patients and physicians to deliberate together; but patients should not deliberate with physicians if physicians cannot understand that technically appropriate actions must *also* be morally good. In other words, physicians will harm the patient if they think treatments are good just because they are medically indicated. The difference between Pellegrino and Veatch can be expressed in terms of the difference between the technically right and the morally good. According to Veatch, physicians cannot make this distinction or, if they do, their understanding of the good differs from the patient’s understanding of the good. Both cases call for “a strong defense of the patient as decisionmaker.”²⁰ Veatch has devoted himself to this end.

In contrast, Pellegrino has devoted himself to a different end: the patient’s fourfold good. By distinguishing technical correctness from moral goodness, Pellegrino shows what the profession to heal means and he articulates medical ethics in terms of the physician’s obligation to make good on his or her profession to heal.

²⁰ Veatch, “The Birth of Bioethics,” 348. The new medicine Veatch heralds in *PHT* is designed to establish the sovereignty of the patient within the clinical encounter. Chapter 5 examines how this new medicine alters the patient-physician relationship.

§23 Veatch's Challenge to Pellegrino's Teleology

Veatch rejects Pellegrino's assertion of medicine's internal morality—or teleological structure—because he thinks physicians fail to distinguish the technically correct from the morally good. Three features of clinical medicine support Veatch's position. First, physicians are trained to understand disease processes and therapeutic interventions in scientific terms so physicians and patients do not share a common language for addressing the questions raised by illness.²¹ Second, when physicians and patients meet as strangers in a pluralist society, they not only lack a common language to talk about maladies and treatment, they also lack a common language to talk about the values that shape treatment decisions. Third, the clinical encounter generally lasts just long enough for technical facts and relevant interventions to be discussed so there is not enough time for physicians and patients to develop the common language needed for mutual deliberation. It therefore seems reasonable for Veatch to argue that patients, not physicians, need to answer the most important question raised by illness: What should be done?

My response to Veatch's challenge of Pellegrino's teleology is twofold. First, patients and physicians share a language based on the experience of illness and the need for healing it generates. The process of becoming a physician requires novices (including students, interns, residents or fellows) to use a scientific language; but their encounters with persons who are ill regularly provide medical students and young physicians with the

²¹ See S. Kay Toombs, *The Meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient* (Dordrecht: Kluwer Academic Publishers, 1992), 1-29.

opportunity to use a more familiar vocabulary that has been shaped over time by the universal human experience of illness. While patients do not bring a common language with them when they come into the clinic as if it were a ready-made product, which when picked up by the physician, generated a shared understanding, physicians are not only well-situated to appreciate different ways of expressing the experience of illness but physicians are also obligated to understand the patients' experience. Otherwise, physicians will not understand their patients' need for healing and, consequently, physicians will be unable to work as healers.

Veatch's response to this point seems clear. He would ask: Why doesn't a common language develop in the clinical encounter? Why do physicians and patients have such a hard time understanding each other? More importantly, he would ask whether we can expect physicians to understand their patients; he would reply negatively and, to remedy this defect, he would argue that we recognize that physicians are limited in their ability to help patients. As to the ideal of the physician as a healer, the next two chapters show that he thinks it should be abandoned as an unrealistic, archaic ideal and he rejects it along with the Hippocratic ethic with which the ideal is associated.²²

Therefore, I will also argue that the lack of communication between patients and physicians does not undermine Pellegrino's thesis because the teleological structure of medicine differs from the practice of medicine. The teleological structure of medicine presents what medicine *should* be, which frequently differs from medicine as it is practiced

²² Ultimately, the dispute between Veatch and Pellegrino turns on two interrelated questions: the question of whether physicians are healers or technicians raises the decisive question of whether patients can trust their physicians.

in the clinic. This difference should be obvious to anyone who works in biomedical ethics since (a) the discipline, among other things, distinguishes between what should and what should not happen in the clinical encounter and (b) this distinction cannot be justified without reference to the difference between what medicine should be and what medicine is. It makes no sense to say that philosophers concerned with medical ethics make a mistake when they articulate what medicine should be because, in doing so, they fail to describe clinical practice accurately. The aim is not to give an accurate description of clinical practice but (1) to clarify the goods that can be realized through the practice of medicine, (2) to disclose how medical practice should be shaped in order to realize those goods, (3) to point out the ways in which the practice of medicine fails to realize those goods, (4) to consider whether and to what extent those failures are the upshot of ill-conceived structures, practices, or decisions, and (5) to think through possible reforms in order to remedy these defects. In sum, as Pellegrino articulates the teleological structure of medicine and medical ethics, he clarifies the standard we invoke as we identify and express our ethical concerns about how medicine is actually practiced; so as our ethical concerns increase, it becomes more rather than less important to articulate what medicine should be.

§24 Sharpening the Contrast between Veatch and Pellegrino

It is, of course, important to consider why physicians and patients have a hard time understanding each other. In particular, it is important to recognize that the tendency to think of medicine as scientific technique of diagnosis and therapeutic intervention poses serious ethical problems. Veatch has focused on problems that arise when physicians

believe that their technical expertise authorizes them to decide what is best for their patients. In response to this paternalistic custom, he asserts the rights of patients. In “Doctor Does Not Know Best: Why in the New Century Physicians Must Stop Trying to Benefit Patients,” Veatch states the issue as follows:

The first problem that we discovered with the Hippocratic patient-benefitting ethic in the twentieth century is that it is very hard—indeed usually impossible—for physicians to know what actions on their part will truly benefit their patients. We began the century (and many people have ended it) still believing that “doctor knows best,” that is, that somehow a physician could be expected—at least in the ideal case—to be able to know what actions would be beneficial to patients. . . . All that was needed for the all-knowing initiate into Hippocratic wisdom to decide what would be beneficial based on his judgment . . . and then prescribe. In the last third of the twentieth century, however, that view has collapsed. We now know that even in the ideal case physicians generally have no basis for knowing what would benefit their patients. Even if they can accurately diagnose disease and prognosticate its future course under various treatment options, they still cannot be expected to have any basis for knowing that one outcome is better than another for the patient who presents the medical problem to them.²³

I will take up Veatch’s position in more detail below; for now it is sufficient to note his central claim: the ability to make a diagnosis and to match treatments with the diagnosis should not be construed as knowledge of the patient’s good. Since Pellegrino recognizes the truth of this anti-paternalist claim, he distinguishes the technical correctness of a treatment plan from its moral goodness and he argues that an action benefits the patient only if it is both technically correct and morally good; only then is it a right and good healing action. Thus Pellegrino and Veatch agree that physicians cannot presume to know what is good for their patients.²⁴

²³Veatch, “Doctor Does Not Know Best,” 703.

²⁴Clearly, Veatch goes further when he argues that physicians cannot know what is good for their patients. However, I speak in terms of a presumption because, as I will argue below, Veatch’s target is the physician who claims to know what benefits the patient *in*

They differ on the question of whether physicians can or should provide more than the exercise of a technical assistance to the patient. It is not clear whether Veatch thinks (a) physicians cannot offer more than technical help so any effort beyond this narrow limit will probably harm the patient or (b) physicians can provide more to patients with whom they share, in general, the same moral orientation, but that they should not try to do so because, for the most part, patients and physicians remain strangers throughout the clinical encounter. In either case, Veatch's conclusion is clear: physicians must work within the narrow boundaries of their technical expertise; otherwise, patients will be harmed by their physicians.²⁵

Pellegrino, in contrast, argues that physicians who offer no more than technical assistance to their patients fail to make good on their profession to heal. Thus Pellegrino thinks physicians harm their patients when they do not exercise their moral agency whereas Veatch thinks that physicians harm their patients when they do exercise their moral agency. In other words, they differ on the question of whether the patient-physician encounter involves one or two moral agents.

Ultimately, Pellegrino and Veatch differ on the question of whether physicians can learn what is good for the patient as they deliberate together. Pellegrino argues that they can, but only if they make the effort and recognize that they cannot know *in advance of*

advance of any discussion with the patient. This presumption is wrong and, with the exception of emergencies, medical treatment based on such a presumption constitutes an assault on the patient. Note that in emergencies, patients are *presumed* to want whatever treatments are needed to preserve life and limb. (Moreover, physicians are legally permitted to exercise reasonable discretion to determine what treatments are necessary.)

²⁵ The patient-physician relationship Veatch proposes in *PHT* has been shaped by his belief that physicians threaten the well-being of their patients.

mutual deliberation what is good for the patient. Nevertheless, physicians do know, before deliberating with their patients, that the patient must affirm that treatment (i.e., intervention) is sufficiently beneficial to accept the associated burdens, and the treatment should not violate the agency, integrity, or dignity of the patient. In contrast, Veatch argues that physicians cannot learn what is good for their patients so they should not try for any effort beyond the limits of their technical expertise is likely to harm the patient excessively.

§25 Ingelfinger and the Problem of the Physician *qua* Technician

In this section, I introduce the work of Franz Ingelfinger, who served as Editor of the *New England Journal of Medicine (NEJM)* from 1967-1977. Ingelfinger's position is important not only because he edited a leading medical journal during the period when Veatch and Pellegrino were working out their positions, but because he presents the physician as a technical expert. According to Ingelfinger, the physician's role should be limited by his or her technical expertise and this limitation maximizes the physician's power to help the patient. As will be seen below, Ingelfinger presents the shortcomings that concern both Veatch and Pellegrino.

In 1976, near the end of his tenure as the editor of the *New England Journal of Medicine*, Ingelfinger asserted that

the doctor's basic responsibility is cure. Yes, CURE. His is the one profession that can reliably detect and treat diabetes or pernicious anemia. He alone, by training and experience, should be qualified to determine when and how to cut for a stone

or tumor. His primary concern, in spite of all the utopian claims to the contrary, is sickness, not overall health.²⁶

Ingelfinger limits the physicians' expertise to the patients' medical good: "Medical pedagogy, both in and after medical school, [should] once again concentrate on scientifically accurate diagnosis and treatment, as [should] the average physician."²⁷ Accordingly, Ingelfinger condemns those who demand more from physicians. His argument is straightforward. Physicians have limited expertise. They diagnose and treat illness, curing patients whenever they can. They should resist any expansion of medical authority beyond the limit of their expertise. Otherwise, physicians will be expected to remedy social problems even though they have no special power to do so. Therefore, he identifies cure as the "doctor's basic responsibility." Ingelfinger's position is a reasonable response to the "medicalization" of social problems, but it drastically limits the power of

²⁶ F. J. Ingelfinger, "The Physician's Contribution to the Health System," *NEJM* 295 (1976): 565. It is worth noting that the Hippocratic Oath forbids physicians from cutting for stones. The physician swears: "I will not the use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work." This translation by Ludwig Edelstein appears in *Ancient Medicine: Selected Papers of Ludwig Edelstein*, eds. Owsei Temkin and C. Lilian Temkin (Baltimore: The Johns Hopkins University Press, 1967), 6 and it reflects Edelstein's solution to the interpretive problem posed by this particular declaration. Edelstein emphasizes the distinction between medical therapies—primarily through diet—and surgery and he explains the puzzles caused by the prohibition in terms of the Pythagorean physician's vow to live a life of purity. (26-33) I do not know whether Ingelfinger has the Oath in mind when he speaks of physicians cutting for stone, but he clearly does not distinguish physicians from surgeons; for Ingelfinger, both are technically competent practitioners capable of helping their patients so long as they stay within the scope of their specialty (such as gastroenterology, which was Ingelfinger's specialty).

²⁷ Ibid.

physicians to help patients because it conceives of medical practice as the application of scientific knowledge and techniques to sick patients.²⁸

In brief, Ingelfinger conceives of the physician along the lines suggested by Veatch: the physician applies a technical expertise to physiological functions and their mechanisms. In particular, the physician knows how to optimize various physiological functions, especially when they have been disrupted. Consequently, Ingelfinger tends to overlook the art of healing as it is shaped by the shared inquiry described in part one. Patient and physician work together to answer three questions: What is wrong? What can be done? What should be done? To answer the last question, the clinical encounter must consider more than the medical good. As Pellegrino points out,

the medical good must be brought into proper relationship with the other levels of the patient's good. Otherwise, it may become harmful. What is medically "good" simply on grounds of physiological effectiveness may not be "good," if it violates higher levels of good.²⁹

In other words, a healing action must not only be *right* insofar as it serves the patient's medical good; it must also serve the patient's higher order goods. Otherwise, it will not be a right and *good* healing action.

²⁸ As will be seen below, there is a tension in Ingelfinger's understanding of how physicians can help patients. In "The Physician's Contribution to the Health System," he argues that physicians help patients get better when they function as clinical scientists, but in "Arrogance," *NEJM* 303 (1980): 1507-11, he recognizes that the physician needs to be more than a scientist. This tension also shows up when Ingelfinger appeals to Francis Peabody, "The Care of the Patient," *JAMA* 88 (1927): 877-82.

²⁹ Pellegrino, "The 'Telos' of Medicine," 26.

Ingelfinger is not wrong to stress the limits of medicine or to assert that social problems require political, not medical, solutions.³⁰ However, he errs when he privileges the science of medicine over the art of healing. His advocacy of biomedicine echoes Flexner's call for the reform of medical education³¹ and foreshadows current calls for evidence-based medicine.³² The motives behind these appeals are not bad. They are, as Pellegrino points out in a recent essay, expressions of "a very old idea. The best physicians have always sought the best empirical evidence available on which to base diagnoses and therapeutic decisions."³³ That physicians need to be well trained in the

³⁰ Leon Kass, for example, makes such arguments throughout *Towards a More Natural Science*, (New York: The Free Press, 1985). See also Kass, *Life, Liberty and the Defense of Dignity: The Challenge for Bioethics* (San Francisco: Encounter Books, 2002).

³¹ Abraham Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching*, (New York: The Carnegie Foundation for the Advancement of Teaching, 1910). Flexner sought to standardize the medical school curriculum and, as a consequence, to ground the practice of medicine in the scientific understanding of disease.

The physician's concern with normal process is not disinterested curiosity; it is the starting-point of his effort to comprehend and to master the abnormal. Pathology and bacteriology are the sciences concerned with abnormalities of structure and function and their causation. Now the agents and forces which invade the body to its disadvantage play their game, too, according to law. And to learn that law one goes once more to the same fundamental sciences upon which the anatomist and the physiologist have already freely drawn,--viz., biology, physics, and chemistry. (Flexner, 24-5)

These fundamental sciences, Flexner continues, "furnish . . . the essential instrumental basis for medical education" (26) and, to a remarkable degree, the reforms he advocated have been adopted.

³² Evidence-based-medicine (EBM) refers to a hierarchical ordering of clinical evidence so as to determine, with methodological rigor, the empirically strongest claims about therapeutic effectiveness. It is well expressed in the Systematic Review Series published in *Annals of Internal Medicine* and the "How to Read a Paper" series published by *BMJ*.

³³ Edmund D. Pellegrino, "Medical Evidence and Virtue Ethics: A Commentary on Zarkovich and Upshur," *Theoretical Medicine and Bioethics* 23 (2002): 397.

sciences for diagnostic, prognostic, and therapeutic purposes is also not a new insight,

as Pellegrino shows:

The emphasis of the Hippocratic treatise “Ancient Medicine” is precisely the emphasis on careful observation and reasoned reflection on what has been observed.

The thrust of “Ancient Medicine” was like the thrust of evidence-based medicine, to free medicine and physicians from idle and dangerous speculation and unproven assertions. Both hope to ground clinical decisions in evidence that can stand the scrutiny of critical reason. This is not to belittle the progress medicine has made toward this end since the Hippocratics. Rather, it is to set evidence-based medicine into a long history of striving for a rational basis for the doctor’s practice.³⁴

Clearly, Pellegrino does not oppose the scientific basis of medicine. He is concerned about the humanity of medical practice, especially when scientifically trained physicians confront persons who are ill. If physicians cannot appreciate the experience of illness, how can they make good on their profession to heal? But how can they appreciate the experience of illness if the education and training of physicians focuses narrowly on the science, rather than the art of medicine?³⁵ Pellegrino’s phenomenology of the clinical encounter responds to these urgent questions. To make good on their profession to heal, physicians must understand the need for healing that brings patients to their attention and

³⁴ Ibid. According to the treatise “On Ancient Medicine,” the art of medicine developed over the ages because the ability to prescribe a particular regimen for a particular patient requires knowledge based on scrupulously detailed observations of previous treatments. Therefore, medicine differs from philosophy because it focuses on the particular and reasons inductively. Accordingly, one should avoid being treated by those who base their treatments on hypotheses.

³⁵ Flexner recognized that the sciences are an inadequate basis for medical practice: “The practitioner deals with facts of two categories. Chemistry, physics, biology permit him to apprehend one set; he needs a different apperceptive and appreciative apparatus to deal with other, more subtle elements.” Flexner, *Medical Education in the United States and Canada*, 26. Presumably these “more subtle elements” concern the *person* who is ill rather than the body that is diseased or injured.

this cannot happen unless physicians understand the experience of illness. Pellegrino traces the nature and end of medicine back to the clinical encounter as a meeting between persons. If this meeting were exclusively shaped by the many abstractions at work in the sciences and the multiplicity of medical specialties produced by scientific medicine, then the clinical encounter would be the meeting of a body in need of repair with a technician capable of making the needed repairs. Pellegrino's teleological account of medicine appropriately resists this myopic vision of medicine.

In contrast, Robert Veatch views physicians through this narrow lens and this motivates his fight to protect patients from doctors who cannot know what is best.³⁶ Indeed, Veatch takes for granted the consequences of specialization implied by a rhetorical question posed by Ingelfinger: "If expertise in the whole of medical science is now impossible, how can the average doctor be expected to possess authoritative knowledge of economics, family relations and all the rest?"³⁷ Veatch elaborates:

As expertise in various areas becomes more complex, experts will become more specialized and their knowledge of other spheres will be correspondingly less. Moreover, as cultures get more and more pluralistic, we can expect people to support widely varying trade-offs among the different spheres of the good and individual physicians to be less likely to understand the value mix of any one of their patients. There is no reason why physicians should be able to know how to balance the medical and the other spheres.³⁸

³⁶ See Veatch, "Doctor Does Not Know Best" and "The Birth of Bioethics." *PHT* shows just how radical Veatch's position.

³⁷ Ingelfinger, "The Physician's Contribution to the Health System," 565.

³⁸ Veatch, "Doctor Does Not Know Best," 705.

Physicians are capable of tending to their patients' bodies, but nothing else; so, in the twenty-first century, Veatch argues, ethical physicians will serve as "patient assistants."³⁹ This alteration in the physician-patient relationship is necessary because medicine has become a scientifically grounded technique of diagnosis and treatment. Consequently, the physician *qua* technician is not qualified to help his or patient to weigh the benefits and burdens of alternative treatment plans.

Veatch's goal of reshaping the physician-patient relationship seems reasonable given the ethical questions raised by Ingelfinger's understanding the physician's limited role in a healthcare system. According to Ingelfinger, the physician is one functionary among many:

The complexities of modern living do demand an umbrella of care, but it is care that has to be provided by a panoply of competent functionaries, each aware of the existence of the other, and all integrating their services for the maintenance of health. In this scheme, the proper role of the doctor is the comfort and, if possible, the cure of the sick.⁴⁰

One does not have to be a thoroughgoing skeptic to raise some crucial questions. For, example, how and by whom are the ministrations of the various functionaries integrated? In what sense can health in its root sense of being whole be achieved if the responsibility for care is distributed in this way? How do physicians provide comfort if their specialized

³⁹ The concluding section of "Doctor Does Not Know Best" bears an especially provocative title, "The New, Limited Twenty-First Century Role for Physicians as Patient Assistants." Veatch, "Doctor Does Not Know Best," 718-20. *PHT* takes this position to its logical conclusion, for which it has been rightly condemned. See Mark A. Hall, review of *Patient, Heal Thyself! How the New Medicine Puts the Patient in Charge*, by Robert M. Veatch, *NEJM* 359 (2008): 2851-2. I discuss Hall's review in §31 below.

⁴⁰ Ingelfinger, "The Physician's Contribution to the Health System," 565.

training prompts them to focus narrowly on the techniques of cure? Veatch draws the

following conclusion about medical ethics in the twenty-first century:

It will acknowledge that physicians normally cannot be expected to figure out on their own what will benefit their patients and that often they should not try to provide such benefits even if they can figure them out. While many people, especially theorists in medical ethics have a vague understanding of this insight, almost no one yet realizes that it means that literally every decision a physician makes, the pattern of every practice, will have to be altered radically. It will mean that in every patient/physician encounter it will no longer make sense for physicians to prescribe, certify “medical necessity,” or even recommend any treatment, let alone give “orders” or claim they know what is best for the patient. I see that radical change on the horizon for the new century.⁴¹

What is the radical change Veatch is able to see clearly, even though most who think seriously about medical ethics can only vaguely apprehend its necessity? First and foremost, “physicians are going to have to realize that, if they want to know their patients’ interest with any reliability, they will have to ask them.”⁴² This is nothing new.⁴³ It seems to be a perennial idea expressed by many. Francis Peabody expressed it quite well in his famous conclusion. “One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.”⁴⁴ Peabody’s conclusion follows an even more telling discussion of the personal in the clinical:

the whole problem of diagnosis and treatment depends on your insight into the patient’s character and personal life, and in every case of organic disease there are

⁴¹ Veatch, “Doctor Does Not Know Best,” 720.

⁴² Ibid., 718.

⁴³ Consider, for example, the following passage from Plato’s *Laws*:

The visits of the free doctor . . . are mostly concerned with treating the illnesses of free men; *his* method is to construct an empirical case-history by consulting the invalid and his friends; in this way he himself learns something from the sick and at the same time he gives the individual patient all the instruction he can. He gives no prescription until he has somehow gained the invalid’s consent; then, coaxing him into continued cooperation, he tries to complete his restoration to health. (720D-E)

⁴⁴ Peabody, “The Care of the Patient,” *JAMA* 88 (1927): 882.

complex interactions between the pathologic processes and the intellectual processes which you must appreciate and consider if you would be a wise clinician. There are moments, of course, in cases of serious illness when you will think solely in terms of the disease and its treatment; but when the corner is turned and the immediate crisis is passed, you must give your attention to the patient. Disease in man is never exactly the same as disease in an experimental animal, for in man the disease at once affects and is affected by what we call the emotional life. . . . The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction in the practice of medicine.⁴⁵

Peabody's ideal, Veatch would likely reply, cannot be realized when doctors and patients are strangers to one another and the institutional arrangements of specialized medical training and practice foster anonymity; they impede, rather than facilitate, the development of personal relationships.

In contrast, Ingelfinger, who opens his essay by complaining that the slogan "care, not cure" has become as tiresome as the call for "death with dignity,"⁴⁶ closes his essay with an appeal to Peabody's ideal of the caring physician:

If the role of the doctor were defined in this fashion [as a narrow, scientifically grounded technique], the services he could offer would not arouse false expectations. Most important of all, he would avoid merely dabbling in the myriad bases of health and thereby neglecting the roles that are uniquely the physician's – those of caring for (in the Peabodian sense), of counseling, and of curing the sick.⁴⁷

⁴⁵ Ibid. The contrast between human patients and laboratory animals should be updated. Today, one would say that patients with the same diagnosis do not have the same (experience of) illness.

⁴⁶ "The curious idea is abroad that the doctor should be a factotum of health. By some singularity of reason, his role as a healer is disparaged, and the words 'care, not cure' are becoming as tiresome as 'death with dignity'" (Ingelfinger, "The Physician's Contribution to the Health System," 565). One could argue that Ingelfinger has a limited goal: to privilege the activity of curing, not to disparage the activity of caring. The problem is that a narrow focus on curing tends to exclude actively caring for the patient as a person.

⁴⁷ Ingelfinger, "The Physician's Contribution to the Health System," 566.

This inconsistency is not surprising. As Pellegrino noted around the time Ingelfinger published his editorial, traditional medical morality is a “mixture of high ideals, common sense, and practical wisdom” that has not been examined philosophically because the image of “[t]he good physician . . . as an authoritative and competent practitioner, devoted to his patient’s well-being” has not been challenged.⁴⁸ Consequently, physicians are not aware of the tensions within the practice of medicine: the science of curing patients does not seem to oppose the art of caring for them. After all, both are included in the single image of the good physician.⁴⁹ However, if physicians pretend to have remedies for social ills they are not competent to address as physicians, they will “arouse false expectations” and, ultimately, they will wind up “neglecting the roles that are uniquely the physician’s – those of caring for (in the Peabodian sense), of counseling, and of curing the sick.”⁵⁰

This consideration of Ingelfinger and Veatch raises a critical question about the clinical encounter: Can the physician *qua* technician help his or her patient decide what treatment is best? Veatch’s response is clear and consistent: physicians can master the techniques of scientific diagnosis and physiological intervention, but they cannot know what is best for their patients. This means that physicians can assist patients who want the treatments physicians offer, but physicians cannot know whether the treatments they offer

⁴⁸ Pellegrino, “Hippocratic Ethic,” 97. See §9 above for a discussion of Pellegrino’s call for the philosophical clarification of traditional medical morality.

⁴⁹ That Ingelfinger defends this image by emphasizing what physicians can do is illustrated by the statement quoted above (121-2) in which he stresses curing over caring: “His is the one profession that can reliably detect and treat diabetes or pernicious anemia. He alone, by training and experience, should be qualified to determine when and how to cut for a stone or tumor.” Ingelfinger, “The Physician’s Contribution to the Health System,” 565.

⁵⁰ Ingelfinger, “The Physician’s Contribution to the Health System,” 566.

help or harm their patients. That they claim this knowledge is, Veatch argues, an unwarranted generalization of expertise (and the subject of the following section).

Ingelfinger's response brings out a different dimension of medical care: one that is too often obscured when emphasis is put on the scientific basis of medicine. Not only does this emphasis tend to narrow the focus of physicians on questions about what can be done to cure the patient; it also encourages physicians to frame the patient's good in terms of the medical power to cure. Consequently, physicians frequently fail to recognize that the power to cure is only a part of the healing art. Nevertheless, Ingelfinger does think the physician has more to offer the patient than the power to cure. The physician has the Aesculapian power to help the patient get better. This power has no basis in biomedical science. Instead, it is rooted in the physician-patient relationship: the patient needs help and turns to the physician because the latter has an authority that comes from his or her training and experience as a healer. Although the use of this authority may seem arrogant to many, Ingelfinger defends the arrogance of physicians precisely because it helps patients get better. I will take up Ingelfinger's defense of arrogance after I have discussed Veatch's objection to the physician's generalization of expertise. The opposition between them will help me defend Pellegrino's position.

In contrast to Veatch and Ingelfinger, Pellegrino emphasizes the dialogue that must take place between patients and physicians because he knows that patients may be harmed rather than helped by medically indicated treatment.⁵¹ Accordingly, physicians and

⁵¹ See Richard Zaner, "Medicine and Dialogue," *Journal of Medicine and Philosophy* 15 (1990): 303-25. In this contribution to "An Overview and an Assessment" of Pellegrino's philosophy of medicine, Zaner brings dialogue to the foreground as he recapitulates

patients need to pursue more than the medical good, which may conflict with more important elements of medicine's complex end: personal goods particular to this patient, the good for human beings, and the spiritual good as it is understood by the patient. These higher goods limit the pursuit of the medical good. Moreover, the physician must discover these limits by talking with his or her patients.⁵² Unless the physician does so, the care provided is inadequate: it aims at only a part of the patient's good rather than the whole of the patient's good. According to Pellegrino, the physician makes good on the profession to heal when the science of curing and the art of healing are integrated through the deliberative process that makes the clinical encounter what it is: an inquiry aimed at healing the patient. In short, the physician must distinguish technical correctness from moral goodness; otherwise, he or she cannot help to heal the patient.

§26 The Generalization of Expertise

In 1973, Veatch published "Generalization of Expertise," in which he argued against the pervasive though unwarranted assumption that the technical expertise of physicians to make diagnoses and to match treatments with their diagnoses gives them the ethical expertise to determine what treatment (if any) is good for their patients.⁵³ As "Doctor Does Not Know Best" shows, Veatch has not changed his mind. More recently,

Pellegrino's achievement: "Conceived as dialogue, the clinical event is essentially open, it inherently seeks to hide nothing pertinent to the themes intrinsic to the clinical encounter between two human beings, one of whom appeals for help and the other of whom professes the ability to give it" (322).

⁵² See chapter 3 above.

⁵³ Veatch, "Generalization of Expertise."

in 2006, Veatch published “How Philosophy of Medicine Has Changed Medical Ethics.”⁵⁴ This essay, which reviews the influence of the *Journal of Medicine and Philosophy* over its first 34 years, concludes as follows: “By the end of the next thirty years we can expect to see the fruits of a radical reformulation of the patient-physician relation and what it means to practice medicine and practice it ethically.”⁵⁵ Not surprisingly, Veatch gives a central place in this revolution to his work, especially his arguments against the generalization of expertise. In this section, I present those arguments and show that they undergird his rejection of Pellegrino’s teleological theory of medicine.

I begin with his provocative suggestion of a shift from modern to post-modern medicine. Under the rubric, “Philosophy of Medicine’s Radical Impact on Medicine,” Veatch writes:

We can understand the twentieth century as the high point in modern medicine, a period which encompasses the epitome of our understanding of how medicine came to be viewed as a clinical science. Physicians came to be expected to be able to rely on modern science to determine what was best for patients and to prescribe for them a “treatment of choice” or “best medical practice” that had the highest probability of benefitting the patient by restoring or preserving health. By the end of the century, however, this understanding of modern, scientifically based medicine had become the victim of . . . philosophical challenges that changed our understanding of the practice of medicine so radically that it is reasonable to say that the era of modern medicine is rapidly coming to an end. It is being replaced by what we can call post-modern or contemporary medicine.⁵⁶

⁵⁴ Veatch, “How Philosophy of Medicine Has Changed Medical Ethics,” *Journal of Medicine and Philosophy* 31 (2006): 585-600.

⁵⁵ Ibid., 597. *PHT* completes Veatch’s reformulation of the patient-physician relationship. See chapter 5 below.

⁵⁶ Ibid., 592.

Veatch explains that this “change in the paradigm for the practice of medicine came in the early 1970s when religious and philosophical ethicists brought their fact/value distinction to medicine.”⁵⁷ Until the technical mastery of medicine as a clinical science was distinguished from the ethical question of the patient’s good, it was typically assumed that the facts expressed in an accurate diagnosis provided sufficient evidence for the doctor to evaluate the possible treatments and exercise his or her technical expertise to determine what should be done. Veatch has been at the vanguard of the movement opposing this expansion of medical expertise: for more than 34 years he has been arguing that “one cannot derive clinical or policy recommendations from medical science.”⁵⁸ As he points out,

[i]n cases like that of Karen Quinlan, reluctant physicians were required to step aside and surrender claims to authority in making decisions about whether it was a good thing for a patient’s life to be prolonged. Just because medical science had progressed to the point that it was technically possible to prolong life in a persistent vegetative state it did not follow that it was a good thing to do so.⁵⁹

Veatch distinguishes the power to intervene from the question whether the intervention is or is not appropriate: that the physician can act does not mean the physician should act. Veatch frames this distinction in terms of the difference between facts and values, which he illustrates by appealing to

other controversial areas of medicine. Just because we technically could abort a fetus with little risk to the pregnant woman, it did not follow that it was moral to do

⁵⁷ Ibid.

⁵⁸ Ibid., 593. In 1973, Veatch began “Generalization of Expertise,” by identifying the assumption that “an individual with scientific expertise in a particular area also has expertise in the value judgments necessary to make policy recommendations simply because he has scientific expertise” and stating his intention to attack it: “This assumption is very pervasive in decision making in scientific areas, but unwarranted” (29).

⁵⁹ Veatch, “How Philosophy of Medicine Has Changed Medical Ethics,” 593.

so; just because we could technically control conception, we were not given an imprimatur to do so; just because we could transplant a heart, it did not mean it was morally licit to do so.⁶⁰

The fact that these practices are (to varying degrees) controversial should not obscure

Veatch's basic point. "Expertise in the medical science underlying each of these innovations [does] not imply expertise in making the evaluations related to them."⁶¹

Moreover, as he argues in "Doctor Does Not Know Best," physicians cannot know whether acting helps or harms the patient, especially in pluralist societies.⁶²

Nevertheless, bioethics has tended to focus on controversial cases, thereby creating the false impression that

these interventions constituted a special class of medical treatments: a class of morally sensitive cases in which physicians had to take time out of their usual operating mode to solicit a moral evaluation from the patient, the community, or experts in moral wisdom (if such could be located). The implied corollary was that most routine medical decisions still could be made in a value-free mode, that the physician who plausibly could claim expertise in the medical science could use that science to go on to decide which treatments were best for their patients.⁶³

⁶⁰ Ibid.

⁶¹ Ibid.

⁶² Obviously, there is significant disagreement about whether the withdrawal of artificial nutrition and hydration (ANH) can benefit the patient who will die in the absence of ANH. However, this controversy falls outside the scope of my dissertation. Additionally, it is clear—at least in the United States—that the physician is not authorized to decide unilaterally whether to continue or to abate ANH. The contrast between abortion and the removal of ANH for persons in persistent vegetative states, for example, underscores some important points. First, no argument can be made that abortion benefits the aborted fetus whereas many argue that the withdrawal of ANH benefits persons in PVS. Accordingly, those who defend the withdrawal of ANH appeal (often implicitly) to the doctrine of double effect; so the controversy turns (at least in part) on whether and how the doctrine applies. The abortion controversy turns on different questions: What is the meaning of personal freedom? Should it be limited? If so, what authorizes the limit? Such questions cannot be settled without addressing the problem of pluralism in democratic societies so they call for a different inquiry and set of arguments than the ones that inform this dissertation.

⁶³ Veatch, "How Philosophy of Medicine Has Changed Medical Ethics," 593.

According to Veatch, the fact/value distinction does not apply only to controversial cases but to each and every treatment decision because they all involve a judgment about what is best.

It is logically impossible to get a judgment about whether a treatment is good or bad, whether it is “medically indicated” or a “treatment of choice,” from the medical facts. While certain cases involving termination of life or manipulations of genes might appear particularly controversial, every drug-taking decision, every recommendation for diet or exercise, involves the imposition of a value judgment upon some set of medical facts.⁶⁴

Put differently, the physician always needs to be morally sensitive to the patient’s understanding of what distinguishes harmful from beneficial treatment and, in addition, to the way in which the patient weighs the benefits of a treatment against its burdens.

Veatch’s opposition to Pellegrino’s theory turns on this point. Morally sensitive physicians need to recognize that their medical expertise gives them no special insight into what is best for their patients and, in addition, they need to realize that the only way they can know what is best for their patients is to ask the patient him- or herself.

According to Veatch, the requirements of moral sensitivity not only run counter to the physician’s tendency to generalize his or her expertise, they transform the patient-physician relationship:

Literally every decision a physician makes, the pattern of every practice, will have to be altered radically. It will mean that in every patient/physician encounter it will no longer make sense for physicians to prescribe, certify “medical necessity,” or even recommend any treatment, let alone give “orders” or claim they know what is best for the patient.⁶⁵

⁶⁴ Ibid., 594.

⁶⁵ Veatch, “Doctor Does Not Know Best,” 720.

Veatch's concern about the generalization of expertise leads to his rejection of the internal morality of medicine:

The source of determination of benefit is radically different from the source of determination of outcome predictions. Doctors cannot know from their knowledge of medical science whether an intervention will be counted by the patient as a benefit. They cannot know whether a treatment, a drug brand, a dose, or a regimen will be best for the patient because it is ultimately a matter outside the realm of medical expertise.⁶⁶

Veatch thinks the practice of medicine does not provide physicians with any insight into what benefits patients because their expertise permits them to predict physiological outcomes, not to evaluate the merit of those outcomes.⁶⁷ Consequently, there can be no internal morality of medicine: moral judgments about patient benefit are not based on medicine, but on matters "outside the realm of medical expertise." Veatch writes:

The patient is normally the best judge of benefit and harm for his or her own welfare. . . . Even in the case, however, in which the patient is not the best judge, there is no reason to believe that the attending physician has the definitive perspective on what counts as a benefit. What is needed is an account of whether there is an objective basis for the value judgments incorporated into medical decisions.⁶⁸

Veatch fails to recognize (1) that Pellegrino's account of the patient's fourfold good is the objective foundation for determining whether a treatment does or does not benefit a patient; (2) that this account is objective in the sense that it presents the universal form of

⁶⁶ Veatch, "How Philosophy of Medicine Has Changed Medical Ethics," 594.

⁶⁷ Veatch seems either to think that physicians do not learn anything from their patients about what it means to be human; or, if he recognizes that physicians learn about being human from their patients, physicians still cannot be trusted to help patients determine what should be done. See Veatch, "Is Trust of Professionals a Coherent Concept?" in *ET&P*, 159-69.

⁶⁸ Veatch, "How Philosophy of Medicine Has Changed Medical Ethics," 594.

the patient's good; and (3) that the fourfold good is internal to medicine precisely because it is the end for the sake of which the clinical encounter comes about.

Veatch thinks this end is external to medicine precisely because the good of the patient exceeds the technical limits of the physician's expertise. "Part of the problem," Veatch observes,

is that the total welfare of a person is complex. Medical benefit is only one component. The most a physician could be expected to provide would be an opinion regarding the medical good of the patient. Since maximizing a complex good will not normally permit maximizing any one of the component goods, if a physician proposes what would maximize medical welfare, it would be rational for the patient to dissent on the grounds that maximizing the one component would have to come at the expense of other goods. . . . Thus, whether the good of a person is viewed as subjective or objective, the physician is an implausible candidate for being the best judge of that good.⁶⁹

Setting aside the question of part-whole interactions in complex goods generally, it is clear that the maximizing the patient's medical good can threaten his or her higher level of goods.⁷⁰ Accordingly, Veatch is right to point out that the patient must be able to refuse unwanted medical treatment. He is also right that, in general, the patient is the "the best judge of benefit and harm for his or her own welfare." He is even right to assert that "the physician is an implausible candidate for being the best judge of that [the patient's] good" *if* the clinical encounter is a meeting between strangers. However, this does not mean that the physician cannot help the patient to determine what treatment is best and why it is best. Indeed, this is what the physician is obligated to do by virtue of his or her profession to heal. As Pellegrino's phenomenology of the clinical encounter shows, the teleological

⁶⁹ Ibid., 594-5.

⁷⁰ Pellegrino underscores this point when he articulates the patient's fourfold good. See chapter 3.

structure of medicine calls upon the physician to attend to the patient and, in this way, learn about the need for healing that has made this person a patient. Then the physician and the patient can deliberate together to choose a right and good healing action.

§27 The Arrogance of Physicians

In 1977, when Ingelfinger gave The George W. Gay Lecture upon Medical Ethics at Harvard Medical School, he chose to speak on arrogance. This lecture was published posthumously in *NEJM* and provides an important contrast to Veatch's theory of the generalization of expertise and Pellegrino's call for mutual deliberation between patients and physicians. I will not take up the contrast between Ingelfinger and Pellegrino until I have discussed the contrast between Ingelfinger and Veatch.

Ingelfinger focuses on three issues. "The first . . . deals with the common accusation that bioscientists are arrogant, i.e., that they are presumptuous and overweening in their attitudes, decisions, and goals; that they exhibit, in the fashionable noun of the day, hubris."⁷¹ Ingelfinger's response to this complaint is noteworthy, not only because the common accusation prompts Veatch to condemn the generalization of the expertise, but also because Ingelfinger includes physicians amongst this arrogant group for reasons that still ring true.

The professional group most often belabored for arrogance is that which uses advanced and complex technology in its thinking and doing. It is the scientist, whether in physics or in molecular biology, or even the parascientist in medicine, who is seen as making policy decisions motivated by self-interest and acting with a total disregard for broad human needs.⁷²

⁷¹ Ingelfinger, "Arrogance," *NEJM* 303 (1980): 1507.

⁷² Ibid.

To a large extent, physicians seem arrogant precisely because medical technology reduces the patient to a body and the body to a set of numbers, images, or both. In this way, the person who is ill entirely disappears: he or she becomes the patient (i.e., the underlying material subject to whom the numbers or images refer) as the physician evaluates evidence that the now passive patient typically does not understand. Moreover, their meetings usually last just long enough for the physician to communicate his or her findings and make a recommendation that focuses on the patient as a body grasped through the media of medical technology: the patient as a person has been absented from the clinical process.

Nevertheless, Ingelfinger sets out to defend the arrogance of physicians: for he refers to the physician—as well as the physicist or molecular biologist—when he provocatively writes: “I shall argue that the bioscientist may be arrogant, but no more so than any other group and perhaps just a little bit less so.”⁷³ Given the ethical issues laid out by Veatch, one wonders how Ingelfinger could argue that physicians, who presume to know what is good for their patients, are less arrogant than other groups; after all, their presumptuousness seems to be an unwarranted expansion of expertise from the bioscientific to the ethical. The basis of Ingelfinger’s argument becomes clear when he introduces the second and third issues to be discussed.

The second issue bears on the personal encounter between physician and patient: Is it marked by authoritarianism, paternalism, and domination? My answer is not only “yes” but also that a certain measure of these characteristics is essential to good medical care. In fact, if you agree that the physician’s primary function is to make the patient feel better, a certain amount of authoritarianism, paternalism, and domination are the essence of the physician’s effectiveness.⁷⁴

⁷³ Ibid.

⁷⁴ Ibid.

Thirdly, I shall maintain that many physicians are indeed arrogant in their behavior toward patients, but in a way that is not identified by any of the dictionary definitions of the word “arrogance.”⁷⁵

If I understand Ingelfinger correctly, he is arguing that the arrogance of physicians differs from what is typically meant by arrogance because it benefits the patient and that benefit cannot come about if physicians were not arrogant. This assertion raises a compound question: How does the arrogance of physicians benefit patients and why does this benefit require the physician to be arrogant? The answer turns on what Ingelfinger means when he talks about authoritarianism, paternalism, and domination. Somehow arrogant physicians are better at helping their patients get well than are physicians who are not arrogant: but how? This is the crucial question.

To answer, Ingelfinger introduces what he calls the “arrogance of ignorance:” the “failure to recognize that a regulation or recommendation may be concocted in a vacuum of knowledge is to my mind a manifestation of the arrogance of ignorance.”⁷⁶ It should be noted that the generalization of expertise condemned by Veatch is an instance of the arrogance of ignorance. Physicians, Veatch claims, fail to recognize their own ignorance of the patient’s good when, on the basis of their scientific or technical expertise, they assert what is good for their patients. Ingelfinger rejects Veatch’s account; indeed, Ingelfinger argues that the contrary is true, as he must to defend the claim that arrogance helps physicians take care of their patients. In the following passage, Ingelfinger begins to

⁷⁵ Ibid.

⁷⁶ Ibid., 1509.

distinguish what might be called the “therapeutic arrogance” of physicians, which he advocates, from the arrogance of ignorance, which he condemns.

I do not assert that conclusions reached in the absence of reliable fact are per se arrogant. Such conclusions unavoidably characterize politics, science, and medicine, especially when the need for action is urgent. Arrogance enters when those reaching various decisions in the absence of adequate data fail to recognize or to admit how empty their cupboard of information is. Superior scientists or doctors, I should like to believe, are always aware of how little they know. Doubt tempers arrogance, and for this reason perhaps some bioscientists might be credited with *sophrosyne* rather than condemned for its opposite, *hubris*.⁷⁷

Ingelfinger points to a crucial element of both scientific and ethical inquiry:

uncertainty. Apparently, Ingelfinger thinks physicians may be less arrogant than other groups precisely because they recognize the uncertainty of their judgments. It is, however, beside the point whether or not this conclusion is true since clinicians surely recognize the truth in the dictum attributed to William Osler: “Medicine is an art of probabilities and a science of uncertainties.” Presumably, this awareness would make physicians modest in their pronouncements. Thus, according to Ingelfinger, the arrogance of physicians does not consist in the issuance of unfounded or unwarranted pronouncements. But this is, of course, precisely what Veatch claims physicians do. Indeed, Veatch suggests that competent physicians possess an expertise that permits them to make judgments about facts, which they can know, but not about the patient’s good (his or her values), which they cannot know.

I will return to Ingelfinger’s understanding of what makes physicians arrogant and why their arrogance helps patients, but first I want to suggest that Veatch overstates his case because he overlooks the uncertainty of clinical judgments as he develops the

⁷⁷ Ibid.

fact/value distinction at work in the clinical encounter. Put differently, I want to consider whether Veatch distinguishes facts from values in the clinical encounter in a way that mischaracterizes the perspective of physicians. In particular, I think Veatch makes medical facts seem certain and medical values seem uncertain in the following sense: as technicians trained in the biomedical sciences, competent physicians can know the salient medical facts because they have access to their patients *qua* bodies but they cannot know the salient medical values because they do not have access to their patients *qua* persons. If the determination of the facts needs to be separated from the evaluation of those facts, and if physicians are competent to establish the facts but only patients can make the necessary evaluation, then competent physicians can help patients only in a limited way: by establishing the facts. Scientific expertise permits physicians to predict outcomes and, while no outcome is certain, each possibility needs to be articulated as precisely as possible. According to Veatch, this is what good, i.e., competent physicians can do—because they are scientists as well as technicians. So, to the extent physicians work within the narrow boundaries of their expertise, they are competent to establish the facts. Veatch writes:

Science can tell us the expected outcomes of alternative interventions and the probabilities of each possible outcome. It can tell us, for example, the probability of surviving a pneumococcal infection with and without penicillin of a particular dosage. It can predict the possibilities of various so-called side effects. What it cannot tell us is whether the possible outcomes are good or bad.⁷⁸

Only patients, Veatch insists, are competent to make the latter determination.

Accordingly, physicians must refrain from imposing their values on the lives of their

⁷⁸ *PHT*, 73.

patients, i.e., physicians cannot be permitted to practice paternalistically. I will explore below the extent to which Ingelfinger objects to this prohibition as he defends the arrogance of physicians. However, I want to frame as forcefully as I can my question about the fact/value distinction as it is drawn by Veatch. If, as Veatch proposes, the competent physician is good at articulating possible outcomes (including the likelihood of each), but incompetent to evaluate the outcome in the context of the patient's life, then physicians cannot help patients answer what Pellegrino identifies as the most urgent question raised by the experience of illness. Patients want physicians to help them figure out what should be done; it is not enough for physicians to determine what is wrong and what can be done. Indeed, patients look to physicians for help precisely because (1) physicians have experience with the uncertain conditions and outcomes that characterize the clinical encounter and (2) clinical decisions must be made when all the salient facts cannot be known. In short, decisions about what should be done need to be made before all the facts can be established. Nonetheless, Veatch calls for physicians to be silent. Therefore, in this qualified sense, Veatch counsels physicians to abandon their patients.⁷⁹

Ingelfinger's defense of the arrogance of physicians responds to the need of patients for help to answer the question: What should be done? Ingelfinger writes:

Sociologists, ethicists and others like to speak disparagingly of what they call the doctor's authoritarianism, paternalism, or domination. Such a position, I submit, is unrealistic or untenable. The physician is a person to whom patients go because they need or think they need help. Let us assume that the physician they select is competent and compassionate. In spite of these virtues, there is usually little the physician can do physically, that is, by cutting or by a chemical manipulation, to eradicate the cause of the patient's distress. . . . [So] if we assume that physicians

⁷⁹ He abandons them to their autonomy.

do make patients feel better most of the time, it is chiefly because the physician can reassure the patient or give medication that is mildly palliative.⁸⁰

In this passage, Ingelfinger identifies another feature of clinical medicine that Veatch tends to overlook: the limits of medical knowledge in the face of the patient's need for help. Ingelfinger insists that physicians would fail their patients if they declared, in advance, that they were ignorant when it comes to the most important clinical question: What should be done? In this respect, Ingelfinger underscores Pellegrino's phenomenology of the clinical encounter. Persons who are ill seek out physicians precisely because the latter profess to heal. In other words, physicians publicly declare that they have the knowledge, experience, and skill needed to help the ill get better and that they will use this power to benefit persons who come to them for help. If, however, medical science is limited, then physicians need to recognize that their power to help patients get better involves more than a scientific understanding of disease processes and the mechanisms of effective physiological interventions. In short, there is more to medicine than scientific expertise.⁸¹

If the physician is to be effective in alleviating the patient's complaints by . . . intangible means, it follows that the patient has to believe in the physician, that he has confidence in his advice and reassurance, and in his selection of a pill that is helpful (though not curative of the basic disorder). Intrinsic to such a belief is the patient's conviction that his physician not only can be trusted but also has some special knowledge that the patient does not possess. He needs, if the treatment is to succeed, a physician whom he invests with authoritative experience and competence.⁸²

⁸⁰ Ingelfinger, "Arrogance," 1509.

⁸¹ Ingelfinger's defense of arrogance needs to be reconciled with his insistence that the work of the physician should be limited to diagnosis and intervention, but that task falls outside the scope of my dissertation.

⁸² Ingelfinger, "Arrogance," 1509.

Here Ingelfinger asserts an authority that helps physicians heal their patients.⁸³

Veatch rejects this claim; he condemns the assertion of such authority as the unwarranted generalization of expertise. Put starkly: Veatch argues that the physician can offer the patient no more than his or her bioscientific expertise whereas Ingelfinger argues that such expertise is not sufficient to help the patient get better. The physician, Ingelfinger insists, must also offer his or her *judgment* about what should be done.

A physician who merely spreads an array of vendibles in front of the patient and then says, “Go ahead and choose, it’s your life,” is guilty of shirking his or her duty, if not of malpractice. The physician, to be sure, should list the alternatives and describe their pros and cons but then, instead of asking the patient to make the choice, the physician should recommend a specific course of action. He must take the responsibility, not shift it onto the shoulders of the patient. The patient may then refuse the recommendation, which is perfectly acceptable, but the physician who would not use his training and experience to recommend a specific course of action to a patient—or in some cases frankly admit “I don’t know” does not warrant the somewhat tarnished but still distinguished title of doctor.⁸⁴

In contrast, Veatch argues that the physician is not qualified to make a recommendation. As he puts it, the physician is “an implausible candidate” for evaluating the patient’s good. However, Veatch fails to recognize a basic clinical reality: the patient needs the physician’s help to get better. Not only must they find out together what is wrong and what can be done, but, most importantly, they must determine what should be done. The physician’s judgment is an essential part of this deliberative process precisely because the physician can place the patient’s experience within a broader context: while the experience of illness is unique for each person, there are common patterns and

⁸³ Ingelfinger does not explicitly refer to Aesculapian power or the therapeutic power of the doctor-patient relationship; for an excellent survey and bibliography of these topics, see *Encyclopedia of Bioethics*, 3rd ed. (2004), s.v. “Healing.”

⁸⁴ Ibid.

responses upon which the physician can draw to help the patient understand his or her condition and select a treatment plan. Diagnosis, prognosis, and effective therapies would not be possible if individual physicians could not draw on the wealth of experience accumulated by generations of physicians. Put differently, no single physician can actualize the art of medicine in its entirety, but each physician can draw on the entire art in response to the patient's experience of illness. Obviously, this often requires referrals to specialists, but the point holds: the history of medicine and clinical research gives the physician a context for answering the patient's questions. In short, the physician has, by virtue of his or her training and experience, developed the power to answer the questions raised by illness: What is wrong? What can be done? What should be done?

Veatch writes as if the power of physicians to help patients answer the first two questions disqualifies them from helping patients answer the last question. If this is the case, it is because the first two questions are factual but the last question concerns values, in particular the patient's values. Physicians are, consequently, disqualified from answering the last question because, in doing so, they would be imposing their own values on the lives of their patients or they would be asserting what they cannot know. In the latter case (if not both), the arrogance of physicians would be what, according to Veatch, is the generalization of expertise or, according to Ingelfinger, is the arrogance of ignorance. Clearly, Ingelfinger has something else in mind when he defends the arrogance of physicians as an essential dimension of healer's art. To help their patients heal, physicians must be trusted to exercise the authority that comes with medical training, knowledge, skill, and experience for the sake of the patient. In particular, patients must trust the good

judgment of their physicians and this judgment cannot be limited to the preliminary questions: What is wrong? What can be done? The judgment of physicians must extend to the ultimate question: What should be done?

Ingelfinger is no less clear when he acknowledges that patients are free to reject the recommendation of their physicians. His point is that these recommendations can be enormously helpful to patients who, given the uncertain situation, do not know what to do. It is in this context, I submit, that his appeal to Peabody makes sense: physicians cannot be trusted to make beneficial recommendations if they do not know who their patients are. In short, “the secret of the care of the patient is caring for the patient.”⁸⁵ Ingelfinger is also aware of the ethical issues that arise when physicians and patient meet as strangers and remain strangers throughout the clinical encounter:

In these days of group practices, ancillary help, specialization, and mobile populations, “getting to know the patient” may be as difficult as containing medical costs. Currently popular measures to enhance medical efficiency also do not help. If a patient—whether an expectant mother, an alcoholic with early cirrhosis, or a heavy smoker with lung cancer—is first processed through a battery of questionnaires or computer terminals, then interrogated and examined by ancillary personnel, and finally seen by the doctor—to be delivered, to be subjected to liver biopsy, or to undergo pulmonary resection—that patient will not know the doctor, and vice versa. How can the doctor under such circumstances be aware of his patient’s thoughts and emotions? Efficient medical practice, I fear, may not be empathic medical practice, and it fosters, if not arrogance, at least the appearance of arrogance.⁸⁶

This is the problem to which Veatch responds. Physicians do not know who their patients are so it is reasonable to say that physicians behave arrogantly when they act as if they do and this arrogance is exacerbated when they falsely claim to know what is good for

⁸⁵ Peabody, “The Care of the Patient,” 882 .

⁸⁶ Ingelfinger, “Arrogance,” 1511.

patients they do not know. Presumably, Ingelfinger would also condemn such behavior, but he does not address the issue that prompts Veatch to assert the rights of patients to determine their own treatment. Veatch would be right to assert the rights of patients and to limit the role of physicians, if the end of medicine was determined by the values of those who participate in the clinical encounter. Then the goods to be achieved through the practice of medicine would be what physicians or patients (1) desired *and* (2) believed could be realized through the exercise of medical skills. However, if medicine has a teleological structure, as Pellegrino argues, then the ability of physicians to help patients determine what is wrong and what can be done provides them with invaluable experience for helping patients figure out what should be done.

While Ingelfinger does not contradict Pellegrino's position, his defense of the arrogance of physicians reflects, once again, the truth of Pellegrino's observation that traditional medical ethics calls for philosophical reflection. Ingelfinger's suggestion that the appreciation of uncertainty and the development of empathy fosters therapeutic arrogance rather than the arrogance of ignorance expresses the moral insight of a thoughtful physician; but this insight calls for philosophical reflection upon two questions basic to medical ethics. First, can the therapeutic arrogance advocated by Ingelfinger be reconciled with a robust account of consent such as the one that emerges from Pellegrino's phenomenology of the clinical encounter? Second, if physicians understand themselves primarily as scientists, as Ingelfinger does, on what grounds can or should they resist the impersonal arrangements and practices that foster the arrogance of ignorance—the very generalization of expertise condemned by Veatch?

These questions present fundamental issues to be addressed as one works out the philosophical foundation for medical ethics. After all, the “authoritarianism, paternalism, and domination” defended by Ingelfinger as “the essence of the physician’s effectiveness” cannot be reconciled (or at least not easily) with the call for mutual deliberation Pellegrino grounds in the phenomenology of the clinical encounter. Moreover, in the face of such arrogance—beneficent or not—it is easy to understand why Veatch asserts the rights of patients to determine their own treatment. Nevertheless, Ingelfinger properly underscores the agency of physicians. The question is whether the agency of the physician can be blended with the agency of the patient. Veatch argues that the clinical encounter sets a primary decisionmaker apart from the other participants and, in respect to the primary decisionmaker, he substitutes the patient for the physician. In the next chapter, I examine Veatch’s reformulation of the patient-physician relationship, as well as his rejection of the Pellegrino’s phenomenological teleology of the clinical encounter. Consequently, chapter 5 addresses the question of whether the physician is a technician or a healer. Then, in chapter 6, I turn to the underlying question of whether patients can trust their physicians. Put differently, can physicians make good on their profession to heal? Veatch argues that physicians cannot be trusted to make good on such a profession. My defense of Pellegrino’s theory will show that Veatch does not understand the teleological structure of medicine. In particular, he fails to recognize the moral significance of the patient’s experience of illness.

Chapter 5

Veatch's Transformation of the Patient-Physician Relationship and his Objections to Pellegrino's Teleology

§28 Introduction to Veatch's New Medicine

As we have seen in chapter 4, Veatch thinks that physicians cannot know what is good for their patients. In this chapter, I develop Veatch's response to this problem more fully. I refer to this response as the principal-agent model of the patient-physician relationship because Veatch thinks that the solution to the ethical issues that arise within the clinical encounter is to have patients relate to their physicians the way principals relate to their agents.¹ Veatch develops this position in his new book, *Patient, Heal Thyself!*

*How the New Medicine Puts the Patient in Charge.*² Veatch describes this book as

the culmination of [my] career-long journey toward what I call a new or post-modern medicine. It is a medicine that had its beginnings in the exciting days of the 1970s when patients first began demanding their right to make medical choices based on their own values. It is a medicine now irreversibly launched as the replacement for what is now old-fashioned modern medicine. It is a medicine that is radically different from modern medicine in the role the layperson must play in medical decisionmaking.³

As I lay out Veatch's position, it will become increasingly clear that the new medicine he describes is incompatible with Pellegrino's account of what medicine is.

¹ As I mentioned in the introduction, it would be more accurate if I were to say that Veatch advocates a master-servant model of the patient-physician relationship because he does not think that patients should work with physicians in the way that principals and agents work together in other professional relationships. See above, note 6 on page 8.

² *PHT*

³ *PHT*, ix.

Were Pellegrino's attempt to reconstruct medical morality to succeed, then the old-fashioned medicine would be reformed, rather than overthrown. There should be no doubt that Veatch's goal is the overthrow of old-fashioned medicine; but what precisely is "old fashioned medicine"? As will be clear soon, the old-fashioned medicine is a practice that is structured by the principle of beneficence. Accordingly, Veatch must reject Pellegrino's thesis that medicine has a *telos*, a univocal good that physicians ought to help their patients realize. Consequently, the chapter ends with Veatch's objections to the fact of illness, the phenomenological starting place of Pellegrino's teleological articulation of medicine.

Despite the provocative and often extreme nature of Veatch's rhetoric, it is important to consider his position for a variety of reasons. First, Veatch is right to worry about how professionals treat their patients. Given the fragmentation of medical care and the impersonal structures for the delivery of that care, it is hard to contest the claim that the health care system has lost sight of the individual patient. Consequently, patients are right to wonder whether they can trust health professionals. Moreover, Veatch could present an enormous amount of empirical evidence to support his claim that physicians cannot be trusted to know what is good for their patients. Second, Veatch conceives of the clinical encounter as an arena for conflict and, consequently, he thinks the primary task of philosophical medical ethics is to resolve conflict. In this respect, Veatch represents the dominant approach of philosophers in the United States to questions about medical ethics. Third, autonomy is widely recognized as the most important good at stake in clinical encounter and physicians often defer to assertions of autonomy. Consequently, Veatch's uncompromising assertion of autonomy within the clinical encounter shows why it is

important to rethink the role of autonomy in the clinical encounter. Fourth, Veatch overlooks an essential feature of the clinical encounter. Patients seek out physicians because they need help. In sum, the clinical encounter should not be seen in terms of a contest between autonomy and beneficence, but as a form of helping persons in need that works well only when the two excesses of medical paternalism and patient sovereignty are avoided. Pellegrino's teleological phenomenology steers this middle course; Veatch's principal-agent model does not.

§29 Autonomy Trumps Beneficence

According to Veatch, the bioethics revolution that began around 1970 was advanced by those who recognized "medical ethics as a conflict between the old Hippocratic paternalism (having the physician do what he or she thought was best for the patient) and a principle of autonomy."⁴ Their research showed that

never in the history of professionally articulated ethics had there ever been any acknowledgement of the patient as a dignified agent free to participate in and exercise self-determination over medical decisions. Not in the Hippocratic Oath, not in the prayer of Maimonides, not in Percival's ethics, the codes of the AMA or the World Medical Association.⁵

Given this history, Veatch writes,

it was proper to conceptualize medical ethics as a two-principle system with autonomy locked in an all-out struggle with individualistic, Hippocratic, paternalistic beneficence. . . . The function of autonomy was to liberate the patient

⁴ Robert M. Veatch, "Autonomy's Temporary Triumph," *Hastings Center Report* 14, no. 5 (1984): 38.

⁵ Ibid.

from the oppression of the physician's paternalism. Autonomy had a limited role, designed to fulfill the transient, narrow purpose of challenging this paternalism.⁶

One might suppose that the struggle is now over and autonomy reigns supreme over paternalism; but this is not the case; we might consider the following passage in which Richard Zaner recalls talking with a physician about a patient who had refused dialysis.

I knew . . . that Jim [the physician] believed . . . deep in his gut . . . that every competent patient had the right to refuse treatment that wasn't beneficial and that no doctor has any business even thinking about overriding that right. The thing was, though, as he later told me about Tom [the patient], dialysis would be therapeutic for him. It *would* help.⁷

This passage presents the problem: situations in which physicians experience their patients as being unreasonable in refusing to be helped cannot be eliminated from the practice of medicine. In the past, however, physicians simply did what seemed best to them. Now that they are deterred by the principle of autonomy from doing so, physicians find themselves wondering whether beneficial treatments, such as dialysis, really ought to be refused.⁸ In short, the practice of medicine regularly involves encounters when physicians think they know best what should be done.⁹

⁶ Robert M. Veatch, "Which Grounds for Overriding Autonomy are Legitimate?" *Hastings Center Report* 26, no. 6 (1996): 42.

⁷ Richard M. Zaner, *Conversations on the Edge: Narratives of Ethics and Illness* (Washington, DC: Georgetown University Press, 2004), 18.

⁸ Ibid.

⁹ The Christian Scientist who refuses medical treatment or the Jehovah's Witness who refuses a transfusion are often cited to illustrate this vexing situation. However, the ethical challenge for physicians to respect the autonomy of their patients is probably not limited to such rare instances. Consider, for example, an oncologist who wonders whether he should scare his patient into "consenting" to another round of therapy by describing, in an especially frightening way, the death that would ensue were the patient to persist in

Veatch is especially alert to this problem and he is uncompromising in his defense of patients' rights when there is a conflict in the clinical encounter: "Respecting the patient's autonomy always takes precedence over benefitting the patient against the patient's autonomous will."¹⁰ Indeed, Veatch takes issue with the widely accepted position of Tom Beauchamp and James Childress on this point. They propose that conflicts within the clinical encounter should be resolved by balancing four principles, (respect for) autonomy, non-maleficence, beneficence, and justice.¹¹ Veatch disagrees:

I think the proper role of autonomy in the system of principles is more complex than just one among several coequal principles. For starters, in the stereotypical conflict with Hippocratic paternalistic physician action, I am convinced that even the modest position given beneficence by the balancers is too much.

Balancers such as Beauchamp and Childress must concede in theory that in some cases if patient welfare is weighty enough, it outweighs autonomy. I know of no such case. At the level of law, no competent patient in the United States has ever been forced to undergo medical treatment for his or her own good. No matter how tragic, autonomy should always win if its only competitor is the paternalistic form of beneficence.¹²

Veatch emphatically rejects the proposition that beneficence authorizes physicians to act on behalf of patients on the grounds that physicians cannot know what their patients would

refusing the treatment. This case was reported to me by an ethicist who consulted with the oncologist. It was the ethicist's view that physicians will sometimes use fear to get their patients to consent to a recommendation.

¹⁰ Veatch, "Autonomy's Temporary Triumph," 38.

¹¹ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001). The first edition was published in 1979. The sixth edition was published this year (2009).

¹² Veatch, "Overriding Autonomy," 42. Veatch might seem to approve of non-paternalistic beneficence. However, Veatch rejects this possibility as well. So when a physician prescribes an antibiotic for a bacterial infection, he or she is acting paternalistically. *PHT*, 117.

consider beneficial.¹³ Therefore, physicians who claim to know what will help their patients are untrustworthy paternalists precisely because they cannot know what is good for their patients.¹⁴ Not only does this mean that medical beneficence is synonymous with medical paternalism; it also means that medical decisions can be made in only one of two mutually exclusive ways: either autonomously by patients or paternalistically by physicians. According to Veatch, there is only one possible alternative to this binary opposition: patients and physicians would need to be matched according to their moral orientation.¹⁵ Until that happens, however, the patient-physician relationship must be reconceived as a principal-agent relationship.

§30 Patients as Principals, Physicians as Agents

Since Veatch thinks of physicians as experts in the science of disease processes and the scientifically informed techniques of altering or ending those processes, his understanding of clinical medicine is shaped by the distinction between facts and values;

¹³ Veatch would argue that even if the physician could know what the patient considers good, patient autonomy trumps medical beneficence: so physicians would have to respect the patient's decision even if they somehow knew that the patient was mistaken in light of his or her own beliefs.

¹⁴ See Veatch, "Is Trust of Professionals a Coherent Concept?"

¹⁵ Veatch calls this proposal "deep value pairing," which I take up in §31 below. Although his deep value pairing suggests a way of overcoming the opposition between autonomy and beneficence (as Veatch understands it), his proposal does not alter the steadfast and uncompromising assertion of autonomy that marks Veatch's thought about conflicts in the patient-physician relationship. Nevertheless, it does show that he is aware that the autonomy model has some limits. Perhaps Veatch would say of the autonomy model what Churchill is supposed to have said about democracy, namely that it is the worst ethical system, except for all the other ones.

for “every medical decision requires value judgments that cannot be based on science.”¹⁶ This insight shapes how Veatch thinks about the patient-physician relationship.

By the end of the twentieth century some physicians and almost all patients recognized [certain] decisions as “ethically loaded” value choices that physicians had to cede to their patients. There is, however, a new medicine emerging. The new medicine pushes further. It claims that not only these ethically dramatic cases but literally every medical choice—no matter how mundane—inevitably requires value judgments and that physicians make them only by imposing their personal and often idiosyncratic views on their patients. Their equally competent colleagues facing similar choices but holding slightly different values would choose differently, even though they agreed completely about the medical facts.¹⁷

Veatch illustrates this claim with three cases that “seem so routine and trivial that many would be tempted to claim that they are devoid of value judgments.”¹⁸ The first case involves the question of how long a cast needs to worn.¹⁹ He says that “there is no objectively correct number of weeks” and elaborates as follows:

The more cast-averse one is and the more comfortable one is trying to be careful, the earlier the cast should come off. On the other hand, for those who live an active life, are nervous about having to try to avoid the risk of injury of the unprotected arm, and are not particularly troubled by the cast, a longer period is surely the right answer. . . .

¹⁶ *PHT* 21.

¹⁷ *PHT*, 22.

¹⁸ *PHT*, 22.

¹⁹ The second and third cases follow the same pattern presented in the first case: clinical judgments necessarily unite facts and values because they involve trade-offs between risks and rewards. The second case assesses the risk that comes with driving after surgery to repair a hernia, particularly, the stress that controlling both the brake and accelerator puts on the surgical wound; so it analyses the question of when the patient can begin to drive a car (with an automatic transmission). This case involves weighing the risk of complications that come from opening the wound, on the one hand, against the reward of being able to drive, on the other hand. The third case involves the trade-offs between different ways of dealing with high cholesterol: diet and exercise, statin drugs, or doing nothing. Since the first case is sufficient to illustrate Veatch’s argument, I do not discuss further the second and third cases.

Something as utterly trivial and devoid of moral controversy as when to remove a cast turns out to depend on the value trade-offs of the one making the choice. . . . If a value trade-off must be made between the nuisance of the cast and the nuisance of being careful without it, it should be [the patient's] values that get traded off, not those of [the physician].²⁰

Veatch's point is straightforward. Since medical decisions involve trade-offs between risks and rewards, physicians must take direction from their patients; otherwise, physicians risk imposing their values on their patients.²¹ In brief, respect for autonomy requires a transformation of the clinical encounter; therefore, Veatch argues for a physician-patient relationship that resembles an agent-principal relationship.

The active participation of patients (and patient surrogates) in medical decision making is grounded on the notion that values from outside medicine must control medical decisions. Patients are the primary persons with the skill to decide what is good medicine, because they are usually the ones who best know what will maximize their own well-being. Even in cases in which a patient does not know best, he or she still bears certain rights of decision making grounded in the principle of autonomy.²²

The case of the broken arm makes Veatch's radical intention plain: he wants to reconceive the way clinical medicine is practiced. According to Veatch, the patient, not the physician, should determine when the cast is removed. He reports the decision as follows. The patient, a college student,

points out that he will be returning to school soon. It will be a two-hour trip each way to come back in four weeks to get the cast removed [as the physician recommended]. He realizes, however, that in five weeks his school will have a break. He will come home for the break, so he can easily come to get the cast

²⁰ *PHT*, 23-4.

²¹ For the sake of argument, I am willing to accept the truth of this claim. However, I do not accept the implication that, absent radical changes, clinical routines impermissibly violate patient autonomy.

²² *PHT*, 65-6.

removed without missing class. For him, five weeks is the right length of time for the cast to be on his arm, and it had nothing to do with the orthopedic issues.²³

In his presentation of the trade-offs between risks and rewards, Veatch exploits the inescapable uncertainty of clinical judgments. No physician can know how long *this* patient should wear *this* cast for *this* fracture to heal because these particulars are so contingent that, even if a physician could formulate the probabilities properly, it would be virtually impossible to specify correctly all of the relevant variables. Consequently, it is reasonable for any physician to recommend a duration grounded in the available evidence and, if necessary, explain the risks that would be associated with taking the cast off earlier. After all, neither the physician nor the patient can *know with certainty* how long the cast should be worn to heal the particular fracture. Therapeutic actions are predicated upon statements of probabilities and it cannot be known where this patient falls along the relevant distribution curve. While this means, as Veatch points out, that every clinical judgment involves a balance between risks and rewards, it does not mean that the physician's ability to think through these probabilities is irrelevant to the question of what should be done. On the contrary, it illustrates why patients need help from their physicians to answer *all* of the questions that structure the clinical encounter. What is wrong? What can be done? What should be done? One might even suggest that patients need their physicians' help most when it comes to answering the last question: since physicians have

²³ *PHT*, 24. Veatch's conclusion that the patient's decision had nothing to do with his physician's orthopedic advice ignores an obvious point. The patient complied with the physician's advice. He wore the cast for the recommended period of time. I assume he followed this advice because he trusted his physician's superior understanding of the orthopedic issues. The physician's judgment would have been challenged had the patient worn the cast for less than the recommended time.

practical experience and expert knowledge that patients lack, they are uniquely qualified to helping their patients think through questions about medical treatment.

Nevertheless, Veatch seems to think that neither clinical experience nor biomedical expertise qualifies the physician to help his or her patient determine what should be done.

The male obstetrician who has delivered a thousand babies cannot possibly get into the mind-set of the young woman in labor for the first time. The oncologist who has chosen out of all the thousands of occupations to give his life to fighting cancer and has cared for thousands of patients who have gone on to die cannot think like the frightened, newly diagnosed breast cancer patient who may have many critical responsibilities flash before her when she learns her diagnosis.²⁴

In this passage, Veatch recognizes the impact of illness on the patient but he rejects the possibility that the physician can understand this impact. As Veatch conceives of the clinical encounter, physicians and patients cannot understand each other: “Just as patients cannot think like health professionals, who have been trained to view medicine with a set of concepts and theories unknown to lay people, so, likewise, physicians and other health professionals lose the capacity to think like the patient.”²⁵

Since Veatch thinks the physician is incapable of understanding what being ill means to the patient, he rejects Pellegrino’s thesis that medical ethics can be traced back to the patient’s experience of illness. In sum, the profession of medicine cannot be understood as responding to the experience of illness if the physician who makes the profession does not understand what his or her patient is going through. Indeed, Veatch is especially suspicious of professional beneficence because he thinks biomedical expertise distorts the physician’s sense of what is good for the patient.

²⁴ *PHT*, vii-viii.

²⁵ *PHT*, vii.

Anyone who has given his or her life to an area of professional specialization ought to be expected to value the contribution of that area in an atypical way. Cardiologists ought to believe atypically that cardiology does good for people. Presumably, this is one reason why people choose to enter a certain profession. . . . Physicians predictably value the medical good differently from the way laypeople value it. They will overemphasize some elements of the medical good (such as preserving life) and underemphasize others (such as relieving suffering). They will give an answer different from that which a layperson, such as the patient, would give. They often, but not always, will overvalue the benefits of their field. Even if they undervalue those benefits, their evaluation is likely to be atypical. . . . In short, if clinicians were asked to guess what will serve the best interest of the patient, they should be expected to come up with the wrong answer.²⁶

§31 Veatch's New Medicine

Veatch's skepticism about whether physicians can help their patients decide what should be done is thoroughgoing and it leads to a startling vision:

Medical ethics in the next [21st] century will be radically different from the outmoded, anachronistic, paternalistic, individualistic ethic attributed to Hippocrates. It will acknowledge that physicians normally cannot be expected to figure out on their own what will benefit their patients and that they often should not try to provide such benefits even if they can figure them out. While many people, especially theorists in medical ethics, increasingly have a vague understanding of this insight, almost no one yet realizes that it means that literally every decision a physician makes, the pattern of every practice, will have to be altered radically. It will mean that in every patient/physician encounter it will no longer make sense for physicians to prescribe, certify "medical necessity," or even recommend any treatment, let alone give "orders" or claim they know what is best for the patient. I see that radical change on the horizon for the new century.²⁷

This passage couples uncontroversial claims about the patient-physician relationship with provocative declarations about medical ethics and the clinical encounter. Few (if any) would disagree with Veatch's first claim that physicians cannot determine *on their own* what is good for their patients. Indeed, there is virtual unanimity that physicians

²⁶ *PHT*, 105.

²⁷ Veatch, "Doctor Does Not Know Best," 720.

should engage the patient in a dialogue so that they can appreciate, and respond to, his or her hopes, fears, and expectations.²⁸ Veatch's second claim that physicians should not try to benefit their patients even if they know how to do so is uncontroversial if the requirement of informed consent is included: most would agree that, in the absence of informed consent, physicians should not treat their patients even if they know the treatment will benefit the patient. These uncontroversial claims are supposed to support his provocative declarations about the physician-patient relationship and medical ethics. The ethics of beneficence must be rejected because, as his first claim shows, it presupposes the impossible and, as his second claim shows, it incorporates the unethical. Consequently, the patient-physician relationship must be radically altered to make sure that patients get the treatment that they themselves determine is best. Veatch's declarations are provocative because they imply that the clinical encounter must be radically restructured to root out beneficence. It must become a principal-agent relationship. Veatch puts the patient in charge and the new medicine he heralds in *Patient, Heal Thyself!* is meant to protect and to serve the *autonomous* patient.

Whether Veatch's new medicine well serves the ill or injured patient is a different question. Veatch's book, *Patient, Heal Thyself! How the New Medicine Puts the Patient in Charge*, was reviewed by Mark A. Hall in the *New England Journal of Medicine*. Hall has no doubt that Veatch's new medicine neither protects nor serves the interests of patients. I quote from his review at great length because he captures so well the spirit of the principal-agent model of the patient-physician relationship Veatch proposes. Hall writes:

²⁸ I cannot think of any one writing about bioethics in the United States who would reject this proposition.

Veatch follows patient autonomy to its logical and outlandish conclusion. . . . Patients alone are in charge, and they have no choice but to assume this active role. . . . To defend this astonishing position, Veatch starts from the assertion that “literally every medical choice—no matter how mundane—inevitably requires value judgments,” and says that “physicians make them only by imposing their personal and often idiosyncratic views on their patients. . . .” From this premise flow a host of startling conclusions. Hospice care is too value-laden to be covered by health insurance. Physicians “will no longer . . . certify ‘medical necessity,’ or even recommend any treatment, let alone give ‘orders’ or claim they know what is best for the patient.” Even prescriptions are too prescriptive. Instead, doctors will merely document a patient’s diagnosis, leaving a patient to decide (in consultation with pharmacists) whether to medicate and which approved drug and dosage to take. We will also need to abandon informed consent in favor of a menulike process in which doctors laboriously explain all plausible options.

Most radical of all is Veatch’s almost total rejection of beneficence on the part of physicians: “even in the ideal case, physicians generally have no basis for knowing what would benefit their patients”; therefore, “doctors often must stop trying to make decisions that benefit patients.” This logic ignores . . . the fact that most patients want physicians to take the lead in deciding treatment, as long as they apprise patients of what they are doing and why. Veatch neglects the possibility that patients may seriously regret systematically making uninformed decisions. He never mentions that, in many situations, doctors know (on the basis of their accumulated experience) that patients often falsely predict their own preferences and values.

In calling for a “new” medicine, Veatch wants to sound progressive, enlightened, and post-modern. Instead, his new world seem postapocalyptic to me. It is a barren isolating world in which sick patients “will have to take charge and heal themselves.” It is a simple, syllogistic world in which anything that is not proven scientific fact is a subjective value over which physicians have no say and little insight. . . .

Veatch does us a real service by mapping such an unappealing world. His articulation of the strongest conceivable version of patient autonomy convinces at least this reviewer of how fundamentally wrong this position is. Therefore, Veatch unintentionally helps to sharpen our appreciation for how medicine necessarily must accommodate more enlightened forms of paternalism than those that prevailed in the past.²⁹

²⁹ Mark A. Hall, review of *Patient, Heal Thyself! How the New Medicine Puts the Patient in Charge*, by Robert M. Veatch, *NEJM* 359 (2008): 2851-2. Hall explains why he has filled his review with quotes from the book as follows: “Veatch’s proposals are so startling that readers of my review may [otherwise] doubt my characterizations” (2851).

While I generally agree with this uniformly negative review, I take issue with a couple of points. First, it does not mention the alternative Veatch proposes to resolve problems that the assertion of autonomy cannot affect. Second, the conclusion that Veatch unwittingly and indirectly confirms the need for a better paternalism suggests that paternalism and beneficence are the same phenomenon. They are not: it is possible to defend beneficence without endorsing paternalism.³⁰ These points are important because they show that Veatch is aware of limitations on the assertion of autonomy and the need for an alternative to the principal-agent model he advances. Nevertheless, he rejects informed consent on the grounds that it neither protects nor serves the patient; consequently, Veatch winds up advocating an uncompromising version of patient autonomy. Therefore, the reviewer does not mischaracterize the new medicine proposed by Veatch, but he also does not call attention to Veatch's claim that his proposal should not be understood simply as privileging patient autonomy over medical beneficence. As Veatch says,

The new medicine is more than an appeal to patient autonomy. Autonomy is fine as an antidote to too much medical dominance. Consent and its partner, refusal of consent, provide the beginnings of a corrective, but the in the end patients will not be able to take over every element of medical decisionmaking. Doctors will, at minimum, have to provide the diagnosis and summary of treatment alternatives. Some of those alternatives may be so offensive to some doctors that they should not be required to even mention them, let alone recommend them. Something more than naked patient autonomy will be needed.³¹

Veatch's qualification is important for two reasons. First, he recognizes that patients need help from physicians; for "physicians and other health professionals can

³⁰ Indeed, this is what Pellegrino does: the right and good healing action is beneficent but it is not paternalistic.

³¹ *PHT*, 107.

provide [patients with] . . . information about the fact of their diagnoses, explanation and advice about the treatment options available, and advocacy in negotiating a complex, alien system called health care.”³² Second, Veatch does not require physicians to violate their conscience in order to realize goals set by their patients.³³ Nevertheless, these acknowledgements do not resolve the problems that flow from Veatch’s presentation of the clinical encounter: if physicians cannot know what is good for their patients, they must take direction from their patients;³⁴ but physicians may be unable to comply with the decisions patients make.

Consequently, Veatch rejects as unworkable a strict consumer model in which physicians present a menu of options and patients select the treatments they think best.³⁵ Instead of this model, Veatch proposes what he calls “deep value” pairing.

Although the typical clinician—even one who is skilled and passionately committed to maximizing the patient’s welfare—cannot be expected to guess exactly what will be in the patient’s best interest, there . . . might be more hope if the patient were to choose her cadre of well-being experts (lawyers, accountants, physicians, et al.) on the basis of what I will call their “deep” value systems. That way, when unconscious bias and distortion occur, as inevitably they must, they tip the discussion in the direction of the patient’s own system. . . . If . . . there were alignments—“value pairings”—based on the most fundamental worldviews of the layperson and professional, then there would be some hope. This probably would mean picking providers based on their religious and/or political affiliations, philosophical and social inclinations, and other deeply penetrating worldviews. To

³² *PHT*, 62.

³³ There is considerable controversy about whether physicians and other health professionals can justifiably refuse to provide legal treatments because they have moral objections to the treatments. On this issue, Veatch and Pellegrino agree.

³⁴ While I set aside the question of whether physicians could understand their patients interest if they were to listen to them, I think that Veatch’s arguments raise the problem of incommensurability. Put differently, it is not clear that Veatch thinks that the interests of patients are intelligible to physicians who are moral strangers.

³⁵ Veatch discusses this model under the following heading: “Choice: The Liberal Alternative,” *PHT*, 106-7.

the extent that the provider and patient were of the same mind-set, then there is some reason that the technically competent clinician could guess fairly well what would serve the patient's interest—at least much of the time.³⁶

This is not the place to debate the merits of Veatch's proposal, or its viability. The importance of Veatch's proposal, for my purposes, is that it underscores a basic assumption of contemporary bioethics: namely, that the most significant ethical problems within the clinical encounter come about because physicians and patients are moral strangers; this is the problem of pluralism. Indeed, Veatch seems to think that the biggest problem is the "unconscious bias and distortion" that inevitably occurs in communication. Consequently, when patients and physicians are moral strangers, they cannot possibly arrive at a shared understanding. Therefore, the task of philosophical bioethics is to determine how to prevent and resolve conflict. Veatch presents two approaches. On the one hand, there is the principal-agent relationship, which attempts to avoid conflict by putting the patient in charge and resolves conflict by making it clear that, within the

³⁶ *PHT*, 107-8. Others have made similar proposals, most notably Ezekiel Emanuel, "A Communal Vision of Care for Incompetent Patients" *Hastings Center Report* 17, no. 5 (1987): 15-20. Emanuel develops his proposal for further in *The Ends of Human Life: Medical Ethics in a Liberal Polity* (Cambridge, MA: Harvard University Press, 1991), 178-244. See also H. Tristram Engelhardt, Jr., *The Foundation of Bioethics*, 2nd ed., (New York: Oxford University Press, 1996), 400-402. Englehardt is frequently recognized for espousing the view that, in modern pluralist societies, secular ethics and politics must be structured by the truth that persons are moral strangers. I believe Alisdair MacIntyre presented an earlier version of the moral stranger thesis. He writes: "We are increasingly moral strangers to each other, reduced not so much to the condition of Hobbesian isolated individuals as to that of inhabitants of small communities at home or at work which survive as fragile islands of moral community in the larger chaos." Alisdair MacIntyre, "Patients as Strangers," in *Philosophical Medical Ethics: Its Nature and Significance*, eds. Stuart F. Spicker and H. Tristram Engelhardt, Jr. (Boston: D. Reidel Publishing Company, 1977), 209. MacIntyre presented this paper at a conference on philosophy and medicine in 1975 and I would not be surprised if his presentation influenced Engelhardt's own formulation of the moral stranger thesis.

bounds of the law, the patient is the ultimate authority concerning what should or should not be done. This model is flawed, as Veatch seems to recognize: even though patients are autonomous, they cannot determine what is wrong or what can be done without the help of physicians. One might even ask whether patients can be in charge if patients must depend on their physicians to answer these questions. However, the principal-agent model suffers from an even more serious flaw, which Veatch does not recognize explicitly. Many patients do not want to figure out what should be done by themselves; they want help from their physicians. It is quite possible that Veatch implicitly recognizes this flaw, for deep value pairing is meant to overcome the biases and distortions that doom the attempts of moral strangers to work together in the clinical encounter and mutually determine what is wrong, what can be done, and what should be done. It seems clear, however, that Veatch thinks this ideal can only be realized if patients and physicians enjoy a common moral orientation.³⁷

Given this pessimistic assessment, Veatch rejects informed consent.³⁸ He expresses this judgment in an especially provocative manner.

³⁷ He speaks of a multiplicity of medicines rather than a single medicine: “there will be a Catholic medicine, a libertarian medicine, a militant feminist medicine, a Marxist medicine, but no such thing as medicine *simpliciter*, no such thing as health and healing without an external framework that specifies what ought to be done to the body to achieve human ends.” Veatch, “The Impossibility of a Morality Internal to Medicine,” *Journal of Medicine and Philosophy* 26 (2001): 638. Veatch’s notion of ethics as a social construct leads him to some absurd positions, such as suggesting that it cannot be known whether a broken bone should be set because it may deprive the person of the opportunity to be a successful beggar (635-6). It also leads to absurd counter-arguments. For example, how many Baptist medicines are there? Can a physician who attends one Baptist church treat a patient who attends a different Baptist church?

³⁸ Veatch has twice published his call to abandon informed consent and both times his call has been accompanied by a recommendation of deep value pairing. Veatch, “Abandoning

Until now no one who accepts the general idea of consent has seriously questioned whether this approach—which permits explicit consent for special and complex treatment, including research and surgery, and implicit or presumed consent for more routine procedures—is adequate. In fact, the consent model buys into the traditional authoritarian understanding of the clinical decision making more than people realize. As in the days prior to the development of the consent doctrine, the clinician still is supposed to draw on his or her medical knowledge to determine what he or she believes is in the best interest of the patient and then propose that course of treatment. . . . [T]he physician is still expected to determine what is “medically indicated,” the “treatment of choice,” or what in his or her “clinical judgment is best for the patient. The clinician then proposes that course, subject only to the patient’s signal of approval . . . of the physician-determined plan.”³⁹

Veatch ignores a great deal of literature about informed consent when he claims to be one of the few who recognizes what informed consent means. Many concerned persons have devoted a considerable amount of thought to what informed consent means and most (if not all) of them would reject informed consent as Veatch describes it, because informed consent should do more than give the patient a veto to check the power of paternalistic physicians. Informed consent is meant to alter the balance of power in the patient-physician relationship. This is not a new insight. More than 25 years ago, the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research published *Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship*.⁴⁰

Informed Consent,” *Hastings Center Report* 25, no.2 (1995): 5-12; *PHT*, 91-109. This leaves the question of how Veatch thinks the patient-physician relationship should be structured now, since he rejects informed consent and deep value pairing has not been implemented. The answer: put the patient in charge, i.e., the principal-agent model of the patient-physician relationship.

³⁹ *PHT*, 94.

⁴⁰ President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions: A Report on the Ethical and*

The Report articulates a middle ground between the extremes of medical paternalism and patient sovereignty.

Both positions attempt to vest exclusive moral agency, ethical wisdom, and decisionmaking authority on one side of the relationship, while assigning the other side a dependent role. In the view of the Commission, neither extreme adequately reflects the current nature and needs of health care. . . . In this Report, the Commission attempts to shift the terms of the discussion toward how to foster a relationship between patients and professionals characterized by mutual participation and respect and by shared decisionmaking. The Commission believes such a focus will do better justice to the realities of health care and to the ethical views underlying informed consent doctrine.⁴¹

Veatch cites this report when he discusses the history of consent, but he does not address shared decisionmaking at all.⁴² The reason for this omission, one might reasonably conclude, is that Veatch advocates patient sovereignty. As we have seen earlier, the reviewer of *Patient, Heal Thyself!* clearly believes this is Veatch's position. However, this conclusion does not take seriously Veatch's proposal for deep value pairing as an attempt to resolve the underlying problem of trust. If patients do not know that their physicians share the same moral orientation, then patients have no basis to trust their physicians and if patients cannot trust their physicians, then the profession to heal physicians make to their patients is without effect. Either the patient-physician relationship must be a principal-agent relationship or there must be deep value pairing. This binary statement summarizes Veatch's position and it highlights two assumptions that shape his approach to medical

Legal Implications of Informed Consent in the Patient-Practitioner Relationship (Washington, DC: Government Printing Office, 1982).

⁴¹ Ibid., 36.

⁴² In particular, Veatch cites the report to support his statement that "the notion of consent is a relatively recent phenomenon." *PHT*, 92 (signaling 262, endnote 2).

ethics: physicians cannot be trusted and the doctor-patient relationship is an arena for conflict and abuse.⁴³

§32 Contrast between Veatch and Pellegrino

Pellegrino's phenomenology of the clinical encounter provides an alternative to Veatch's distrustful conclusions about medical ethics. By tracing the meaning and ethics of medicine back to the fact of illness, Pellegrino displays the moral structure of medicine. When physicians respond well to their patients as persons in need of healing, then the complex good that medicine promises to deliver to the patient can be realized. As Pellegrino lays it out, this complex good has four levels: the biomedical good (optimal

⁴³ The historical background of Veatch's position has been set out in David J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: Basic Books, 1991). Rothman states the general question that structures his inquiry as follows: "How did it happen that physicians, who had once ruled uncontested over their domain, came to confront committees, forms, general principles, and active patients?" (4). To answer this question, he focuses on "the critical period of change . . . from 1966 to 1976" that began with Henry Beecher's exposure of "abuses in human experimentation" and "closed with the New Jersey Supreme Court ordering doctors to yield to parental requests to remove twenty-two year old Karen Ann Quinlan from a respirator" (3). Hence Rothman's conclusion: "After Quinlan there was no disputing the fact that medical decision making was in the public domain and that a profession that had once ruled was now being ruled" (222). As Rothman notes, Veatch helped the Quinlan's attorney, who, after consulting with members of the Kennedy Institute of Ethics at Georgetown University, "went to the Hastings Institute to review his arguments with Robert Veatch" (244). Rothman continues: "in this way, the *Quinlan* case represented both the emergence of a new authority over medicine and a new alliance among outsiders to medicine. The Quinlans first took counsel with the clergy, but to effect their wishes, they had to turn to a lawyer, who, in turn, consulted with bioethicists so as to sharpen his argument before a court" (244). Rothman's history helps to explain the core of Veatch's project: outsiders must assert authority over the clinical encounter because the insiders falsely claim to know what is best and, even worse, they claim the moral authority to do what they think is best. Patient autonomy must trump medical beneficence and to eliminate the threat posed by beneficence, deep value pairing is necessary.

physiological function), the personal good of the patient (desires, preferences, plans), the generic human goods (agency, integrity, and dignity), and the ultimate good (the patient's understanding of what it means to be human as well as why it is good to be human). According to Pellegrino, these levels are hierarchically ordered so that the realization of the biomedical good helps the particular patient if, and only if, its realization does not disproportionately harm the patient at any of the other three levels. At the top of this hierarchy is the patient's ultimate good so actions that bring about other goods are harmful to the patient if they violate his or her ultimate good. Consequently, a blood transfusion will harm the devout Jehovah's Witness even if it would save his or her life. However, these cases may be the easiest to resolve since compromising the patient's ultimate good is hard to justify.

The difficult cases are those which require benefits to be weighed against harms either at the same level, or at a higher level. For example, the side effects of certain curative treatments will prevent some patients from realizing important personal goods; if this loss is greater than the benefit of the promised cure, then the treatment is harmful to the patient. Obviously, this evaluation will focus on the particulars of the patient's life so the patient will have to determine whether the treatment is worthwhile. However, this determination may be especially difficult for the patient to make precisely because it involves a great deal of uncertainty. Not only is the result of any medical treatment uncertain, but this uncertainty is compounded when there are alternative treatments to

consider.⁴⁴ How does one determine which of several uncertain futures is most desirable? Veatch and Pellegrino approach this question in very different ways.

Since patients must find a way to answer this difficult question, they often look to their physicians for advice. That Veatch thinks this is a bad idea seems quite strange because physicians have experience with the kinds of decisions that patients are called upon to make. Moreover, the vast majority of physicians in the United States recognize that different persons make different decisions, just as they know that the same decision can produce different outcomes in different persons. Consequently, physicians typically have a familiarity with thinking through the different sets of outcomes corresponding to each of the different alternatives.⁴⁵ This familiarity would be especially helpful to patients who are typically thinking through these alternatives for the first time and with considerable anxiety.⁴⁶ In chapter 4, I said that Veatch abandons patients to their autonomy. Now I can underscore why he does so; he thinks physicians cannot be trusted to use their experience in a way that helps their patients. In particular, Veatch thinks that physicians are likely to give advice that favors one of two goods. If it is the biomedical good they know how to produce, then physicians will, in effect, be discounting the harmful

⁴⁴ Since doing nothing is always a possibility, there are always at least two possibilities to be weighed alongside each other.

⁴⁵ But see Peter A. Ubel, "Is Information Always a Good Thing? Helping Patients Make 'Good' Decisions," *Medical Care* 40 (2002): V-41-V-42. Ubel notes that many persons, including physicians, have trouble making good decisions when there are more than two alternatives.

⁴⁶ Even if the patient has made such decisions before, every difficult medical decision produces anxiety for the patient because he or she is deciding his or her own future and the alternatives do not appear as good, better, or best. That would be easy: who wouldn't choose the best? Instead, the alternatives appear as bad, bad, and bad and the task is to choose the least worst one.

effects at the higher levels about which the patient might reasonably be worried. This thesis finds expression throughout Veatch's work. The following passage from *Physician, Heal Thyself!* is especially pointed:

Anyone who has given his or her life to an area of professional specialization ought to be expected to value the contribution of that area in an atypical way. Cardiologists ought to believe atypically that cardiology does good for people. Presumably this is one reason why people choose to enter a certain profession. . . . Physicians predictably value the medical good differently from the way laypeople value it. . . . They often, but not always, will overvalue the benefits of their field.⁴⁷

Alternatively, if physicians favor their own understanding of the ultimate good, then they will be substituting their judgment for the judgment of their patients. As I interpret Veatch, he advocates deep value pairing because it minimizes the chances that physicians will harm patients when they substitute their judgment for the judgment of their patients. This point needs to be emphasized, for deep value pairing has a different task than the mere assertion of autonomy. Deep value pairing does not serve patients by keeping physicians from trying to benefit their patients; Veatch asserts patient autonomy to bar such beneficence. Deep value pairing would serve simply to limit the harms that flow from physicians trying to benefit their patients; if patients and physicians are matched according to their deep values, then "when unconscious bias and distortion occur, as inevitably they must, they tip the discussion in the direction of the patient's own system" of beliefs and values.⁴⁸ Put differently, Veatch proposes deep value pairing to create the circumstances in which physicians could try to benefit their patients. If the patient and the physician share the same moral outlook, "then there is some reason [to believe] that the

⁴⁷ *PHT*, 105.

⁴⁸ *PHT*, 107.

technically competent clinician could guess fairly well what would serve the patient's interest—at least much of the time.”⁴⁹ When patients and physicians are not aligned in this way, then physicians cannot attempt to benefit their patients because, according to Veatch, beneficence and paternalism are the same thing. In short, deep value pairing reduces the risk of patient harm enough for Veatch to allow beneficence (i.e., paternalism) in these narrowly defined circumstances.

To be clear, Veatch assumes that physicians want to benefit their patients but he thinks that such beneficence threatens patients because physicians cannot know what is good for their patients. Therefore, he asserts patient autonomy within the clinical encounter to protect patients from being harmed by medical beneficence. However, he proposes deep value pairing to allow medical beneficence. That he makes this proposal raises an interesting question. Does Veatch think deep value pairing provides a better solution to the problem of pluralism or does he think deep value pairing produces better medical care? I do not answer these questions in this dissertation. However, the questions themselves prompt me to wonder whether Veatch's new medicine is coherent.

According to Veatch, patients are protected and served when they relate to their physicians as principals relate to their agents. Nevertheless, he recognizes that the principal-agent model of the patient-physician relationship has some problems. Since it functions by asserting patient autonomy, it cannot effectively resolve problems that stem from the patient's dependence on the physician. In particular, the patient cannot know what is wrong or what can be done without help from the physician. Moreover, Veatch

⁴⁹ Ibid., 108. In chapter 6, I interpret deep value pairing as Veatch's attempt to establish the conditions of trust.

permits the physician to omit certain possibilities from the presentation of therapeutic alternatives because mentioning them would violate the physician's conscience.⁵⁰ Deep value pairing would overcome these problems, but if my interpretation of this proposal is correct, then Veatch, the champion of lay decisionmakers, winds up advocating a form of paternalism that, for the most part, has been stripped of its power to harm patients. In sum, Veatch's account of the patient-physician relationship makes little sense: the assertion of patient autonomy is ultimately limited by the fact that patients are ineradicably dependent upon physicians.⁵¹ Consequently, Veatch abandons patient autonomy in favor of the least worst kind of paternalism.

Pellegrino's teleological account of medicine and medical ethics provides an alternative to Veatch's position by showing that a physician can act beneficently without being paternalistic. Such non-paternalistic beneficence happens when the physician acts for the sake of the patient's complex good and not simply to optimize the patient's biomedical good. Were the biomedical good the only good to be realized through the clinical encounter, then the physician could make unilateral decisions. However, the biomedical good is subordinated to higher levels of the patient's good. Accordingly, the patient's good is a complex whole that cannot be realized unless patients and physicians exercise their agency together. Consequently, the clinical encounter achieves its end of a right and good healing action only when physicians recognize that their obligations as

⁵⁰ As I pointed out before, it is not clear whether and how the patient can be in charge when he or she must depend upon the physician for crucial information that concerns the being of the patient.

⁵¹ As will be seen below, Veatch focuses on chronic illness to advance his goal of restructuring the practice of medicine.

professionals can be traced back to the patient's experience of illness; for the profession to heal arises in response to the fact of illness.

Veatch objects to Pellegrino's alternative on three grounds. He claims that: (1) as professionals, physicians are excessively devoted to the biomedical good and, consequently, have a distorted understanding the patient's complex good;⁵² (2) as persons, patients and physicians are moral strangers so there is no basis for them to achieve a shared understanding of what should be done; and, finally, (3) medicine will not be good for patients unless (a) they are put in charge of the clinical encounter and the clinical tasks are divided according to the distinction between facts and values or (b) patients and physicians are paired according to their deep values.

When Veatch rejects Pellegrino's teleology, he overlooks the fact (or experience) of illness as the ground upon which patients and physicians can develop a shared understanding. The experience of illness directs physicians to understand the biomedical good in the context of their patients lives as concrete wholes; with this shift in attention, physicians can learn to appreciate their patients' need for healing and in this way, the interests of physicians become aligned with the interests of patients. Pellegrino unpacks the teleological structure of medicine to make this very point. Healing can only happen when patients and physicians share the same end: the one that is specified by the patient's experience of illness. Since the experience of illness gives rise to the practice of medicine and specifies the end of healing for the sake of which medicine is practiced, the experience

⁵² That Veatch's account of the patient's good differs from the Pellegrino's account is irrelevant for my purposes since both agree that this good is complex and involves much more than the biomedical good.

of illness establishes both the origin (*arche*) and the end (*telos*) of medicine. As such, a defense of Pellegrino's claims concerning the experience of illness provides a defense for his teleological theory as a whole. I will take up the task of defending those claims in the next chapter, after I have laid out Veatch's objections in the remaining sections of this chapter.⁵³

§33 Veatch's Commentary on Pellegrino's *Reconstruction of Medical Morality*

Although Veatch has written about Pellegrino's philosophy of medicine on several occasions, it was not until 2006 that he published an essay that focuses specifically addresses Pellegrino's phenomenology of the clinical encounter. This essay, "Assessing Pellegrino's Reconstruction of Medical Morality," is a commentary on "Toward a Reconstruction of Medical Morality," the seminal essay in which Pellegrino first grounded the teleological structure of medicine in the phenomenology of the clinical encounter. Pellegrino originally published this essay in 1979. He published a briefer version in 1987, which was reprinted by the *American Journal of Bioethics* in 2006.⁵⁴ Veatch contributed

⁵³ Chapter 6 will show that a phenomenological approach to the clinical encounter calls upon physicians to look beyond the biomedical good and recognize that the practice of medicine aims at the good of the person who is ill. Often this can be achieved by optimizing bodily functions; at other times, something else is required. Veatch distrusts physicians because he thinks they are clueless about what this something else is. Pellegrino shows that good physicians are far from clueless: the key to discovering what healing requires is the patient's experience of illness.

⁵⁴ Edmund D. Pellegrino, "Toward a Reconstruction of Medical Morality," *American Journal of Bioethics* 6 (2006): 65-71.

the first of several commentaries published alongside Pellegrino's essay and I rely upon this commentary to set forth Veatch's objection to Pellegrino's teleology.⁵⁵

In four brief sentences, Veatch distills Pellegrino's description of being ill. Veatch writes:

[Pellegrino] says that illness, which he contrasts to "disease," changes one's "existential state." Our body is "no longer our ready instrument." Moreover, the ill person "has lost some of his freedom." He becomes "dependent," and therefore, "vulnerable."⁵⁶

Veatch here identifies (1) the difference between illness and disease, (2) the change in existential state, (3) the altered experience of the body, (4) the loss of freedom, (5) dependence, and (6) vulnerability, as the basic features highlighted by Pellegrino's phenomenological account of illness. I will now briefly discuss each feature in order to recapitulate Pellegrino's claim that medicine and medical ethics begins with the moral significance of illness. Then I will turn to Veatch's commentary and present his objections to Pellegrino's teleology.

(1) Pellegrino distinguishes illness from disease to emphasize what matters most: the patient's own experience. He or she is ill and in need of healing even when there is no disease; so the physician's obligation runs to the patient as a person, not to the patient as a body. Put differently, the physician who focuses on disease (or other disorders) can only offer technical assistance to the patient; consequently, his or her capacity to help the patient is limited: by the nosological categories used to identify diseases and by the

⁵⁵ Veatch, "Assessing Pellegrino's Reconstruction of Medical Morality," *American Journal of Bioethics* 6 (2006):72-5.

⁵⁶ Veatch, "Pellegrino's Reconstruction," 72. The quotations are from Pellegrino, "Reconstruction" (2006), 67.

availability of treatments that specifically target the disease. In short, the search for disease hides the person from view and tends to limit medical treatment to actions that cure diseases or ameliorate their symptoms. Good medical care, Pellegrino insists, requires a broader perspective: one that lets the patient speak for him- or herself and calls upon the physician to take in what the patient has to say about his or her experience of illness.

(2) The physician is not listening to the patient simply to identify symptoms.⁵⁷ The physician who cares for the patient as a person wants to find out how being ill has changed the patient's life. What kinds of disruptions has the patient suffered? Is he or she worried about further disruptions or threats thereof? Pellegrino refers to illness as an ontological assault because it is a blow that calls the being of the ill person into question. In this sense, illness is an existential crisis. We experience ourselves differently when we are ill. Moreover, we cannot know the extent to which we can (or whether we will) return to the life we enjoyed before the onset of illness. This encounter with limitation discloses our perishability. What I can do today, I may be unable to do tomorrow, and someday—

⁵⁷ Zaner also criticizes Pellegrino in this regard. He argues that Pellegrino's analysis of clinical judgment limits the meaning of the patient's talk as follows: in respect to diagnosis and the specification of possible treatments, the patient's talk is only a locational index for the physician's dialogue with the patient's body. Zaner, *Ethics and the Clinical Encounter*, 99-103. Zaner recognizes that, in respect to choosing a right and good healing action, Pellegrino fully appreciates the significance of the patient's talk. For the most part, Zaner focuses on Pellegrino, "The Anatomy of Clinical Judgments: Some Notes on Right Reason and Right Action," in *Clinical Judgment: A Critical Appraisal*, eds. H. Tristram Engelhardt, Jr. et al (Dordrecht: D. Reidel, 1979), 169-94. He cites Pellegrino and Thomasma, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethics of the Healing Professions* (New York: Oxford University Press, 1981) for the physician's dialogue with the patient's body. Pellegrino and Thomasma write: "Diagnosis not only compares scientific classes of disease to symptoms of the lived self but is also guided by the unique historical configuration presented by the lived body. It [diagnosis] must create a dialogue with this body to ascertain the nature of the disease" (112-3).

perhaps soon—I will be no more. Each experience of illness intimates such existential changes: they may be postponed or denied, but they cannot be eliminated.

(3) Illness is also experienced as an existential change because, when we are healthy, we experience ourselves as engaged in the world. In contrast, when we are ill, our body does not respond spontaneously to our desires and choices. It no longer functions as a “ready instrument” for fulfilling desires and attaining goals. Instead, it functions as an impediment that thwarts plans, rather than executing them. When we are healthy, the body stays in the background and permits one to focus on the targets of action but when we are ill, the body comes into the foreground and action becomes much more difficult. Put differently, the body is at the center of our existence but, for the most part, we don’t pay attention to it.⁵⁸ We experience the intertwining of self, body, and world without recognizing that the fluid correlation of self and world depends upon the dynamic integration of self and body. Consequently, when illness disturbs the integration of self and body, the correlation of self and world is no longer fluid: it is punctuated by

⁵⁸ See Drew Leder, *The Absent Body* (Chicago: The University of Chicago Press, 1990). Leder describes three ways in which the body disappears. *Focal* disappearance and *background* disappearance refer to the bodily surface, which disappears so that perception can go outward from the body into the world (11-35). If, for example, I am gazing at the Grand Canyon, my eyes are not part of the field of vision (focal disappearance) and I am not paying attention to the conversations of other tourists, various smells, the feel of the ground under my feet, etc. (background disappearance of non-focal sensory fields and the related organs of sensation). In contrast to the self-effacement of the perceptually active surface, the body disappears as the visceral depths recede from awareness. Leder refers to this inability to perceive visceral happenings as *depth* disappearance (36-68). Depth disappearance permits the organism to focus on its surroundings. Illness reverses the body’s tendency towards disappearance. When I am sick, I feel my insides, or the surface will not remain in the background: consequently, I am unable to stay focused on the world; I cannot do what I want to do and, frequently, I cannot do what I need to do. Leder speaks about this disruptive appearance of the body as *dys*-appearance (69-99).

interruptions, calls for concentrated effort, and may be difficult to sustain. In short, illness is experienced as an alienation of the body from the self and results in an alienation of the self from the world.

(4) It follows that illness involves a loss of freedom and a loss of independence. (5) The ill person may realize how much he or she takes for granted when healthy. In this sense, illness brings out the extent to which we depend upon our bodily agency. Illness also reveals our dependence upon others because we must rely on them to do things we can do for ourselves when we are healthy. In the clinical context, however, the ill person depends upon the physician to get better. In sum, illness reveals different levels of dependence: on our bodies, on our family, friends, neighbors, or co-workers, and on those who profess to heal. In addition, (6) illness makes us vulnerable at each of these levels because that which we depend upon may fail to meet our needs. This vulnerability becomes especially acute in the clinical encounter because the ill person places him- or herself in the care of strangers who promise to help, but these strangers may be more harmful than helpful.

In summary, the patient depends upon the physician for healing. Consequently, the patient makes him- or herself vulnerable to the physician. Not only must the patient trust this stranger, the patient must disclose and deliver him- or herself to this stranger. The foregoing makes clear why illness is the starting place for Pellegrino's philosophy of medicine. Illness gives rise to medicine and specifies its end; for the person who is ill has a need for healing to which both the practice of medicine and the person who practices medicine respond. The foregoing also makes clear why Pellegrino argues that the ethics

of medicine can be articulated by thinking about the fact of illness: for if one thinks about what it means to be ill, then one also recognizes the enormous responsibility undertaken by the person who declares that he or she is ready and able to help the ill become whole again. Since the physician's profession (or promise) to heal only makes sense in response to the patient's experience of illness, I want to return to Veatch's commentary on what Pellegrino says about being ill.

§34 Veatch on the Insignificance of Acute Illness

That Veatch faithfully recapitulates the starting point for Pellegrino's philosophy of medicine does not mean he thinks the fact of illness is relevant to the ethical questions that arise within the patient-physician relationship. On the contrary, he thinks illness is irrelevant to medical ethics.⁵⁹ He gets directly to the point. Picking up the four sentences quoted above, we can quote Veatch as follows:

[Pellegrino] says that illness, which he contrasts to "disease," changes one's existential state." Our body is "no longer our ready instrument." Moreover, the ill person "has lost some of his freedom." He becomes "dependent" and therefore "vulnerable."

This is a factual claim of substantial moral significance. But is it correct? It may have been the case that persons seeing physicians in an earlier era were sufficiently ill that they became dependent and lost their freedom. If it was ever true, it is not the case in the twenty-first century. Most patients seeing physicians today are not even ill. They see physicians for annual physicals, well-baby exams, mandatory consultations to obtain medicines they desire, immunizations, prostrate

⁵⁹ Other than his discussions of Pellegrino's work, I have found no text in which Veatch pays attention to the patient's experience of illness. This would seem strange for a philosopher who has devoted his career medical ethics were it not for the fact that few philosophers pay any attention to the experience of illness as they develop theories about medical ethics; the exceptions tend to be phenomenologists such as Richard Zaner or Kay Toombs.

exams, pap smears, and mammography. Medicine is increasingly a screening and preventive enterprise practiced on normal humans.⁶⁰

While preventative medicine has become more important (and there can be no doubt that the development of effective tests has made preventative medicine possible), Veatch writes as if physicians no longer treat persons who are ill. One might even get the impression that Veatch thinks illness no longer happens; but he must know that people still get sick. Accordingly, I interpret Veatch's objection to Pellegrino's description of the fact or predicament of illness as follows. If there ever was a time when illness made persons so dependent and vulnerable that they could not make decisions for themselves, that time is long past. The clinical encounter cannot be described as the meeting between dependent and vulnerable patients who cannot function as moral agents and physicians who must decide what is best for their incompetent patients. After all, preventive medicine involves examining competent persons who feel healthy to determine whether (a) they are diseased but asymptomatic or (b) they are in danger of becoming diseased. In such circumstances, patients have not lost any freedom and they are not dependent. They are, as Veatch puts it, "normal humans." Therefore, Pellegrino's description of illness does not have "substantial moral significance" in respect to this population of "patients" because they are not ill.

What about persons who are ill? Does Veatch think Pellegrino's description has any normative effect in respect to the meeting between the person who is ill and the person who professes to heal? Veatch rejects this possibility in two-steps. First, he dismisses

⁶⁰ Veatch, "Pellegrino's Reconstruction," 72.

acute illness as trivial. Then he focuses on chronic illness as if it were an entirely distinct phenomenon. About acute illness, he writes:

Among those who have some medical problem that motivates seeing a physician, most problems are not freedom-depriving. People see physicians for lacerations, urinary tract infections, pulled muscles, or broken bones. These are acute problems that may need professional attention but hardly change one's "existential state" or core identity.⁶¹

Veatch's examples suggest that acute illness do not involve significant existential changes. The general practitioner sets the broken bone, stitches up the laceration, or prescribes an antibiotic for the infection; consequently, patients do not feel limited by their injuries or illnesses because medical treatment is uncomplicated and effective. There is a technical solution for acute problems so patients are free to accept or reject the proffered treatment. Other acute problems do not require medical treatment: in time, the pulled muscle heals itself; or the flu lasts for a few days and is gone. This glib presentation rests upon several contestable assumptions: first, that persons do not feel limited by their ailment; second, that physiological interventions are always effective; and third, so long as the person is competent to make a treatment decision, the fact of illness imposes no particular obligation on the physician to help the patient make the decision.

Persons typically seek medical help because they feel limited by their ailment. Indeed, they are bothered by the limitation and they recognize that they need help to heal. Even if they do not, strictly speaking, *need* help to heal because the body heals itself, the fact that they come to the physician for help underscores the extent to which they feel vulnerable; they *want* help precisely because they feel vulnerable. This vulnerability

⁶¹ Ibid.

cannot be dismissed even when there is plenty of evidence that treatment will be effective; for the availability of treatment does not guarantee the result predicted by the physician and desired by the patient. Veatch fails to appreciate this vulnerability because he focuses on the question of whether the patient does or does not have the capacity to make a decision. However, the sense of loss and vulnerability that frequently comes with being ill is independent of the question of capacity. Put differently, Pellegrino does not presuppose that patients are too impaired by illness to make decisions. On the contrary, he pays attention to the predicament of illness that makes a person a patient because this transformation gives rise to the practice of medicine and defines the physician's obligation as a healer. The core of this transformation can be expressed quite simply. Illness or injury makes us uncertain. We do not know what is wrong, what can be done, or what should be done; furthermore, we need help to answer these questions. Veatch tries to deny this dimension of acute illness by providing examples in which these questions are immediately and easily answered. That's why I called his presentation of acute illness and injury glib.

§35 Veatch on the Significance of Chronic Illness

Veatch's discussion of chronic illness is equally flawed, but the flaw is different. In the case of acute ailments, Veatch presupposes the physician's knowledge and skill but he does not recognize the patient's vulnerability and dependence. Consequently, he ignores the fact that the patient's suffering obligates the physician to use that knowledge

and skill in particular ways. In respect to chronic illness, Veatch focuses on the issue of knowledge.

More typically today, the modal, archetypical disease is a chronic condition—high blood pressure, heart disease, early-stage cancer, or kidney disease. Chronic disease has produced a fascinating change in the patient-physician relationship. It is the nature of chronic disease that it progresses slowly. While early stages may be cause for concern or even alarm, they are not debilitating in ways that make the patient dependent. They do not cause loss of freedom. In fact, patients diagnosed with chronic disease regularly are well enough to study and master the details of their condition and its treatment options. They can actively learn and take responsibility for choices that will need to be made over the course of months or years. It is common place that for many chronic diseases the patient may know the condition as well as the general practitioner.⁶²

Veatch's claims about persons with chronic illness raise an important question: if they "are well enough to study and master the details of their condition and its treatment options" and "it is common place that . . . the patient may know the condition as well as the general practitioner," why does the person with a chronic illness go to the doctor? The answer is that chronic illness poses the same questions as acute illness. What is wrong? What can be done? What should be done? Whether the illness is acute or chronic, the person becomes a patient for the same reason: he or she experiences a change in his or her condition that disrupts his or her life. The body does not stay in the background so the person can be engaged in the world as he or she sees fit. Instead, it comes into the foreground, demands attention, and, in this way, becomes an obstacle. The person no longer experiences him- or herself as healthy, but as ill.

Veatch might argue that this response overlooks the difference between chronic and acute illness. In respect to chronic illness, patients and physicians are not distinguished in

⁶² Veatch, "Pellegrino's Reconstruction," 72.

terms of knowledge or skill because chronic illness gives the patient time to become an expert in his or her condition. Nevertheless, the patient needs the physician because the latter is licensed to provide treatment. Does this mean that the patient with a chronic illness can tell the doctor what should be done? I believe Veatch would answer affirmatively because, as he interprets it, chronic illness more clearly exemplifies the principal-agent model of the patient-physician relationship that Veatch advocates. Put differently, people with chronic illness do not need doctors for the same reason that people with acute ailments do need them.⁶³ In general, physicians but not patients have the knowledge and skill to resolve acute health problems. Physicians can explain the problem and describe what can be done about it; then patients can decide what should be done. In contrast, persons with chronic illness initially need physicians to make a diagnosis and to describe what can be done, but, in time, they will not need physicians to understand their condition or possible treatments. Instead, patients will need physicians to implement the treatment plans they (the patients) have chosen. In cases of chronic illness, the patient is the principal and the physician is the agent. According to Veatch, this is how it should be: his presentation of chronic illness provides a paradigm for the new medicine that puts the patient in charge.⁶⁴

⁶³ If it is true that persons with chronic illness do not need physicians after they have learned enough to manage their malady, then it would also be true that persons with acute illness do not need physicians if they happen to know enough to manage their acute health problem. Then physicians would only be necessary for those who don't know how to take care of their own health problems; but isn't this just about every ill or injured person?

⁶⁴ If Veatch's assumptions about chronic illness were true, then physicians could be able to take care of themselves without any difficulty. As the literature on physicians who treat themselves shows, they do so poorly. Hence the witticism: "the doctor who treats himself has a fool for a patient" to which it is sometimes added, "and a fool for a doctor." Robert

The flaw in Veatch's analysis becomes clear if we consider his observation about the onset of chronic illness: the "early stages may be cause for concern or even alarm." Surprisingly, Veatch does not pause to consider the meaning of this remark. Apparently, he thinks the concern or alarm is trivial and requires no elaboration, even though it supports Pellegrino's position, which is the subject of his essay. I will return to this point later;⁶⁵ for the moment, I want to consider the context of Veatch's remark:

It is the nature of chronic disease that it progresses slowly. While early stages may be cause for concern or even alarm, they are not debilitating in ways that make the patient dependent. They do not cause loss of freedom. In fact, patients diagnosed with chronic disease regularly are well enough to study and master the details of their condition and its treatment options.

Apparently, Veatch thinks the concern or alarm is a temporary phenomenon. It is part of what might be called an adjustment period, during which the person "can actively learn" about his or her condition. Ultimately, he or she will be able "to take responsibility for choices that will need to be made over the course of months or years." In other words, the adjustment period may be difficult but the condition will neither undermine the patient's agency nor make the patient dependent on the physician. In this limited sense, chronic illness does not cause a loss of freedom. Once more, we see Veatch's narrow focus. So long as the patient can make his or her own decisions, then the clinical encounter can

A. Hahn, *Sickness and Healing: An Anthropological Perspective* (New Haven: Yale University Press, 1995), 236. Hahn's survey of several autobiographical narratives of illness written by physicians shows more than how physicians respond to being ill and being patients, it illuminates what it means to be a patient and to be a physician. (234-61)

⁶⁵ See the section "Toombs on Chronic Illness" in chapter 6.

function as it ought: without patients being vulnerable or dependent and with physicians acting as patient assistants.⁶⁶

Veatch distinguishes chronic from acute illness by stressing the equality of physicians and patients. While this distinction serves his theoretical purposes, it overlooks two important changes that make acute ailments seem unproblematic. First, public sanitation and personal hygiene have drastically reduced the conditions for the development and spread of infectious diseases. Second, thanks to the biomedical model, many effective medical treatments (including preventative measures such as vaccines) are now available; so patients regularly expect to be cured. Injuries that used to result in fatal infections are routinely treated and patients now recover; diseases that used to spread across entire populations, killing or disabling many persons, can be cured and some have been eradicated. Consequently, Veatch can ignore acute ailments as non-threatening, temporary problems, effectively resolved by biomedicine.

In contrast, Veatch presents chronic conditions as the ethically significant instances of illness. However, as I read Veatch, the significance of chronic illness derives from the fact that, generally speaking, chronic illnesses are health problems that cannot be treated effectively.⁶⁷ A curious consequence follows from this presentation of the difference between acute and chronic conditions. Since physicians have the knowledge and power to

⁶⁶ Veatch, "Doctor Does Not Know Best," 718-20. In "The Birth of Bioethics," Veatch insists that the professional decisions physicians make are "necessarily secondary to the choices made by patients and family" (350).

⁶⁷ Drugs or surgery may ameliorate some (even many or all) of the symptoms, but they do not function as cures. It would be worthwhile to distinguish treatments that cure a condition from treatments that ameliorate (or eliminate) symptoms. If a meaningful distinction can be made, would it tell us anything about the difference between health, illness, and disease?

help acutely ill persons, acute conditions are not ethically interesting; and since physicians do not have the power to treat chronic conditions, their actions on behalf of patients are not ethically significant (except as threats). Therefore, the ethical significance of illness tells us two important things about physicians. First, they should confine their activity to the technical execution of their craft and, second, they should execute their craft at the direction of their patients. When the medical power to cure exists, the patient can choose an effective treatment (or decide to forgo treatment) as he or she sees fit. Obviously, such action is helpful, but the patient, not the physician, determines whether it is or is not helpful. When cure is not possible, the medical power to help the patient is quite limited, so the physician's expertise does not promise any special benefits that the patient cannot figure out how to secure for him- or herself.⁶⁸

Veatch's analysis of chronic illness is flawed because it overlooks what should be obvious. What causes concern or even alarm in the early stages of a chronic condition is, I submit, more than the way in which the body claims attention and disrupts the patterns of daily life. It is the realization that the source of the disruptions cannot be eliminated: the person will be ill for the rest of his or her life.⁶⁹ This means that being healthy—in the sense of being fit to do what one wishes—will require accommodating oneself to being ill. In other words, chronic illness involves the morally significant features of being ill that

⁶⁸ On this point, the alternative Veatch proposes to prescription writing is quite relevant. Instead of writing prescriptions, physicians would certify the patient's diagnosis and the patient's competence to select the pharmaceutical product that the patient thinks would be best. Obviously, this model of certification could be extended so that the patient could obtain medical devices or other modalities that address his or her chronic condition. See *PHT*, 126-33.

⁶⁹ Kay Toombs makes this point when she recalls the moment of her own diagnosis. Toombs, "Sufficient unto the Day," 4. See §40 below.

Pellegrino identified: the experience of an existential change characterized by an altered experience of the body, the loss of freedom, increased dependence, and a sense of personal vulnerability. That acute illness may not be accompanied by such an experience when it is treated promptly and effectively does not mean that medical ethics should be informed by the difference between chronic and acute illnesses. After all, the acutely ill suffer similar transformations and confront similar questions, especially when the illness is serious or life-threatening. In both cases, the patient's experience is what matters. How has his or her life been affected by illness? What can be done to help him or her recover the sense of wholeness enjoyed prior to the onset of illness? What should be done?

§36 Veatch Ignores the Moral Significance of Illness

As seen above, Veatch identified six features when he summarized Pellegrino's position on illness. Five of them are specific to the experience of illness: the change in existential state; the altered experience of the body; the loss of freedom; dependence; and vulnerability.⁷⁰ In his commentary, Veatch focuses on the last three: freedom, dependence, and vulnerability. Since these features have the most impact on the exercise of agency in the clinical encounter, it is not surprising that Veatch privileges them over the first two, even though the change in existential state and the altered experience of the body are more closely associated with how illness is originally registered by the person who is ill. Put differently, Veatch discounts the fact that illness is felt as a bodily event that changes how one lives, whereas he emphasizes freedom, dependence, and vulnerability

⁷⁰ The sixth feature was the first one listed by Veatch: that illness differs from disease.

because they are relevant to his concept of agency. This shift in emphasis—away from the personal experience of illness to the narrow question of decisionmaking capacity—causes Veatch to overlook what Pellegrino means when he identifies loss of freedom, dependence, and vulnerability. Consider Veatch’s concluding comments on Pellegrino’s articulation of being ill.

Pellegrino’s formulation emphasizing dependence and loss of freedom is strangely inconsistent with his general affirmation of the maturity and responsibility of the patient. He repeatedly affirms that it is the patient’s interests and values that must provide the basis for decisionmaking. . . . These notions of maturity, responsibility, and moral agency are strangely inconsistent with the claim that patients suffer from illness that renders them dependent and reduced in freedom. Only by recognizing the inappropriateness of the vulnerability and dependence themes and affirming that these claims are factually incorrect for almost all interactions between doctors and lay decision-makers can the way be cleared for the relationship that Pellegrino espouses: one of “two individuals [who] interact as moral agents.”⁷¹

When Veatch says that Pellegrino’s claims about vulnerability and dependence are factually incorrect or *false*, he seems to deny the vulnerability and dependence that comes along with being ill. I find it very difficult to believe that Veatch means persons who are ill are not dependent on anyone (family, friends, co-workers, acquaintances, or non-professional strangers) or anything (over-the-counter remedies and medications, pharmaceutical products, medical devices, etc.); such a claim is too ridiculous to credit. Nevertheless, it is clear that Veatch overlooks this sense of dependence and it is possible that he intends to deny it. Additionally, he overlooks an important sense of vulnerability that comes with being ill: sick persons are vulnerable because the many persons and things they depend upon may fail to meet their needs. In this context, Veatch also overlooks the

⁷¹ Veatch, “Pellegrino’s Reconstruction,” 73. The quote is from Pellegrino, “Reconstruction” (2006), 65.

ways in which patients must depend upon their physicians, not to mention the other health professionals, staff persons, employees, managers, executives, and regulators throughout the medical “industry,” as well as the complexly layered, globally scattered, arrangement of persons, things, and processes that produces the medical armamentarium itself.⁷² In sum, Veatch ignores the fact that patients depend upon a vast network whenever they consult with their physician. Consequently, patients are quite vulnerable when they seek medical help. Veatch also ignores the vulnerability that comes with dependence.

It is especially shocking that Veatch would deny this vulnerability when he insists that physicians cannot be trusted to know what is good for their patients. After all, trust is important because one is vulnerable. In particular, the actions of physicians who do not know what is good for their patients are likely to be harmful rather than helpful. Clearly, this means patients are vulnerable in the clinical encounter. Were Veatch to deny this proposition as *factually incorrect*, then his work in medical ethics would be nonsensical. Why then does Veatch say patients are neither dependent nor vulnerable in their meetings with physicians? The answer to this question appears in the passage that precedes the one

⁷² As Richard Zaner points out in “The Phenomenon of Trust,” the clinical encounter involves unavoidable trust:

Patients must trust not only physicians, but a host of other people as well, such as nurses, lab technicians, researchers, administrative personnel, manufacturers. They also have no choice but to trust a great many things: the material used to repair bodily parts, bandages, drugs, surgical equipment, and the like. They also have to trust numerous procedures: sterilization, the administration of anesthetics, surgical techniques, referrals, the preparation of drugs, and so on (49).

See also Zaner, “A Meditation on Vulnerability and Power,” in *Health and Human Flourishing: Religion, Medicine, and Moral Anthropology*, eds. Carol R. Taylor and Roberto Dell’Oro (Washington, DC: Georgetown University Press, 2006), 146.

I just quoted, in which Veatch discusses the relationship between doctors and surrogate decisionmakers:

The small child, the senile, and the seriously impaired person who is incompetent either prior to or because of serious illness is not the lay participant in the lay professional relationship that requires freedom and independence; the surrogate is. Granted that some surrogates may find themselves distraught by their loved one's medical condition, . . . [no right-thinking person] would want to label them "ill." Only in the most rare circumstances must a doctor interact with a lay person who is simultaneously the decision-maker and vulnerable to the point of dependence and loss of freedom.⁷³

In my view, Veatch must talking about individuals who are physically or mentally vulnerable in the sense that their decisionmaking capacity might be lost; in that precarious condition, it is not clear whether they can understand the salient facts and evaluate them in a reasonable manner. In short, I conclude that he is talking about borderline cases: instances in which reasonable persons could disagree about whether the decisionmaker is sufficiently healthy, both physically and mentally, to make decisions competently. Not only must such cases be rare, as Veatch points out, they must be cases of patients who are vulnerable in the sense of becoming (or being) incompetent. This sense of vulnerability clarifies what Veatch means when he refers to loss of freedom and dependence. Loss of freedom would be the loss of decisionmaking capacity. Dependence would be the inability to understand the situation, assess it reasonably, and communicate one's own decision: then one would have to depend on others to make decisions. The following passage, which concludes Veatch's comments of Pellegrino's thesis about the fact of illness, confirms this interpretation.

⁷³ Veatch, "Pellegrino's Reconstruction," 72-3.

Fortunately, in twenty-first century medicine almost all professional encounters with lay decisionmakers involve substantially autonomous and mature decisionmakers, whether they be seeing the physicians as healthy patients, as those with isolated acute conditions that do not challenge one's identity, as patients with chronic conditions that leave one intellectually and emotionally stable enough to be a full participant in the interaction, or as healthy, competent surrogates for the obviously incompetent.⁷⁴

As this statement makes clear, Veatch ignores the features of illness Pellegrino identifies or he regards Pellegrino's articulation of these features as irrelevant. Instead, Veatch focuses on a single question: does the patient have decisionmaking capacity? If so, then, with the rare exception noted above, the patient is neither vulnerable nor dependent in any sense that seems significant to Veatch. In this respect, Veatch represents the starting place of many philosophers in the United States who address the ethical questions that arise in the practice of medicine. The clinical encounter is seen as a source of conflict and/or abuse. In turn, the philosophical task is to develop a theory or method for dealing with this conflict. Given this task, it is reasonable to focus narrowly on questions about the patient as a moral agent in a medical setting. What are his or her interests and values? Is it reasonable or permissible to pursue these interests, or act on these values, in any medical setting? What about this particular medical setting? With this physician in particular? These questions can be answered without thinking through the meaning of illness, perhaps even without thinking through the meaning of medicine. The task is either to find an accommodation between competing sets of interests and values, or to determine a hierarchy of interests and values.

⁷⁴ Ibid., 73.

§37 Summary

As we have seen, Veatch establishes a simple hierarchy within the clinical encounter: so long as the patient's interests and values are socially sanctioned, they trump those of the physician.⁷⁵ Framed in this way, Veatch expresses a position shared by many persons, including many bioethicists.⁷⁶ Some would also agree with Veatch's claim that treatment decisions should be made by patients, not physicians. However, even those who disagree with Veatch and defend some version of shared decisionmaking would generally agree with Veatch's basic rule that autonomy trumps beneficence. Ruth Faden and Tom Beauchamp, two leading bioethicists, put the point as follows.

The language of rights is the language of valid entitlement—a demand by some upon the conduct of others.

This emphasis is the new kid on the block in medical ethics. Its tone and connotation carry a message, usually reserved for law, that has never before been a part of physicians' thinking about patients. When turned in the direction of

⁷⁵ However, Veatch makes an exception for physicians who cannot serve a patient's interests without violating their moral integrity. In addition, it seems reasonable to infer from his proposal for deep value pairing that Veatch exempts health care institutions from providing services that would contradict the deep values they affirm as an institution. Presumably, this would require public hospitals and clinics to provide all socially sanctioned treatments. I assume this obligation would fall upon each and every professional within the public institution. Veatch does not address the question of whether public clinics or hospitals, and their professional staffs, must provide all legal medical treatments.

⁷⁶ For example, Rosamond Rhodes, who is otherwise sympathetic to Pellegrino's position, specifically objects to his assertion that a physician can refuse, on the basis of personal moral commitments, to fulfill a patient's request or desire for a legal treatment that is socially sanctioned or medically indicated for persons in the patient's condition or situation. According to Rhodes, such a refusal privileges the physician's personal beliefs over those of the patient and, consequently, violates the physician's obligation to rank the patient's personal interests above his or her own personal interest. Rhodes, "The Ethical Standard of Care," *American Journal of Bioethics* 6 (2006): 77. Rhodes and Veatch also disagree on this point.

medical decisionmaking, it literally invites the replacement of the beneficence model with the autonomy model.⁷⁷

The language of rights and entitlement can easily be squared with the new medicine

Veatch advocates in *Patient, Heal Thyself!*

It is a medicine that had its beginnings in the exciting days of the 1970s when patients first began demanding their right to make medical choices based on their own values. It is a medicine now irreversibly launched as the replacement for what is now old-fashioned modern medicine. It is a medicine that is radically different from modern medicine in the role the layperson must play in medical decisionmaking.⁷⁸

Veatch goes further than most in his assertion of patient autonomy, but there is widespread agreement that the beneficence model of professional ethics must be rooted out by the assertion of patient autonomy. Indeed, I think that the “old-fashioned modern medicine” to which Veatch refers, and has devoted his career to overthrowing, is the most recent version of the professional practice that, according to Faden and Beauchamp, provided “no place for informed consent within its domain. As long as the beneficence model remained the unchallenged model for medical ethics . . . physicians were able to rely almost exclusively on their own judgment in the medical management of their patients.”⁷⁹ Here is the common ground between Veatch and other leading bioethicists: in the clinical encounter, beneficence and paternalism involve the same unjustified assertion of professional power; only the assertion of patient autonomy can correct this violation of the patient’s basic rights.

⁷⁷ Ruth L. Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986), 94-5. This passage was brought to my attention by Richard Zaner who refers to it in “Trust and Patient-Physician Relationship,” *Ethics, Trust, and the Professions*, 56.

⁷⁸ *PHT*, ix.

⁷⁹ Faden and Beauchamp, *Informed Consent*, 101.

In contrast, Pellegrino's reconstruction of medical morality advances a theory of beneficence; so it opposes mainstream bioethics. Moreover, Pellegrino's attempt to ground his theory in the teleological structure of medicine makes his approach seem especially old-fashioned and, consequently, even more alien when compared to mainstream bioethics, with its focus on the clinical encounter as an arena for conflict. Pellegrino does not begin with conflict because he thinks of the clinical encounter differently. It is not primarily a forum for conflict, but rather a meeting between two persons who share the same end: patients and physicians come together for the sake of healing. This end, healing, is specified by and specific to the patient's experience of illness. Moreover, patients and physicians deliberate when they meet because, on the one hand, patients want to know what is wrong, what can be done, and what should be done and, on the other hand, physicians help patients answer these urgent questions. This is how physicians take care of their patients: by caring for them.⁸⁰ Clearly, the fact of illness is the key to Pellegrino's theory. In the following chapter, I will defend Pellegrino's account of being ill against the objections leveled by Veatch.

⁸⁰ This restatement of Francis Peabody's insight comes from Richard Zaner, whose attention to trust in the clinical encounter begins with the patient who must trust, rather than with the physician who ought to be trustworthy. See "Trust and the Patient-Physician Relationship," 45-63. See also Zaner, "Physicians and Patients in Relation: Clinical Interpretation and Dialogues of Trust" in *Handbook of Bioethics: Taking Stock of the Field from a Philosophical Perspective*, ed. George Khushf (Dordrecht: Kluwer Academic Publishers, 2004), 223-50.

Chapter 6

Response to Veatch

§38 The Question of Trust

This chapter begins and ends with a discussion of trust because Veatch's dispute with Pellegrino comes down to the question of trust. Veatch objects to the teleological structure of medicine because it presupposes that physicians can be trusted. Veatch thinks this presupposition is a mistake: physicians, he claims, cannot be trusted. Therefore, Veatch presents what Pellegrino calls an "ethics of distrust."¹ As will be seen below, Veatch's argument that physicians cannot be trusted to benefit their patients cannot be separated from his argument that the experience of illness has no significance for medical ethics. In contrast, Pellegrino's ethics of trust cannot be separated from his teleological phenomenology of the clinical encounter.

In chapter 5, we saw that Veatch rejects Pellegrino's position on the grounds that the fact of illness does not involve dependence, vulnerability, or an ethically significant loss of freedom. This claim is so outlandish in its denial of what should be obvious that it might seem best to ignore Veatch. However, Veatch should be taken seriously because he has always been motivated by the conviction that the medical profession has not served the patient well. Consequently, he challenges the claim that patients can trust their physicians. In sum, it is important to respond to Veatch because he raises the most troubling question that can be raised about the clinical encounter: Can patients trust their physicians?

¹ Pellegrino uses this expression throughout his essay in *ET&P*. See "Trust and Distrust."

This question presents a fundamental challenge to the teleological thesis advanced by Pellegrino, for if Veatch is right and patients cannot trust competent and beneficent physicians, then Pellegrino is wrong when he claims that the nature of medicine directs physicians to the specific goods that their patients hope to realize. According to Veatch, physicians must be directed to these goods in one of two ways: either by patients who relate to their physicians as principals relate to agents, or when patients and physicians are paired according to their deep values. As we have seen, Pellegrino's teleological account of medicine provides an alternative that calls upon patients and physicians to deliberate together. However, the trust necessary for mutual deliberation is only warranted if physicians understand themselves as healers. This shift in attention is crucial because the work of healing cannot be completed without an understanding of the person who needs to be healed. Put differently, physicians who understand themselves as healers know that they must respond to their patient's experience of illness and, in this way, physicians are directed to their patients' sense of what healing means. Therefore, it is as healers that physicians appreciate the goods their patients hope to realize through medical treatment.

Pellegrino's teleology also suggests an alternative explanation of why patients cannot trust their physicians. The work of healing has been obscured by several overlapping influences. The scientific paradigm of biomedicine, the specialization of biomedical care, and the technologies designed to deliver biomedical care focus on the following objects that are treated as universals in abstraction from the personal lives of the patients: disease, physiological processes, or anatomical structures. The upshot of this

abstraction is that the concrete particulars of the patient's personal life fade into the background and, from the physician's perspective, they may disappear entirely.

Obviously, these particulars do not escape the patient's attention; indeed, patients often focus on little else.² Veatch's discussion of the patient-physician relationship assumes this incongruence. An unstated premise of his position seems to be that physicians are uninterested in what interests their patients. However, Veatch does not say this indifference makes them bad or inadequate as physicians. Instead, he infers ignorance from indifference and argues that the physician's ignorance constitutes a limit on professional competence that cannot be overcome.³

Trust and professional discretion

According to Veatch, patients cannot trust their physicians because physicians cannot know what is good for their patients. If this is true, then physicians cannot competently advise their patients. Thus Veatch's objections to Pellegrino's teleology cannot be separated from his ethics of distrust. Indeed, the proposals he makes for the practice of medicine, both the principal-agent model of the patient-physician relationship and deep value pairing, are expressions of distrust.

² A qualification is necessary: patients also focus on their bodies, which demand attention and keep patients from attending to the details of their lives. In contrast, physicians frequently focus on the patient's body as if it were not involved in those details. The contrast between the two perspectives could hardly be presented in a more striking manner.

³ The inference of ignorance from indifference is reasonable when it comes to practical questions, but Veatch is making a theoretical argument that the limits of professional competence are grounded in the physician's incapacity to know the patient's good. This incapacity cannot be inferred from the physician's indifference.

The principal-agent model severely restricts (and might even eliminate) the professional discretion exercised by physicians. As we have seen, there are several reasons why Veatch thinks this assertion of autonomy is necessary: first and foremost, physicians cannot be trusted to know what is good for their patients; second, even if they happen to know what is good for their patients, they cannot be trusted to respect the autonomy of their patients; and third, physicians tend to violate their patient's autonomy when they mistakenly believe they know what is good for their patients. In the end, beneficent physicians present the greatest danger to patients because they are most likely to substitute their judgment for the judgment of their patients.

Nevertheless, the principal-agent model cannot resolve the problem of trust. Since the patient depends upon the physician to determine what is wrong and what can be done, the principal-agent model cannot eliminate the patient's need to trust the physician. Although the problem of trust is now specifically limited to the twofold task of making a diagnosis and listing possible treatments, Veatch thinks that the physician cannot be trusted to provide a complete and undistorted account to the patient; for every account is necessarily shaped by the physician's own convictions as a moral agent and by his or her commitments as a professional.⁴ Moreover, the patient is generally not in a position to

⁴ Veatch provides the following example of how the physician's personal beliefs shape the presentation to the patient: "The obstetrician who believes abortion is murder probably should not be trusted to present the option of amniocentesis and abortion for women with a marginal risk of an afflicted fetus." "Is Trust of Professionals a Coherent Concept?," 164. According to Veatch, the more pernicious bias concerns statements about medically indicated treatments or best practices. See *PHT*, 71-88. Veatch summarizes his skepticism about the objectivity of clinical judgments in "How Philosophy of Medicine has Changed Medical Ethics," where he writes:

judge the account's accuracy or completeness.⁵ Veatch proposes deep value pairing to deal with this set of problems: then the distortions or omissions that occur are most likely to be consistent with the patient's own interests and values.

Finally, one might argue that the virtuous physician is trustworthy. If so, the best way to deal with the question of trust is to focus on the way physicians form their character as professionals. Veatch rejects this solution for the same reason he proposes deep value pairing.

Even though there are different virtues for different roles, it is not that the virtues are inherent in that role, independent of any underlying foundational ethical system. Rather, there may be as many different conceptions of the virtues of a particular profession as there are underlying foundational systems capable of generating a conceptualization of the professional role in question. . . . The Talmudic physician's role may have so little to do with the feminist physician's role that they are essentially different professional roles. There is no ideal type role of the professional physician abstracted from the Talmudic or feminist or Hippocratic or Christian conception of physicianing [sic]. . . . Rather, each [ideal role model] grows out of the underlying system of belief and value that generates it.⁶

According to Veatch, there is a multiplicity of medicines; so there is no single set of virtues that makes a physician trustworthy. Instead, there are multiple sets of virtues and each is correlated to a specific moral system.

even panels of the most expert scientists given a mandate to formulate consensus accounts of the best possible summaries of the relevant medical facts in a particular sphere should be expected to incorporate conceptual and evaluative commitments that different panelists, equally competent and equally committed to avoiding bias, would not be expected to incorporate. Even consensus estimates of facts formulated by the world's best scientists will incorporate idiosyncratic conceptual and evaluative commitments. (596)

⁵ Some patients will be able to make an assessment, but whether most chronically ill patients will be able to do so, as Veatch supposes, is far from clear.

⁶ Veatch, "Is Trust of Professionals a Coherent Concept?," 167-8.

If Veatch is correct, the consequences for medical ethics in a pluralist society are extreme. Although trust seems to be an essential ingredient of the patient-physician relationship, distrust is appropriate:

It is a mistake to assume that professionals can be trusted to know the best interests of their clients, to present facts and options to them objectively, or to manifest virtues inherent in professional roles. This does not imply that professionals are “untrustworthy” in the sense that they are lacking in dedication, integrity, or good character. It does not even imply that they are self-serving or conflicted by the demands to serve the interests of those other than their clients. Even if the professional is impeccably committed to the client, still, in theory, the professional ought not be able to know the client’s interest, ought not be able to present the relevant facts in a value-free manner, and ought not be expected to manifest some set of virtues inherent in the professional role.⁷

Veatch’s ethics of distrust might seem reasonable given the widespread distrust of the medical profession and the healthcare system more generally.⁸ However, he does not

⁷ Ibid., 168-9.

⁸ Tom Beauchamp and James Childress observe that “trust is a fading ideal in contemporary health care institutions . . . as is evidenced by the dramatic rise in medical malpractice suits and adversarial relations between health care professionals and the public.” *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001), 35. That Veatch’s career as a bioethicist expresses this adversarial spirit should come as no surprise since he has focused on controversies surrounding death and dying from the time he joined the Hastings Center, even before his involvement in the Karen Ann Quinlan case. Beauchamp and Childress also note that “[o]vert distrust has been engendered by mechanisms of managed care . . . and by the incentives some health organizations create for physicians to limit the amount and kinds of care they provide to patients” (35). Consequently, “[t]alk has increased of the need for ombudsmen, patient advocates, legally binding “directives” to physicians and the like” (35). Such responses, in Pellegrino’s view, are features of the ethics of distrust. Pellegrino would surely agree with the assessment of Beauchamp and Childress, especially when they make the following observation: “Among the contributing causes of the erosion of trust are the loss of intimate contact between physicians and patients, the increased use of specialists, and the growth of large, impersonal, and bureaucratic medical institutions” (35). Beauchamp and Childress cite the work of David Mechanic for this final point. Mechanic, “Public Trust and Initiatives for New Health Care Partnerships,” *Milbank Quarterly* 76 (1998): 281-302 and “Changing Medical Organization and the Erosion of Trust,” *Milbank Quarterly* 74 (1996): 171-89. Veatch gives a different account for the distrust of physicians: in a pluralist

propose the principal-agent model to establish the conditions for trust. Instead, Veatch assumes that such conditions cannot be established in a pluralist society unless patients and physicians are paired according to their deep values; such pairing allows this patient to trust this physician, but the cost is very high.

Deep value pairing would destroy public trust in the medical profession as a whole for reasons that Robert Sokolowski makes clear by in his essay, “The Fiduciary Relationship and the Nature of the Professions.”⁹ Sokolowski explains that

the professional is presented as trustworthy not primarily in the way a friend is found to be faithful, by having proved himself or herself in many situations, but by being certified as a professional. There is an elegant anonymity to professional trustworthiness; if I get sick away from home and must go the emergency room of a hospital, I can in principle trust doctors and nurses I have never met before. I enter into a fiduciary relationship with them because they are presented as members of the medical *profession*, persons who are certified by the profession and who can, *prima facie*, be taken as willing to abide by its norms. I do not have exactly the same kind of trust if my car breaks down somewhere away from home; I am delivered over rather to the personal honesty, trustworthiness, and competence of the local mechanic. It is as though I had to find a temporary friend rather than being able to appeal to a professional.¹⁰

If physicians, certified as competent by the profession, practice different kinds of medicine when they have different moral convictions, then the profession of medicine would have no inherent meaning because it could not *anonymously* establish the trustworthiness of any professional. A person could not know whether the physician-

society, the commitments of physicians, both as professionals and as persons, create insurmountable obstacles to a shared understanding.

⁹ Robert Sokolowski, “The Fiduciary Relationship and the Nature of Professions,” in *ET&P*, 23-39. As I interpret Veatch, he would not recognize this cost because he thinks it is irrational and harmful for the public to trust the medical profession. If I am correct, then Veatch has vitiated his triple contract theory of medical ethics because the terms of the contract between society and the medical profession cannot be determined when it is irrational to trust the profession as a whole.

¹⁰ *Ibid.*, 31.

stranger from whom he or she seeks medical help could be trusted until the physician *confessed* his or her moral orientation. Veatch seems to recognize this strange requirement for professional trustworthiness when he writes that “[t]rust requires . . . a commitment to the client, a confession of inability to present value-free facts, and an acknowledgement of which underlying belief system generates the set of virtues and the role conception under which the professional is operating.”¹¹

Several points need to be made in response to Veatch’s statement about what trust requires. First and foremost, these requirements would be especially difficult to satisfy because most persons do not think through their moral beliefs in any systematic way so it would be virtually impossible for many physicians to articulate the belief system that shapes how they practice medicine.¹² Additionally, those physicians who could articulate their belief systems would likely be hard pressed to explain how those beliefs shaped their practice of medicine, especially since diagnosis and treatment are based on objectively determined standards established through controlled and repeated experiments in the

¹¹ Veatch, “Is Trust of Professionals a Coherent Concept?,” 169.

¹² But see Alisdair MacIntyre, “Patients as Agents,” in *Philosophical Medical Ethics: Its Nature and Significance*, eds. Stuart F. Spicker and H. Tristram Engelhardt, Jr. (Dordrecht: D. Reidel Publishing Company, 1977), 197-212. MacIntyre argues that patients cannot exercise their agency in respect to healthcare unless and until it is required of every practicing physician or surgeon and . . . every hospital or clinic that they publish the [moral] code held and practiced; and it would be necessary to enforce the practice of the published code. Patients would then be able to choose to whom they would entrust their medical care with a clear understanding of the moral stances of everyone involved. (211).

MacIntyre recognizes that this requirement imposes a serious burden but he points out that “what makes the problems of medical ethics unresolvable in our culture is the lack of any shared background of beliefs which could provide a context for moral reasoning by providing a view of human nature and society” (211). Presumably, he hopes that such public declarations, or *professions*, will establish communities for the practice of medicine.

laboratory or by methodologically rigorous clinical trials. In short, it is very difficult to explain how personal beliefs could shape the assessments of evidence-based medicine so significantly that the medicine practiced by a Marxist would not be the same as the medicine practiced by a libertarian. After all, the standards for good care, while established by the profession as a whole and thus shaped by particular values or interests, are based on empirical evidence and, consequently, these standards are subject to challenge on empirical grounds. In short, the inherently public nature of scientific inquiry and evidence limits the influence of private or personal beliefs.¹³

¹³ Nevertheless, Veatch could point out that how one practices medicine is shaped by the habits one develops over time and these habits have probably been shaped by one's personal beliefs; but this would bring us back to my primary point. Many physicians would be unable to articulate the beliefs that shape their habits as clinicians or, if they could articulate those beliefs, the connection between them and clinical habits would probably be obscure; or the beliefs and habits would be linked by an understanding of how science shapes (or disciplines) the practice of medicine. This does not mean that Veatch is wrong to suggest that personal beliefs shape how individuals practice medicine. There are undoubtedly differences that would play out at the margins of clinical practice, where reasonable person can disagree about what is or is not permissible (or appropriate or wise); of course, these are precisely the kinds of cases that generate controversy so they are especially interesting for philosophers who think their primary task is to limit or resolve conflict.

Examples of such cases would be the distribution of resources such as beds in the ICU, organs for transplantation, or physicians throughout the population. Clearly, in respect to such questions, Marxists and libertarians would give different answers; however, it is not clear that they would care for their individual patients differently. In other words, it is unlikely that the care they provided to their patients would be so different that Marxist medicine should be distinguished from libertarian medicine. However, in respect to controversial practices (such as abortion) or claims (such as futility), there may be some differences but here, too, these differences are not so great that one could distinguish kinds of medicine on the basis of such controversies. However, one could distinguish kinds of policies and insist upon a disclosure of how particular policies favor or exclude certain practices. As I understand it, this is what deep value pairing is supposed to do: match patients with physicians in practices that are known, by virtue of the moral orientation they declare, to favor or exclude certain practices. In this way, patients are likely to get the kind

Finally, if confessional professionalism is the only way to establish the trustworthiness of any physician in particular, standards of care cannot be legally enforced; for legal judgments are predicated upon a shared public understanding of what constitutes sound medical practice.¹⁴ This understanding is secured by the scientific foundation of biomedical practice and it is by appeal to this publicly secured evidentiary basis that courts can determine whether or not a particular practice meets the standard of care for medicine as such, not the standard of care for some particular kind of medicine: Marxist, libertarian, Baptist, etc.

Teleology in a pluralist context

As we have seen, Veatch and Pellegrino present radically different perspectives. Veatch understands the clinical encounter as a meeting between strangers in a pluralist society; so the patient-physician relationship appears to him as a forum for conflict. Since he sees the practice of medicine through the lens of conflict, his goal is to limit and to resolve conflict in the way that serves the interests and values of patients, as those interests and values are understood by the patient. He asserts patient autonomy to achieve this goal. Moreover, he views physician beneficence as a threat to patient autonomy because he thinks physicians cannot know what is good for their patients. Therefore, he condemns any assertion of professional beneficence as a form of paternalism. While he proposes

of treatment they want from physicians they do not know. Put differently, the anonymity of trustworthiness is secured by an institutional “confession.”

¹⁴ I owe this insight to Dr. Juergen Wallner of the Law Faculty at the University of Vienna, with whom I had many fruitful conversations while we were both Visiting Scholars at the Center for Clinical Bioethics at Georgetown University.

deep value pairing as an alternative, it has little bearing on the dispute between Pellegrino and Veatch because, for the most part, patients and physicians meet as strangers.

Pellegrino acknowledges that the typical clinical encounter is a meeting between strangers, but he does not accept Veatch's conclusion that the physician cannot know what is best for the patient because, unlike Veatch, Pellegrino sees the clinical encounter teleologically: the patient and the physician come together for the sake of healing and their encounter culminates in a right and good healing action. Consequently, Pellegrino does not see the clinical encounter as an arena for conflict. On the contrary, it is forum for answering the three questions raised by illness: What is wrong? What can be done? What should be done? As such, the clinical encounter calls for mutual deliberation. Furthermore, Pellegrino articulates the teleological structure of medicine in order to show that the profession of medicine requires patients and physicians to make shared decisions: then the clinical encounter functions as a healing relationship.

Ultimately, the opposition between Veatch and Pellegrino turns on the question of trust. Pellegrino thinks patients can trust their physicians; Veatch disagrees. It must be pointed out that this disagreement takes place at a theoretical level. The question is not whether there is a basis for trust in a particular encounter, but whether there is anything about the profession of medicine as such that functions to make physicians trustworthy. In answer to this question, Pellegrino points to the experience of illness. As illness threatens the integrity of body and self, it generates a need for healing; when the ill person acts on this need by seeking medical help, he or she becomes a patient. In this way, illness initiates the practice of medicine. Moreover, the patient needs a specific kind of help: he

or she wants to know what is wrong, what can be done, and what should be done. Not only do these questions structure the practice of medicine, they determine healing as the end of medicine: physicians and patients work together to renew (to the greatest extent possible) the sense of wholeness the patient enjoyed prior to becoming ill (or being injured). This teleological account of medicine calls upon physicians to learn from their patients because, as Veatch makes clear, physicians cannot know anything about the sense of wholeness their patients want to recover unless they ask their patients.¹⁵ Consequently, the experience of illness functions within the teleological structure of medicine to make physicians trustworthy. As we have seen in chapter 5, Veatch rejects Pellegrino's interpretation of illness: he simply denies that illness involves dependence, vulnerability, or a loss of freedom. In my view, Veatch reaches this surprising conclusion because his concern with conflict in the clinical encounter narrowly focuses his attention on patient autonomy. Given this perspective, the experience of illness cannot show up as a significant feature of the clinical encounter. What counts is whether patients have the capacity to make their own decisions.

¹⁵ That this common ground turns out to be the source of Veatch's disagreement with Pellegrino can be seen in the following statement by Veatch: "The only way physicians in the future will be able to approximate knowledge of what serves their patients' interest is to ask them." Veatch, "Doctor Does Not Know Best," *Journal of Medicine and Philosophy* 25 (2000): 708. Since Pellegrino does not think physicians are presently incapable of knowing what serves their patients' interests, Pellegrino would not use the future tense; nor would he speak of the physician approximating knowledge about the interests of patients.

§39 Toombs on the Experience of Illness

In this section and the next, I appeal to the phenomenological work of S. Kay Toombs to support Pellegrino's account of illness and to bring out the shortcomings in Veatch's position, especially the distinction he makes between acute and chronic conditions. Toombs focuses on the way illness is experienced by patients because, like Pellegrino, she thinks "the act of healing *requires* an understanding of illness-as-lived."¹⁶ But how, according to Toombs, is illness lived or experienced? Her answer supports Pellegrino's insight that the experience of illness (illness-as-lived) is the starting point for thinking about the meaning and the end of medicine.

Illness is fundamentally experienced as a global sense of disorder—a disorder which includes the disruption of the lived body (with the concurrent disturbance of self and world) and the changed relation between body and self (manifested through objectification and alienation from one's body).¹⁷

At the heart of Toombs' identification of illness as "a global sense of disorder" is the claim that the experiential unity of self and world is disrupted by the way illness alters the integration of body and self. Illness disrupts the person's engagement in the world precisely because it alters the integration of body and self that makes it possible to be engaged in the world.¹⁸ As illness threatens the experience of being well integrated, it also

¹⁶ Toombs, *The Meaning of Illness*, 90.

¹⁷ Ibid.

¹⁸ At the same time, corporeal integrity requires metabolic engagement in the world, as Hans Jonas makes clear. Jonas, "Is God a Mathematician? The Meaning of Metabolism," in *The Phenomenon of Life: Toward a Philosophical Biology* (New York: Harper & Row, 1966), 64-92. There is, of course, a difference between being engaged in the world as a plant, on the one hand, and being engaged as an animal, on the other hand. While both plants and animals are, for Jonas, individuals, animals exemplify what it means to be a self. Jonas, "Biological Foundations of Individuality," in *Philosophical Essays: From Ancient Creed to Technological Man* (Englewood Cliffs, Prentice-Hall, Inc., 1974), 185-205.

threatens the way of life the ill person has established (or hopes to establish) for him- or herself. Thus, as Toombs points out, the disorder brought about by illness affects the specific wholeness of a human agent: to be ill is to feel uncertain and out of control; but also restricted and estranged.¹⁹ Toombs demonstrates the merit of the phenomenological perspective on illness, and develops Pellegrino's insight, when she writes:

Further reflection on this global sense of disorder which *IS* the lived experience of illness in its qualitative immediacy, discloses that the lived experience exhibits a typical way of being—a way of being which incorporates such characteristics as a loss of wholeness, a loss of certainty, a loss of control, a loss of freedom to act, and a loss of the familiar world.²⁰

Toombs also notes that the body appears as an object to the person who is ill and, in a sense to be clarified, he or she feels alienated from his or her body. Toombs observes:

Illness is primarily experienced as a fundamental *loss of wholeness* . . . that manifests itself in several forms. Fundamentally, of course, this loss of wholeness manifests itself in the awareness of bodily disruption or impairment—an awareness that is not so much a simple recognition of specific symptoms (e.g. shortness of breath) as it is a profound sense of the loss of total bodily integrity. The body can no longer be taken for granted or ignored. It has seemingly assumed an opposing “will” of its own, beyond the control of the self. Rather than functioning effectively at the bidding of the self, the body-in-pain or the body-malfunctioning thwarts plans, impedes choices, renders actions impossible. Illness disrupts the fundamental unity between body and self.²¹

That illness is experienced as a loss of wholeness does not mean that the body and self are no longer integrated when we are ill. Indeed, illness demonstrates how thoroughly

¹⁹ This bears out Pellegrino's claim that illness threatens the generic human good of integrity: not only at the corporeal level, but also at the psychological and axiological levels.

²⁰ Toombs, *The Meaning of Illness*, 90. Toombs immediately adds the following remark to emphasize the difference between illness and disease: “Such characteristics are intrinsic elements of the illness experience regardless of its manifestation in terms of a particular disease state” (90).

²¹ Ibid.

intertwined body and self are, as Toombs knows well. “Bodily dysfunctions disclose the latent implications of embodiment, and reveal what it means to be embodied. While the sense of ‘otherness’ of body is by no means peculiar to illness, it is concretely felt in this experience.”²² The experience of illness is distinctive precisely because it alters the way we experience our bodies: “the fundamental unity of body and self” to which Toombs refers involves the tendency of the body to disappear as the self focuses on the targets of its desires and choices.²³ When we are ill, however, the body claims our attention and, by showing up, it keeps us from satisfying our desires and making our choices effective. In this way, the body shows up in opposition to the self, but not as a separate or separable entity. Toombs states: “My body appears as Other-than-me in that it opposes and frustrates my intentions; yet I *am* my body for I cannot escape my impaired embodiment.”²⁴

As Toombs develops this point, it becomes clear that illness alters how we experience the integration of body and self.

The corporeal nature of the malfunctioning body is rendered explicit in that the body becomes an oppositional force in illness. One may, for example, concretely experience the heaviness of one’s limbs, the resistance of stiffened joints, the powerlessness of weakened muscles, the contrariety of trembling hands. The sheer physicality of the body impedes one’s interaction with the world providing inert and overt resistance. Rather than being that which enables one to carry out one’s intentions in the world, the physical, material body presents itself as an impediment which must be overcome. . . . [T]his experience . . . is a direct apprehension of physical encumbrance.²⁵

²² Ibid., 72.

²³ See above, footnote 58 on page 180.

²⁴ Toombs, *The Meaning of Illness*, 75.

²⁵ Ibid., 72.

As a malfunctioning physiological organism, the body is out of one's control in important ways. This lack of control reveals the symbiotic relationship between body and self. In illness one comes face-to-face with one's inherent vulnerability and dependence upon one's body. "It could really happen to me!" is felt as a concrete actuality and not simply as an amorphous possibility. Moreover, try as one might, one cannot altogether dissociate oneself from the malfunctioning body. One must explicitly take it into account as a precondition of one's plans and projects. Thus, one is uncomfortably aware of the contingency of being embodied in this particular malfunctioning body and the implications of such embodiment in terms of the threat to the self. The sense of inescapability and limitation are intrinsic to illness-as-lived.²⁶

Illness communicates an inescapable fact. The dynamic integration of body and self that allows us to be who we are is perishable and since the experience of illness alters how we experience this integration, being ill can change our sense of who—or what—we are, particularly when the pains and impediments of illness keep us from doing what we want to do. "Even if the body is eventually restored to health, the perceived loss of bodily integrity remains, especially if the illness is serious."²⁷

Toombs shows how this loss remains when she addresses the impact being ill has on how we experience ourselves. She writes:

Illness forces one to recognize in an explicit way the tenuous nature of bodily integrity and the lack of control one has over bodily functioning. Obviously, this is most evident in chronic and life-threatening illness. But it is also an intrinsic element of less serious bodily disorders. Having once experienced illness, one recognizes that one can no longer take the body's future compliance for granted.²⁸

Toombs shows why Pellegrino says illness functions as an ontological assault: since it discloses to us that our lives and lifestyles are perishable, illness calls our being into question and makes us recognize how vulnerable we are. This apprehension of

²⁶ Ibid., 73.

²⁷ Ibid., 91.

²⁸ Ibid. By "compliance," I assume that Toombs means the spontaneous responsiveness that characterizes the way the body is integrated with the self when the person is healthy.

vulnerability comes about because being ill involves experiencing an alienation of the body and the self that stands in stark contrast to the integration we enjoy when healthy.

The body, which was hitherto simply lived, becomes the unwelcome object of one's attention. This objectification necessarily results in a sense of alienation from one's body. In particular, the body is experienced as no longer embodying. Rather, it manifests itself as if [it were] a material physical object or as an oppositional force which must be overcome in carrying out one's projects.²⁹

When I am sick, I cannot carry out the projects I had planned and, if I do not completely recover, I will be unable to do much that is important to me. Accordingly, a partial recovery will be experienced as a significant loss. Moreover, the recognition that I may not recover at all—or even survive this illness—will be experienced as a terrible threat. “The radical loss of certainty that accompanies illness is cause for considerable anxiety and fear.”³⁰ This response is exacerbated by the fact that there is, in addition to “the profound sense of loss of wholeness and loss of certainty, . . . an acute awareness of *loss of control*. The familiar world, including the self is suddenly perceived as inherently unpredictable and uncontrollable.”³¹ By alienating the body and the self, illness reveals our vulnerability: we recognize that the integration of body and self will come to an end. Illness also discloses our dependence: first, on our bodies as the animate organism that we are as human beings; second, on those who care for us when we cannot take care of ourselves; and, finally, on those who have the knowledge and skill to help us to heal.

²⁹ Ibid., 91.

³⁰ Ibid., 93.

³¹ Ibid.

Toombs' general discussion of illness supports Pellegrino's phenomenology of the clinical encounter. Moreover, she articulates the features of being ill that Veatch identifies when he summarizes Pellegrino's position. As we have seen, Veatch writes as follows:

[Pellegrino] says that illness, which he contrasts to "disease," changes one's existential state." Our body is "no longer our ready instrument." Moreover, the ill person "has lost some of his freedom." He becomes "dependent" and therefore "vulnerable."³²

Veatch does not deny the moral significance of these features. He denies the truth of the description and claims that our freedom is not essentially diminished by these phenomena. In contrast, Toombs develops these features with considerable insight and, to the extent her descriptions articulate the experience of being ill, Toombs refutes Veatch.

§40 Toombs on Chronic Illness

Toombs' description of chronic illness also differs sharply from the account presented by Veatch. She writes:

While the paradoxical relation between body and self is explicitly recognized in all forms of illness, it is felt most profoundly in chronic illness. . . . [T]he objectification of body in illness results from a forced attention to physical function and the awareness of some impairment or other physical change. In chronic illness, this forced attention to body is daily occurrence.³³

Toombs, who has multiple sclerosis (MS), remarks that, "whether I like it or not, I am aware of my dysfunctional body as both physical encumbrance and malfunctioning

³² Veatch, "Pellegrino's Reconstruction," 72.

³³ Toombs, *The Meaning of Illness*, 75.

physiological organism.”³⁴ Then, speaking generally, she adds: “This is obviously the case for all those who suffer from chronic ailments which disrupt everyday functioning on an everyday basis.”³⁵ The point of these remarks is not the ill person’s capacity to become an expert in his or her chronic condition, which Veatch emphasizes. While many who suffer from chronic illnesses surely come to master what is known about their condition and the effects (both helpful and harmful) of possible treatments, this aspect of their experience is beside the point: persons who suffer from chronic illness have the same need for healing as do persons who suffer from acute illness. Unfortunately, in many cases, no known treatments for chronic illnesses are especially effective. Treatments do not cure the condition and, while they may lessen the disruptions, treatments do not reverse the changes chronic illness brings about.

The prolonged attention to body which occurs in chronic illness engenders a kind of metamorphosis. The body is transformed into a new entity, “the diseased body.” The “diseased body” with its ongoing demands, necessarily stands in opposition to the self. One must continually compensate for its dis-abilities, allow for its weaknesses, pay unwilling attention to its pains, and so forth, before one can carry out one’s projects in the world.³⁶

Since chronic illness does not go away, there is “a sort of Gestalt switch in that the experience of bodily disruption becomes one’s normal expectation and non-disruptive moments appear as fleeting anomalies.”³⁷ Toombs’ description shows that chronically ill persons suffer in ways that are both like and unlike the acutely ill. All persons who are ill suffer the disruptions Veatch identifies in his summary of Pellegrino’s position: the change

³⁴ Ibid.

³⁵ Ibid., 75-6.

³⁶ Ibid., 76.

³⁷ Ibid.

in existential state; the altered experience of the body; the loss of freedom; dependence; and vulnerability. As we have seen, Pellegrino refers to these interrelated disruptions as an ontological assault. Toombs expresses these disruptions in terms of the interrelationship between body and self and, by doing so, she shows why illness generates a need for healing. The alienation of body and self disrupts the correlation of self and world precisely because this correlation is founded upon the integration of self and body. Put differently, both chronic and acute illnesses threaten the generic human good of integrity so the person who is ill wants to recover: to experience anew the sense of wholeness he or she enjoyed before the onset of illness.

However, unlike acutely ill persons, chronically ill persons are constantly threatened because their illness is *chronic*. There is an ongoing need for healing; but this need cannot be fulfilled so the person must accommodate him- or herself to being ill.

In this sense, the “diseased body” (rather than being that which is routinely overlooked in carrying out one’s projects in the world) is experienced *on an ongoing basis* as an insistent presence against which all else is background.

Not only is the “diseased body” constituted as a malfunctioning physiological organism but with chronic illness there can be no expectation of return to normal function. One perceives one’s body to be permanently impaired. Consequently, for the chronically ill the sense of alienation from, and unwilling identification with, body is particularly profound.³⁸

In addition to her general description of being chronically ill, Toombs describes her own experience of being chronically ill. The latter provides an especially telling counterpoint to Veatch’s claim that the fact of illness is without moral significance. She

³⁸ Ibid.

remembers the moment of her diagnosis “in the most exquisite detail”³⁹ because it changed her life so dramatically:

I was not going to get well—ever. Though I might have periods of remission, I would not (and could not) be cured. My expectation had been that medicine would restore me to health. Now that expectation was dashed, along with my cherished illusion that I was in control of my life.⁴⁰

Toombs’ distress raises serious doubts about Veatch’s glib characterization: “It is the nature of chronic disease that it progresses slowly. While early stages may be cause for concern or even alarm, they are not debilitating in ways that make the patient dependent. They do not cause loss of freedom.” Indeed, what Toombs expresses cannot be dismissed as a transitory phase that happens in the early stages of chronic illness as Veatch seems to do, particularly as he goes on to describe how chronic illness alters the patient-physician relationship. According to Veatch,

patients diagnosed with chronic disease regularly are well enough to study and master the details of their condition and its treatment options. They can actively learn and take responsibility for choices that will need to be made over the course of months or years. It is common place that for many chronic diseases the patient may know the condition as well as the general practitioner.⁴¹

If Toombs has devoted herself to learning as much as can be known about MS, I submit that this devotion does not express a desire for expertise but rather a desire for healing. The expertise is for the sake of healing. I would add that Toombs has every reason to suppose that her physician has become an expert for the sake of healing as well. However, the fact that Toombs could know as much about MS as her physician knows does not mean that she does not want the physician to help her heal; for Toombs (like many others who

³⁹ Toombs, “Sufficient unto the Day,” 4.

⁴⁰ Ibid.

⁴¹ Veatch, “Pellegrino’s Reconstruction” 72.

have accepted being chronically ill) still experiences a need for healing. Indeed, her description of chronic illness in terms of the alienation of body and self underscores the need for healing.

Toombs' personal account underscores another point: healing is specific to the person and remains as a possibility even when medicine does not have the power to cure. Hence, in stark contrast to the moment of her diagnosis, Toombs writes: "I am not sure exactly when it was that I began to reclaim my life" and she tellingly adds, "[n]or what enabled me to do it."⁴² This statement reflects that healing involves (at a minimum) developing a more resilient sense of wholeness; yet chronic illness continually tests this resilience: "every new attack revived my anxieties about the future. Each time, I had to begin anew actively to constrain my imagination, to reign in the latent feelings of terror. This was hard work. Some days I was more successful than others."⁴³ One might say that chronic illness differs from acute illness because it does not permit one to experience a stable sense of wholeness. Instead, the chronically ill may suffer more intensely than the acutely ill because their sense of integrity is especially unstable. Toombs suggest as much in her summary of how multiple sclerosis has affected her life.

Perhaps the greatest challenge of all for the multiple sclerosis patient is to learn to live with ongoing and permanent uncertainty. From the moment of diagnosis the future assumes an inherently problematic character. One does not know when the next attack will occur, how severe it will be, how long it will last, what effects it will have, whether there will be a residual or increasing disability, whether treatment will be effective, or what the long-term prognosis might be. Neither does

⁴² Toombs, "Sufficient Unto the Day," 21.

⁴³ *Ibid.*, 21-2.

one know, on a day-to-day basis, whether one will feel energetic or abnormally fatigued, vigorous or enfeebled.⁴⁴

In chapter 5, I suggested that Veatch distinguishes chronic conditions from acute conditions because the possibility that patients can be experts about their own medical condition advances one of his principal goals. Veatch wants to undermine the claim physicians have traditionally made to justify their moral authority over patients: namely, that by virtue of their *professional* training and experience, physicians are uniquely qualified to determine what is good for the patient. Veatch has consistently rejected this claim.⁴⁵ However, in his zeal to assert the sovereignty of the patient within the clinical encounter, he distinguishes between acute and chronic illnesses in a way that conceals their similarities. Whether their condition is acute or chronic, the ill seek medical help because they cannot manage—*on their own*—the disruptions or threats that come with being ill.

§41 Trust and the End of Healing

The fact that patients appeal to physicians for help does not mean that physicians know how to respond to their patients as persons. This problem raises the question of

⁴⁴ Ibid., 20. This description explains why Toombs' says illness is "experienced as a global sense of disorder." Toombs, *The Meaning of Illness*, 90. However, one might wonder whether only chronic illness creates a *global* sense of disorder. An adequate response to this query would have to acknowledge that the sense of disorder is quite variable: some persons experience more disorder and some less. Nevertheless, I would argue that the scope of the disorder shapes, at least in part, the decision to seek medical help. I would also argue that the decision to seek medical help should be credited as the experience of more disorder than the person feels able to manage without help. In short, the desire for healing is a desire for order. It might be better to say that illness is experienced as a kind of chaos and the need for healing evidences the desire to recover a sense of harmony between the body, the self, and the world, i.e., being as cosmos.

⁴⁵ Chapters 4-5 provide ample evidence that Veatch has always rejected the claim that, as professional, physicians are competent to judge what is good for their patients.

trust. Any patient can ask: does my physician know how to respond to me, *personally*?

While different persons will provide different answers, each answer will be grounded in the particular details of the illness and the clinical encounter. In contrast, Veatch answers the question categorically, and without reference to particulars; for Veatch, the question of trust is a theoretical question, to be answered from an abstract point of view. Therefore, he can answer unequivocally: physicians cannot be trusted because they cannot know their patients as persons. Consequently, medicine must be practiced in a way that protects rather than violates their rights as persons. In effect, Veatch asserts the impossibility of trust and concludes that only patients can be moral agents in the clinical encounter.

In contrast, Pellegrino's teleological response to the question of trust is grounded in the phenomenology of the clinical encounter. Since the experience of illness gives rise to the need for healing that initiates the clinical encounter, the patient's appeal to the physician for help is shaped by the experience of illness. Additionally, the patient's appeal brings the issue of trust into the clinical encounter. As Pellegrino puts, trust is ineradicable.⁴⁶ The patient's need for healing comes with a need to trust those who profess to heal: if trust could not be established, the clinical encounter is as dangerous an event in the patient's life as Veatch seems to think that it is. Consequently, the healing action that completes the clinical encounter must not only be right in the sense that it is likely to be effective biomedically; more importantly, the action must be good in the sense

⁴⁶ Pellegrino opens "Trust and Distrust in Professional Ethics" with the following observation: "Trust is ineradicable in human relationships. Without it, we could not live in society or attain even the rudiments of a fulfilling life. . . . Yet to trust and entrust is to become vulnerable and dependent on the good will and motivations of those we trust. Trust, as ineradicable as it is, is also always problematic" (69).

that it is responsive to the patient's need for healing. In sum, a good healing action addresses the patient's experience of illness. It can now be seen why Pellegrino says physicians can be trusted if they come to understand themselves as healers; because, as healers, physicians will recognize that they cannot know what should be done until they learn how being ill has changed the patient's life. However, if physicians do not understand that they must turn to, and work with, their patients in order to determine what should be done, then physicians cannot be trusted to help their patients heal.

While the foregoing statement indicates that Pellegrino and Veatch share some common ground, it does not reconcile their different answers to the question of trust. Instead, it calls attention to why Veatch and Pellegrino provide different answers. According to Pellegrino, physicians are healers, who ought to care for their patients as persons. According to Veatch, physicians are technicians, who treat their patients as bodies.⁴⁷ Indeed, Veatch takes the position that physicians are not competent to be anything other than technicians precisely because they cannot know what is good for their patients. It clearly follows that he would reject the assertion that, if physicians understand themselves as healers, then they could be trusted by their patients.

However, Veatch makes a different argument in his contribution to a *Festschrift* honoring Pellegrino. Veatch writes:

Pellegrino's approach is to reflect on core concepts such as *medicine* and *healing* to determine the essence and the ends and the moral constraints they contain. . . . The

⁴⁷ A strong argument can be made that Veatch used to agree with Pellegrino in the sense that he once thought shared decisionmaking was possible even if patients and physicians had different moral outlooks. See Veatch, "Models for Ethical Medicine in a Revolutionary Age," *Hastings Center Report* 2, no. 3 (June 1972): 5-7. I discuss this essay in note 76 below.

core problem with the Pellegrino approach is that any effort to determine the proper normative content of these concepts will necessarily rely on some broader conceptualization of the ends of human life. The point here is not that one must appeal to a human social conceptualization of these ends. All conceptions of the ends of human life are social constructions, even if they perfectly mirror reality or some important part of it. The point is that it is impossible to give any content to critical concepts such as *medicine* or *healing* or *health* without going well beyond medicine to some system of belief and value that is external to medicine.⁴⁸

Veatch is quite mistaken. Pellegrino does not reflect on concepts. He reflects on the clinical encounter as it unfolds and he pursues questions such as the following: Why does the clinical encounter come about? Who participates in it? What happens while it lasts? Why does it come to an end? Such questions focus on the experiences that bring two persons—a patient and a physician—together in a medical setting. These questions can only be answered by showing what distinguishes patients and physicians from other kinds of persons, how their encounter differs from other kinds of encounters, and whether and how their encounters can be evaluated by the participants and by others. The result of this inquiry is Pellegrino's phenomenology of the clinical encounter. The patient is distinguished by the experience of illness and the need for healing that comes with being ill. Furthermore, the clinical encounter comes about to answer the questions raised by illness (what is wrong? what can be done? what should be done?). In particular, a person who is ill initiates a clinical encounter because he or she cannot answer these questions

⁴⁸ Veatch, "Internal and External Sources for Morality for Medicine," in *The Health Care Professional as Friend and Healer: Building on the Work of Edmund D. Pellegrino*, eds. David C. Thomasma and Judith Lee Kissell (Washington, DC: Georgetown University Press, 2000), 81. Since the purpose of my dissertation is to defend Pellegrino's phenomenology of the clinical encounter as the foundation for this teleological theory of medical ethics, I have set aside the opposition between social constructionism and essentialism. Pellegrino sets out his position in "Philosophy of Medicine: Should it be Teleologically or Socially Constructed?," *Kennedy Institute of Ethics Journal* 11 (2001): 169-80.

without help. By initiating the encounter, this person becomes the patient: this is an act by an agent, unlike a dog or a cat brought to a veterinarian.⁴⁹

In turn, the physician is distinguished by the act of profession. When a person declares to the public at large that he or she has the skill and the knowledge required to help patients answer the questions raised by illness, then he or she professes to heal. By making this profession, the person takes on a professional identity. He or she becomes a physician and, in meetings with patients, the physician either makes good on his or her profession, or falls short thereof. The standard for making this evaluation is built into the encounter. The patient comes to the physician with the questions raised by illness precisely because the physician declares that he or she can help answer them. Therefore, the clinical encounter is a deliberative inquiry that starts with the question of what is wrong and ends with the question of what should be done. Accordingly, the clinical encounter can be evaluated in terms of how these questions are answered, especially the last one, which is answered with a particular action: one that is right in respect to medical science and good in respect to the patient's life, i.e., the patient's fourfold good is optimized. Ultimately, the clinical encounter is completed by a right and good healing action, or it terminates before the work of healing is done. No matter how the clinical encounter ends, it must be stressed that, according to Pellegrino, the meaning of healing is always defined in terms of the patient's life.

⁴⁹ An agent brings the dog or cat to the vet precisely because the agent cares about the animal (typically the agent's pet) and wants to know what is wrong and what can be done; notice that the vet and the pet do not deliberate together to figure out what should be done, but the vet and the agent might weigh the alternatives together, but this weighing differs from the mutual deliberation that takes place between physicians and patients because the pet's good is a far simpler object to consider.

That physicians too often harm the patients they think they are healing does not prove Veatch's point that physicians cannot be healers; instead, it means that these physicians failed to heal in these instances at least. Nevertheless, Pellegrino would readily concede Veatch's point: many (if not most) of these failures happen because physicians do not acknowledge that the patient, not the physician, is competent to determine whether a healing action is good. Since the patient's life has been disrupted by illness, what constitutes a *good* response to that disruption cannot be determined without reference to the patient's life. That the physician has expertise when it comes to making a diagnosis and determining what treatments are available does not mean that he or she knows what is *good* for the patient; the physician's expertise is limited to determining whether an action is right. Every physician must learn what healing means to each patient in particular. In this way, the end of medicine—healing—directs the physician to this patient's interest and values. In other words, the teleological structure of medicine requires the physician to look beyond the biomedical good, to the good of the patient as a person.

Veatch also misunderstands the sense in which Pellegrino claims that medicine has an internal morality. Pellegrino is not saying that the goodness of actions within the clinical encounter can be determined without reference to non-medical moral sources. Pellegrino asserts that the patient's need for healing specifies the end of clinical encounter: to heal this patient. Therefore, what healing means in each case is a function of how this illness has disrupted the life of this patient. Consequently, the meaning of healing varies considerably since it always depends on the individual patient, whose understanding of healing, Veatch rightly notes, points "well beyond medicine to some system of belief and

value that is external to medicine.”⁵⁰ That Veatch is right on this point cannot be denied; but he is wrong to think that the end of healing undermines the claim that medicine has an internal morality. Veatch simply misunderstands the imperative built into the structure of medicine: it is the physician’s job to find out what healing means to each patient in particular because healing is what the patient needs from the physician and what the physician promises to provide. In short, the physician’s job is to heal, but the physician needs the patient’s help to know what healing means.

Toombs’ description of the experience of illness as a sense of global disorder helps us to see that the work of healing requires the physician to look beyond the medical good defined in respect to the patient as a body to the complex good enjoyed by the patient as a person; for healing means restoring order to patient’s life and only the patient knows what this would mean. Therefore, the end of healing directs the physician’s attention to external sources: the interests and values of the patient. In this sense, the patient functions within the clinical encounter as the principal and the physician is the patient’s agent. However, the principal-agent relationship disclosed by the end of healing involves the physician as a moral agent. When the principal-agent model of the patient-physician relationship is structured by the end of healing, it can function as a model for shared decisionmaking. Since the principal is unable to realize certain goods without the help of an agent who professes the ability to realize those goods, the principal vests the agent with the authority to pursue those goods. At the same time, the principal must trust that the agent will take care to find out from the principal what those goods are; otherwise, the agent’s actions will

⁵⁰ Ibid.

not benefit the principal. When the principal is the patient and physician is the agent, then the agent's actions are guided by the principal's understanding of what healing means.

The foregoing recapitulation of Pellegrino's phenomenology of the clinical encounter and the teleological structure it displays reveals the similarities and differences between Pellegrino and Veatch. It also raises, from a different perspective, the question of why Veatch rejects Pellegrino's teleology. In particular, since Veatch admires "physicians who have mastered the art of respecting patients and given them the freedom to heal," why does he reject Pellegrino's claim that the end of medicine is healing?⁵¹ In the following section, I turn to the work of Drew Leder to show why Veatch rejects Pellegrino's medical morality. The problem is that Veatch does not trust physicians because he thinks that, as biomedical professionals, physicians tend to be technicians incapable of knowing what is good for their patients. Veatch recognizes a few physicians as healers, but he seems to think that the most physicians are incapable of this achievement, for reasons that he overlooks, but Leder makes clear.

⁵¹ This quote is from the dedication page of *PHT*. It is quite interesting that Pellegrino is one of the four physicians to whom Veatch dedicates the book in which he rejects the proposition that physicians should be healers. The other three physicians are Willard Gaylin, Andre E. Helligers, and Victor W. Sidel.

§42 Drew Leder's "Tale of Two Bodies"⁵²

The two bodies to which Leder refers are the corpse or cadaver, on the one hand, and, on the other hand, the lived body. The clinical encounter involves both, but Leder argues that medicine privileges the former: "I consider modern medicine to be based, first and foremost, not upon the lived body, but upon the dead, or inanimate, body."⁵³

According to Leder, this counterintuitive assertion follows from Descartes' metaphysics.⁵⁴

⁵² Drew Leder, "A Tale of Two Bodies: The Cartesian Corpse and the Lived Body," in *The Body in Medical Thought*, ed. Drew Leder (Dordrecht: Kluwer Academic Publishers, 1992), 17-35. In *Ethics and the Clinical Encounter* (Engelwood Cliffs, NJ: Prentice-Hall, 1988), 104-29, Richard Zaner makes many of the same points that Leder develops in his essay. Zaner pursues the following questions:

What is it that patients, and the rest of us while we are not patients, are invited and powerfully encouraged . . . to think about when our usual, everyday understandings of our aches and pains are replaced by the clinical-diagnostic terms of medicine?

What is "the human body" within this framework? If a patient's everyday understanding of and discourse about himself and his own body stands in need of being displaced and replaced—at least within clinical encounters—what precisely is inaccurate or wrong with that everyday view of things, including one's own body? (105)

⁵³ *Ibid.*, 17.

⁵⁴ Descartes' metaphysics needs to be distinguished from "Cartesian dualism", which refers to the strict separation of mind and body and the assertion that being is either mind or body, and never a unity composed of both. That Descartes was not a Cartesian dualist has been well argued by Richard Zaner. See *Ethics and the Clinical Encounter*, 106-26. Zaner refers to an earlier essay by Richard Kennington, "Descartes and the Mastery of Nature," in *Organism, Medicine, and Metaphysics*, ed. Stuart F. Spicker (Boston and Dordrecht; D. Reidel Publishing Company, 1978), 201-23. Zaner (118) and Kennington (217) identify the same triad, articulated by Descartes as he addresses the problem erroneous judgments pose for the claim that runs throughout the *Meditations*: that which is "taught by nature" is true. (Kennington interprets the *Meditations* by distinguishing the practical teachings of nature from the theoretical teachings of nature. Kennington, "The 'Teaching of Nature' in Descartes' Soul Doctrine," *Review of Metaphysics* 26 (1972): 86-117.) In the "Sixth Meditation," Descartes writes:

I should define more accurately what I would then properly understand when I say that "I am taught something by nature". Here, namely, I take "nature" more strictly than just as the complex of all the things that have been given to me by God. For there are many things contained in this complex that pertain to the *mind alone*. . . .

Descartes replaced [the pre-modern] vision of an animate ensouled nature with that of nature as *res extensa*—a plenum of passive matter driven by mechanical forces. This is a *dead* universe, devoid of subjectivity and intention. The human body is then regarded as a part of *res extensa*, and thereby modeled upon the lifeless machine.⁵⁵

Two aspects of the transformation noted by Leder have had a particularly strong influence on the practice of medicine. The first is the mechanical understanding of physical bodies.

Once we understand the mechanical elements and forces involved in a natural process, we can in principle alter or artificially duplicate it. This sort of knowledge thus grants us power over nature. Such was not the case with the final causes and substantial forms studied by the medievals. These were basically immutable, indivisible, God-given essences, to be contemplated, not altered at will. The mechanist world-view allows the crucial shift from passive contemplation to the active manipulation which characterizes the modern age.⁵⁶

The second influential aspect of Descartes' project follows from the first. When formal and final causes are excised from scientific explanation, medical science seeks to discover the material and efficient causes at work in the body. However, when stripped of formal and final causality, the body can readily be conceived as a machine and medical examinations become physical investigations of the complex mechanisms within the patient's body. Consequently, "the lived experience of illness came to be seen as epiphenomenal; the real disease unfolded in the material world of *res extensa* and could

There are also many things . . . that pertain to the *body alone*. . . . Rather I am dealing only with the things that have been given by God to me just as a *composite of mind and body*.

Rene Descartes, *Meditations on First Philosophy*, Monolingual Edition, trans. George Heffernan (Notre Dame: University of Notre Dame Press, 1992), 79-80 (emphasis added).

⁵⁵ Ibid., 20.

⁵⁶ Ibid., 21.

best be exposed by the pathologist's knife."⁵⁷ Other tools or tests also display or report on operations of the body that are ordinarily hidden.

Taken together, this transformation of the patient's body and his or her experience leads Leder to assert that the "epistemological primacy of the corpse has shaped not only medical technology, but diverse aspects of training and practice."⁵⁸ He elaborates as follows:

Medical education still begins with the dissection of a cadaver, just as the clinical case ends in the pathologist's lab. In between, the patient is often treated in a cadaverous or machine-like fashion. We see this, for example, in the traditional physical examination. The patient is asked to assume a corpse-lie pose, flat, passive, naked, mute. The entire ritual and context serves to reduce the living body to something almost dead. Personal identity is stripped away as the patient is removed from his or her habitual surrounding, activities, even clothes. Then too, the patient's voice is, for long stretches, silenced. After all, a heartbeat cannot be heard over a patient's query. . . . While the doctor performing a physical examination is an active and engaged explorer, the patient is placed in a position of corpse-like passivity. Even when called upon to act or respond, it is largely in the machine-mode; the knee is tapped to provoke reflexes; the abdomen is poked to see if pain ensues; the patient is asked to take a deep breath to hear whether the lungs produce audible rattles.⁵⁹

When the personal experience of illness has been grasped as the effect of disease on the mechanisms of the body, the clinical encounter tends to produce "mechanistic forms of treatment." In a typical case of heart disease, for example,

the doctor uses means which will alter the body as one would a mechanical thing, substituting parts, altering inputs and outputs, and regulating processes. At the core

⁵⁷ Ibid.

⁵⁸ Ibid., 22.

⁵⁹ Ibid. Veatch is to be applauded for wanting to liberate the patient from this enforced passivity, but he fails to recognize that the proper starting place for this project is the patient's experience of illness. The patient must be encouraged to give voice to his or her experience of illness and this experience should shape the physician's response to the patient; then the patient and the physician can work together to arrive at a right and good healing action.

of modern medical practice is the Cartesian revelation: *the living body can be treated as essentially no different from a machine*. Though any good clinician also engages the patient-*as-person*, the predominant thrust of modern medical therapeutics has been upon such mechanistic interventions.⁶⁰

As Leder points out, “the mechanist model of nature subserves a project of control.”⁶¹ However, this control cannot be exercised unless the patient is examined and treated in conformity with the model. Leder explains:

Once we analyze a natural object into its component parts and their interactions—that is, see how it is made—we can make it ourselves, or alter it in desired directions. Herein lies the enormous power of modern medicine. We have learned to understand, remake or transform components of the body-machine. When disease intervenes, we can intervene too. We know enough about the mechanics of bodily processes to assert over them a degree of intentional control. Few of us would want to abandon this therapeutic power. If faced with heart disease, most will gladly reach for the medical armamentarium—drugs, diet, surgery, and the like—and its promise, often delivered, of a prolonged or improved life.⁶²

Since the unprecedented power of biomedicine works by focusing on the patient as a diseased or disordered body, the patient’s personal life and his or her experience of illness becomes unimportant. Leder’s response to this problematic orientation goes beyond the “cliché that modern medicine often neglects the import of psychosocial factors in the etiology and treatment of disease.”⁶³ He gets at

the metaphysical roots of this neglect. Insofar as the body is modeled upon a lifeless machine, the role of subjective experience in determining one’s health history will tend to be overlooked. After all, a machine does not experience, does not inhabit an “existential world.” When it misperforms, this can be explained with exclusive reference to mechanical forces. Not so with human disease and the

⁶⁰ Leder, “Two Bodies,” 23. This tendency has expanded in scope dramatically. For example, anti-depressants are routinely prescribed for adults as are stimulants for children diagnosed with Attention-Deficit-Disorder, whether it is accompanied by hyperactivity or not.

⁶¹ Ibid., 23. See also 20-21.

⁶² Ibid., 23.

⁶³ Ibid.

response to treatment. Here, experiential factors seem to play a huge part—emotions, desires, perceptions, interpretations. There is mounting evidence that emotional stress, intersubjective losses, and personality styles can play a crucial role in bringing about illness. Similarly, one's response to treatment may depend upon such "subjective" factors, as one's affective state, one's "will to live," or the quality of the treater-patient relation. . . . While clinicians will often acknowledge the importance of such subjective phenomena, medicine's ability to address them has been systematically hampered by the Cartesian model of embodiment.⁶⁴

Leder concludes his discussion of the relationship between the corpse and the practice of medicine by noting the way that the mechanistic model of the human body has distorted the relationship between patients and the professional who care for them.

Patients often complain that they have been dealt with . . . in a dehumanized fashion: as if they were but a disease entity, or a piece of meat to be prodded, punctured, and otherwise ignored. This practice is rooted not simply in personal insensitivities but, again, in a metaphysical model. Insofar as the patient to be examined is modeled on the automaton, he or she as *living person* with wishes, questions, pains and fears, can all too easily be overlooked. When fixing a machine such things need not be considered. Within this framework, human sensitivity to the suffering of a fellow human being remains possible, but is hardly encouraged. In fact, it demands an almost schizophrenic shift between, at one moment, examining the machine-body, and at the next, acknowledging the person to whom it belongs.⁶⁵

Given Leder's presentation of the ontological presuppositions that shape the contemporary practice of clinical biomedicine, Veatch's distrust of physicians makes much more sense; for when measured against the phenomenological account of illness, the biomedical understanding presented by Leder reflects considerable bias and distortion. Thus Leder shows why Veatch can argue that unconscious bias and distortion makes it impossible for physicians to know how to benefit their patients. In sum, I think Veatch conceives of physicians as technicians who are incapable of overcoming the biomedical

⁶⁴ Ibid., 23-4.

⁶⁵ Ibid., 24

perspective: not only have they have been trained to perceive their patient as presenting technical problems, but they have been trained to think that the physician's job is to identify the problem(s) presented by the patient and to list the possible physiological or anatomical interventions that could treat the problem. The person of the patient is irrelevant to this task. As we have seen, Veatch takes the position that physicians, as biomedical professionals, are uniquely unqualified to determine what would benefit their patients. Leder also shows us why Veatch would draw this conclusion. Persons benefit from treatment, not their bodies. However, physicians know about the bodies they treat; they do not know about the persons who are ill.

As it turns out, Veatch presents the same problem in a different context: he does not think the experience of illness is relevant to the ethics of medicine. In my view, this objection to the starting place of Pellegrino's teleology shows that Veatch buys into the ontological presuppositions Leder discloses; or, at the very least, Veatch fails to question these presuppositions. The best evidence I can offer for this claim is Veatch's rejection of Pellegrino's claim that healing is the end of medicine. Either Veatch fails to recognize that healing provides an alternative conception of the physician and the task of medicine, or he does not recognize the need for such an alternative. In both cases, it is clear that Veatch thinks of the physician as a technician who knows about the patient as a body but does not know about the patient as a person. Therefore, the physician is obligated to be competent but is barred from being beneficent.

Whether or not Veatch goes along with the ontological presuppositions Leder finds within the biomedical model of medicine, Veatch endorses that model without objecting to

its presuppositions. Instead, Veatch argues that, in general, physicians are biomedical professionals, i.e., technicians; so they can be competent but they cannot be beneficent. At the same time, Veatch recognizes that physicians think of themselves as helping their patients.⁶⁶ Herein lies the problem to which Veatch responds by developing an ethics of distrust: in general, the physician's promise to help the patient cannot be trusted.

§43 Teleology and Shared Decisionmaking

Pellegrino's teleological account of medicine presents an alternative to Veatch's conclusion without dismissing his basic concern that, as technicians, physicians cannot be trusted to benefit their patients. As will be seen shortly, a principal strength of Pellegrino's alternative is that it develops common ground that Pellegrino in fact shares with Veatch, even though Veatch thinks he differs with Veatch on this point. In short, Pellegrino agrees with Veatch on precisely the point that Veatch thinks is the crippling flaw in Pellegrino's position. In his commentary on Pellegrino's "Toward a Reconstruction of Medical Morality," Veatch levels the following charge against Pellegrino's articulation of the clinical encounter:

Pellegrino's essay makes a great deal of the "gap in information" signaled by the physician's necessarily unique expertise. . . . What is often not mentioned by those who propound the inequalities in knowledge in the patient-physician relationship is that there is also a knowledge gap in the other direction. In order to know what counts as well-being, . . . one must have knowledge of the patient's beliefs and values, goals and interests. In this area it is the patient who is the expert. The physician is reduced to the dependent status of one who has a very partial, limited, and distorted view. He or she may know something of the patient's medical condition and perhaps even what is medically important to the patient, but cannot know most of what commands primary place in the patient's total life picture.

⁶⁶ He heralds the new medicine to disabuse everyone of that notion.

There is an inequality of knowledge of a different kind in which the physician is in a uniquely poor position to know what is most important.⁶⁷

Veatch's point goes the question of trust. The knowledge gap between patients and physicians in respect to diagnosis and available therapies has received considerable attention, especially among those who develop an ethics of trust grounded in the inherently asymmetrical nature of the patient-physician relationship.⁶⁸ There is, however, a second gap between the patient and the physician and it gives rise to Veatch's ethics of distrust. In respect to the patient's interest and values, Veatch makes the following argument: the patients are the experts and physicians are in the dependent position; in general, physicians are unable to benefit their patients because they fail to recognize this basic limitation on their understanding of the patient's good; therefore, physicians cannot be trusted to benefit their patients. Clearly, Pellegrino disagrees with Veatch's conclusion. (Otherwise, Pellegrino could not present an alternative to Veatch.) However, Veatch does not recognize that Pellegrino integrates this second gap into his teleological account of medicine when he claims that the healing action that completes the clinical encounter must be both right and good.

Instead, Veatch calls the attention of Pellegrino's readers to statements such as the following in which Pellegrino discusses the fact of illness. Pellegrino points out that the patient

⁶⁷ Veatch, "Pellegrino's Reconstruction," 74.

⁶⁸ In addition to Pellegrino's work, see Richard Zaner, "Trust and the Patient-Physician Relationship," *ET&P*, 45-63; and Zaner, "Physicians and Patients in Relation: Clinical Interpretation and Dialogues of Trust" in *Handbook of Bioethics: Taking Stock of the Field from a Philosophical Perspective*, ed. George Khushf (Dordrecht: Kluwer Academic Publishers, 2004), 223-50.

does not have the knowledge personally to discern the answers to the three fundamental questions that occur to anyone in a state of illness: *What's wrong?* *What can be done?* and *What ought to be done?* Since the patient cannot make his own decision unaided, he must put himself in the hands of another person. He becomes dependent upon the person and is therefore vulnerable.⁶⁹

After his discussion of the fact of illness, Pellegrino turns his attention to the act of profession, which he describes as follows: “in the presence of one vulnerable human being who is ill we have another human being who promises to help, to heal, to restore the balance insofar as scientific knowledge will allow.”⁷⁰ Pellegrino concludes his discussion of the act of profession by stressing the asymmetrical relationship of the patient to the physician. “The relationship between someone who is ill and someone who promises to help is perforce a relationship of inequality. . . . The physician-patient relationship is of its nature an unequal relationship built on vulnerability and on a promise.”⁷¹ Pellegrino’s understanding of the physician’s professional obligations to the patient follows from his understanding of the inequality, dependence, and vulnerability within the clinical encounter: “Implicit in the act of profession are two things. The first implication is that the physician possesses the necessary knowledge—that he is competent. The second is that he will use that competence in the patient’s interest and his own, for the patient’s good.”⁷² Here is the core of Pellegrino’s medical morality: competence and beneficence.

The assertion of beneficence gives rise to Veatch’s objection to Pellegrino’s position. According to Veatch, Pellegrino fails to recognize the knowledge gap concerning the patient’s good; for Veatch supposes that if Pellegrino did recognize this gap, then he

⁶⁹ Pellegrino, “Reconstruction” (2006), 67.

⁷⁰ Ibid.

⁷¹ Ibid.

⁷² Ibid.

would also recognize that shared decisionmaking is impossible. According to Veatch, this gap cannot be overcome because he does not trust physicians to bridge it effectively; for he claims that the physician “is reduced to the dependent status of one who has a very partial, limited, and distorted view.” This claim expresses Veatch’s distrust. The physician has a distorted view of the patient and, consequently, the physician “is in a uniquely poor position to know what is most important” to the patient. Hence Veatch’s assertion about the physician: “He or she may know something of the patient’s medical condition and perhaps even what is medically important to the patient, but cannot know most of what commands primary place in the patient’s total life picture.”⁷³

As we have seen before, Veatch thinks that physicians cannot know what is good for their patients; so he rejects professional beneficence as an impossibility. Furthermore, as a bulwark against beneficence *cum* paternalism, Veatch proposes the principal-agent model of the patient-physician relationship. By making this proposal, Veatch meets what he believes to be the primary responsibility of the philosopher who deals with questions of medical ethics: he responds to the opposition between patients and physicians in a pluralist society. As I interpret Veatch, there is no middle ground. The philosopher must take one side or the other: autonomy or paternalism. This interpretation presupposes that Veatch is harshly prejudiced against physicians, but not in the sense that he thinks physicians are morally flawed or corrupt agents. Instead, I think that Veatch conceives of physicians as generally incapable of learning *from* each of their patients what is good *for* this patient in particular. In other words, the professional commitments of physicians tend to establish “a

⁷³ Veatch, “Pellegrino’s Reconstruction,” 74.

very partial, limited, and distorted view” of the patient’s good; so in contrast to other persons, physicians are “in a uniquely poor position to know what is most important” to the patient.⁷⁴ A weaker version of this thesis would posit that Veatch conceives of physicians as technicians, with a tendency towards paternalism.⁷⁵ However, since this conception of the physician as a technician points back to the dualistic presuppositions discussed by Leder, the thesis gives rise to the same harsh judgment; for when the exercise of medicine is reduced to the skillful exercise of scientifically informed techniques for altering physiological processes and anatomical structures, competent physicians have a distorted view of their patients because they have a distorted understanding of what the task of medicine is.

Herein lies the crucial difference between Veatch and Pellegrino. While both acknowledge that there are many reasons for patients to distrust physicians, Pellegrino’s teleological account of medicine provides theoretical insight into how the conditions of trust can be established where they have been undermined, and preserved when they are threatened. In contrast, Veatch provides a theoretical account of why patients cannot trust their physicians. Consequently, he rejects the project of establishing or preserving the conditions of trust.

⁷⁴ As seen in chapters 4-5, Veatch believes that, as professionals, physicians have an especially distorted view of the patient’s good precisely because they “are specialists who are uniquely committed to health. As such, they ought to be biased when it comes to balancing health and other goods.” Veatch, “The Foundations of Bioethics,” 213. See also *PHT*, 36-7.

⁷⁵ As seen in chapter 4, Ingelfinger exemplifies this understanding of what it means to be a physician. Veatch’s positions developed in response to physicians like Ingelfinger.

This difference raises the questions of whether Veatch has properly framed the important ethical questions. That there are plenty of reasons to distrust physicians does not mean that patients can avoid trusting their physicians. On the contrary, patients have no choice but to trust physicians because patients need help and physicians profess that they are able to provide the help patients need. Nevertheless, physicians often fail to make good on their profession to heal. This is a serious problem to which both Veatch and Pellegrino have responded. Veatch responds by putting the patient in charge.⁷⁶ Pellegrino

⁷⁶ This response reflects a fundamental change in Veatch's position: the principal-agent model of the patient-physician relationship that he recommends resembles the engineering model he condemned in "Models for Ethical Medicine in a Revolutionary Age." In this essay, Veatch describes the engineering model in the following passage:

In an applied science like medicine choices based upon what is "significant," what is "valuable," must be made constantly. The physician who thinks he can just present all the facts and let the patient make the choices is fooling himself even if it is morally sound and responsible to do this at all the critical points where decisive choices are to be made. Furthermore, even if the physician logically could eliminate all ethical and other value considerations from his decision-making and even if he could in practice conform to the impossible value-free ideal, it would be morally outrageous for him to do so. It would make him an engineer, a plumber making repairs, connecting tubes and flushing out clogged systems, with no questions asked. (5)

One might try to reconcile his earlier condemnation of the engineering model with his later recommendation of the principal-agent model by focusing on the suggestion that, in respect to "all the critical points where decisive choices are to be made," it would be "morally sound and responsible" for the physician to "present all the facts and let the patient make the choices." One might then draw the conclusion that Veatch's condemnation of the engineering model leaves room for the principal-agent model he now advocates. However, this effort would be a clear misreading of the earlier essay. His unequivocal condemnation is evidenced by the following pair of statements: "With the engineering model the physician becomes a plumber without any moral integrity" (7); "Only in the contractual model can there be a true sharing of ethical authority and responsibility. This avoids the moral abdication on the part of the physician in the engineering model" (7). Taken together, these statements leave no room for reconciling his earlier condemnation of the engineering model with his recent efforts to put the patient in charge of the clinical encounter by establishing the principal-agent model. As I see it, the key difference between his earlier and later positions is that Veatch now believes "a

gives a very different response. He articulates the end of healing that patients and physicians come together to realize: to heal is to optimize the patient's fourfold good. In this way, Pellegrino provides theoretical insight into the ways that the practice of medicine fails to help the patients it promises to benefit as well as the theoretical resources to describe how medicine can provide the benefits it promises.

Some of those resources can be seen if we return to Veatch's objection that Pellegrino fails to recognize the knowledge gap between patients and physicians in respect to the patients' good. Pellegrino does not explicitly acknowledge this gap in "Toward a Reconstruction of Medical Morality," the immediate target of Veatch's commentary. However, it is clearly implied in that essay, especially when Pellegrino discusses the need for disclosure and consent, which go to the possibility of shared decisionmaking. Pellegrino writes: "Disclosure of medical fact becomes a first moral imperative: the physician cannot really heal unless he enhances the patient's moral agency, his [the patient's] capacity to make his own moral and value decisions based on a knowledge of alternatives."⁷⁷ In other words, the physician works to heal the patient by creating the conditions (through disclosure of medical facts) for the patient to realize, among his or her other goods, the generic human good of agency by making an autonomous decision.

Pellegrino also understands that consent is meant to protect and to serve the generic human good of agency. However, Pellegrino understands consent as a deliberative process in which the patient and the physician make decisions together:

true sharing of ethical authority and responsibility" is impossible when patients and physicians are moral strangers. Consequently, Veatch would have to reject the contractual model he advocated in that early essay.

⁷⁷ Pellegrino, "Reconstruction" (2006), 68.

True consent (the word comes from the Latin *con* and *sentire*, meaning both to know and to feel together) implies that the patient and the physician together must know what they are dealing with, and what the alternatives are. We cannot have a morally valid consent when information is withheld or manipulated, when freedom is lacking, when there is insufficient reflection on the values at issue. The physician has a responsibility to underscore the moral questions so that the patient can act in a way consistent with his or her belief systems. Clearly, he [the physician] must avoid imposing his own values on the patient.⁷⁸

Given this interpretation of informed consent, there should be no doubt what Pellegrino means when he writes that “[t]o act in the patient’s interest implies the promise that the physician will act in such a way that the patient’s interpretation of the good life will be protected and that he will have an opportunity to make the value choices that so often underlie the decisions about what should be done.”⁷⁹ According to Pellegrino, the generic human good of agency imposes a limit on the physician’s power to make decisions. Indeed, this good affirmatively obligates the physician to create the conditions for the patient to make decisions, which means to create the conditions of trust, because without such trust the patient will be constrained in the exercise of his or her agency.

However, the question of whether Pellegrino recognizes that patients, not their physicians, are the experts when it comes to the good to be achieved by the clinical encounter can be resolved with debating the reliability of my inferences. In 1991, Veatch and Pellegrino participated in a seminar on trust in the professions. In the published proceedings of this seminar, Pellegrino writes:

The doctor has an obligation to help define the patient’s medical good, that is, the good that the recommended treatment can achieve. In this the physician is, or should be, the expert. But if the physician is to “heal” in any true sense, he or she must place the medical good in the context of the patient’s assessment of his total

⁷⁸ Ibid.

⁷⁹ Ibid., 67.

good. In this the patient is the expert. The whole concept of patient autonomy is vitiated if it is assumed that trust entails granting to the physician determination of the other levels of good beyond medical good. The other levels of patient's good include the patient's own assessment of what is good given his or her values, age, sex, occupation, aspirations, and the myriad things each of us as individuals think more important than medical good or which would modify the degree and kind of medical treatment we would choose.⁸⁰

§44 Conclusion

To practice medicine without acknowledging that the patient is an agent would be to violate the patient's good at every level beyond the medical good and, consequently, the physician's pursuit of the medical good would harm rather than help the patient. That this is the starting point of Veatch's new medicine does not mean that Veatch is right to advocate the new medicine. Instead, it suggests that Veatch presupposes that medicine should be practiced in a way that benefits the patient but he fails to recognize this presupposition and its obvious implication. The end of medicine is to benefit the patient. By articulating the teleological structure of medicine and the patient's fourfold good that is to be realized when medicine is practiced well, Pellegrino provides an invaluable service to those who take the time to understand his philosophy of medicine; for Pellegrino's teleological phenomenology of the clinical encounter provides a perspective from which the shortcomings of medical practice can be identified and, at the same time, it permits the critic to describe what medicine should be. Obviously, this is an exceptionally difficult practical task, but it is one that is facilitated by a theory of medicine that hews as closely as

⁸⁰ Pellegrino, "Trust and Distrust in Professional Ethics," 80.

possible to the invariable features of the clinical encounter: the fact of illness, the act of profession, and the act of medicine.

§45 Building on Pellegrino's Work

Pellegrino's teleological phenomenology of the clinical encounter lays down a foundation upon which an ethics of trust can be built.⁸¹ In this section, I want to explore some avenues for developing the position Pellegrino advances by responding to three questions about his philosophy of medicine. For the most part, my responses will be limited to brief discussions of the scholarly literature to show that these questions can be answered affirmatively. I end this section by briefly contrasting Richard Zaner's phenomenological approach to medicine with Pellegrino's own approach. This contrast points the way forward for more phenomenological contributions to the task of clarifying the teleological structure of medicine.

Whether physicians can appreciate their patients' experience of illness

Eric Cassell and Rita Charon answer this question affirmatively. Cassell emphasizes that the most important instrument available to the physician is the physician him-self or her-self, i.e., by cultivating his or her *self*-awareness, the physician develops the

⁸¹ In *For the Patient's Good: The Restoration of Beneficence in Health Care* (New York: Oxford University Press, 1988), Pellegrino and co-author David Thomasma advance a theory of beneficence-in-trust. *For the Patient's Good* provides a systematic statement of the teleological position presented in part one of this dissertation, so it is also in need of development along the lines I briefly suggest in this section.

capacity to appreciate his or her patient as a person who is suffering illness.⁸² Cassell also points out the physician's ability to develop this subjective manner of knowing the patient has been impaired because medicine has been shaped by a quest for scientific objectivity, particularly the technological means of obtaining objective measures: "in medicine a conflict has arisen between objective and subjective information. Objective knowledge is considered scientific and valuable, whereas subjective information is thought to be 'soft' and second-rate. For the relief of suffering, that conflict is not only false, but an impediment."⁸³

Cassell calls upon physicians to attend to their patients with an understanding that subjective information about the patient must be appreciated by the physician in order to relieve the patient's suffering. In encounters with patients, Cassell tells the physician,

One needs to listen to what is said and unsaid, watch face and body for expression and actions, smell (fear, hygiene, or perfume), learn to let it all come in without interpreting or judging, and stay silent inside and out (beyond small talk). In doing this, one begins to know something about the patient, still unspoken but enough for the care of many sick patients.⁸⁴

Cassell is describing a disciplined form of self-awareness that lets the physician be a healer. However, Cassell knows that the care of the suffering or the dying patient requires more than self-awareness: it requires an openness to the patient's self. He writes:

Now comes the hard part: learning to be simply open in the presence of the patient, as though there were a door to the inside of you—to your heart or soul, call it what you will—and you consciously opened it so the patient would flow into you. If this

⁸² See Eric Cassell, "Diagnosing Suffering: A Perspective," *Annals of Internal Medicine* 131 (October 5, 1999): 531-4. See also Cassell, *Doctoring: The Nature of Primary Care Medicine* (New York: Oxford University Press, 1997).

⁸³ *Ibid.*, 533.

⁸⁴ *Ibid.* 534.

has a touchy-feely . . . sound, do not be put off; good clinicians are strange instruments.⁸⁵

Here is the crucial point: the clinician is the healing instrument. Cassell points out that the use of this instrument, the clinician's self, "has sometimes been labeled sympathetic listening, empathic communication, or empathic attentiveness and it can be taught and learned."⁸⁶ To summarize his approach to patients as a way of listening that opens the physician to encounter each patient as a person suffering from illness, Cassell writes:

This stance is not something you do as much as something you are. Properly done, no one but you will know exactly what is happening, not even the patients. They will simply experience you as being trustworthy, caring, and understanding. It may seem threatening to you at first, as though your defenses were down. Remember that you are working. It is you, the doctor, doing and being this way, not the personal you. What will you learn? For one, what the patient is feeling.⁸⁷

Rita Charon, a professor of medicine at Columbia University who has a Ph.D. in literature, also emphasizes that good medicine calls for physicians to be self-aware in their encounters with patients. She has developed a narrative approach to medicine that she uses to help students develop their self-awareness. Her students maintain a "parallel chart" in which they learn to narrate their encounters with patients; by doing so, they come to appreciate their patients' experience of illness as well as their own experience as physicians. Charon has identified three key movements that allow her students to develop the capacities they need to heal their patients: attention, representation, and affiliation.⁸⁸

First, the students must pay attention to the patient's story of illness. Then, as narrators,

⁸⁵ Ibid.

⁸⁶ Ibid.

⁸⁷ Ibid.

⁸⁸ See Rita Charon, "Narrative Medicine: Attention, Representation, Affiliation," *Narrative* 13 (October 2005): 261-70. See also Charon, *Narrative Medicine: Honoring the Stories of Illness* (New York: Oxford University Press, 2006).

they must represent the patient's story and this requires them to become aware of their own reactions or responses to the patient. Finally, through the work of attention and representation, the students become aware of the complex relationship between persons who are ill and persons who profess to heal so the students are better able to form therapeutic bonds with their patients: this affiliation is essential for the work of healing.

The emphasis Cassell and Charon place on the self-awareness of physicians helps to develop Pellegrino's insight that consent involves a knowing and feeling together. In particular, Cassell and Charon point the way toward an examination of medicine as an intersubjective phenomenon.

Whether and how physicians and patients can discern the end of healing

Clearly, physicians cannot make good on their profession to heal if they cannot deliberate with their patients to determine a right and good healing action. Moreover, this end cannot be achieved if physicians do not develop the kind of disciplined self-awareness they need in order to be healers. Indeed, the mutual deliberation that Pellegrino calls for can only take place as a dialogue between the physician and the patient. Otherwise, each party deliberates separately and they either agree or disagree; then, in the case of disagreement, the question of who decides becomes a subject for political (or moral) theory and the philosophy of medicine is irrelevant to the decisionmaking process.⁸⁹ To deal with this problem, I would turn to the considerable body of work on hermeneutics in the clinical encounter. I would begin with the work of Svenaeus, not only because his hermeneutical

⁸⁹ It is also possible that one party does not deliberate; then there is a *de facto* (as opposed to a *de jure*) unilateral decision.

approach to the clinical encounter takes him back to Aristotle's account of practical judgment in the *Nicomachean Ethics* as the proper context for understanding Pellegrino's philosophy of medicine, but also because Pellegrino's philosophy of medicine is the starting point for Svenaeus' hermeneutical theory of medical practice.⁹⁰ Svenaeus' theory of medical practice is consonant with the teleological structure of medicine articulated by Pellegrino. Svenaeus writes: "Medical practice . . . consist in an interpretive, attentive dialogue geared toward healing actions."⁹¹ Svenaeus summarizes the work of this dialogue by appealing to Gadamer:

With the help of Gadamer's hermeneutics we can understand the interpretive dialogue of the medical meeting as the gradual fusion of two horizons—the patient's perspective of unhomelikeness and the doctor's perspective of medical expertise and mission to help. The meeting of the two horizons as the inter-nesting of interpretations means that both parties must come to see things from the other party's point of view in order to reach a new, more productive understanding. The doctor must understand the patient's perspective and vice-versa, and this can only happen in the shared language of a dialogue. The two parties of the meeting must also, through this process of gradual fusion of horizons, ultimately reach a, to some extent, shared understanding, which results in a therapeutic decision.⁹²

This passage shows the extent to which Svenaeus' work in the philosophy of medicine responds to the question I have posed about whether (and how) patients and

⁹⁰ See Frederik Svenaeus, *The Hermeneutics of Medicine and the Phenomenology of Health: Steps Towards a Philosophy of Medical Practice* (Dordrecht: Kluwer Academic Publishers, 2000). See also Svenaeus, "Hermeneutics of Clinical Practice: The Question of Textuality," *Theoretical Medicine and Bioethics* 21 (2000): 171-89, and "Hermeneutics of Medicine in the Wake of Gadamer: the Issue of *Phronesis*," *Theoretical Medicine and Bioethics* 24 (2003): 407-31. In addition to Svenaeus' work, I would draw on Dan Davis' dissertation, "*Phronesis* and the Physician: A Defense of the Practical Paradigm of Clinical Rationality," (Ph.D. diss., Georgetown University, 1991). Pellegrino's teleology is the starting point for Davis' theory of clinical rationality.

⁹¹ *Ibid.*, 179.

⁹² *Ibid.*, 179-80. Svenaeus' use of the expression of 'unhomelikeness,' shows his debt to Heidegger, for this expression is meant to convey the uncanny feeling that is anxiety. (See Svenaeus, 93).

physicians can, together, discern the good to be achieved through mutual deliberation. This passage also shows a parallel to the work of Richard Zaner, who interprets Pellegrino's philosophy of medicine to show that medicine should be understood as a kind dialogue.⁹³ Zaner's primary criticism of Pellegrino's work is expressed in the following question.

Whether Pellegrino pays enough attention to the patients' need to trust

Zaner's criticism of Pellegrino raises a subtle, but important point that goes to the question of trust and the adequacy of Pellegrino's phenomenology of the clinical encounter. To develop this difference fully would require a substantial essay, if not a second dissertation, so I confine myself to the following brief presentation. According to Zaner, Pellegrino's work displays the tendency to shift attention from the patient's need to trust the physician to the question of whether the physician is trustworthy.⁹⁴ If more attention were paid to the patient's need to trust, then a key feature of illness could receive the attention it deserves: namely, the patient's need to trust the physician is especially acute because illness involves what could be called a breakdown of trustworthiness or a crisis of trust. In particular, illness undermines the variety of interrelated structures of the life-world that the patient could take for granted before the onset of illness. In this sense,

⁹³ See Richard Zaner, "Medicine and Dialogue," *Journal of Medicine and Philosophy* 15 (June 1990): 303-25. It is reasonable to assume that Zaner influenced Svenaeus directly since Svenaeus spent the 1997-98 academic year at the Center for Clinical and Research Ethics Zaner established at Vanderbilt University. See Svenaeus, *Hermeneutics of Medicine*, xi. Svenaeus' book is "a slightly revised version" of the dissertation he defended in April, 1999. (ix)

⁹⁴ See Zaner, "The Phenomenon of Trust."

the need for healing that comes with being ill could be expressed as the patient's need to be able to rely once again on the background structures of everyday life that made the patient's own life possible. When illness is framed in terms of the taken for granted aspects of daily life, then Pellegrino's description of illness as an ontological assault can be recapitulated as a crisis of trust: patients cannot rely upon that which made it possible for them to be who they are.⁹⁵ Consequently, the patient's need for healing cannot be separated from the patient's need for trust. However, when the examination of the clinical encounter shifts too quickly to the trustworthiness of the physician, then the connection between trust and healing is not fully appreciated.⁹⁶

⁹⁵ This statement comports well with Svenaeus' description of illness as uncanniness or unhomelikeness. See Svenaeus, *The Hermeneutics of Medicine*, 111-8. See also Svenaeus, "Das Unheimliche—Toward a Phenomenology of Illness," *Medicine, Health Care and Philosophy* 3 (2000): 3-16, and "The Body Uncanny: Further Steps toward a Phenomenology of Illness," *Medicine, Health Care and Philosophy* 3 (2000): 125-37.

⁹⁶ Notice also that when this connection is properly understood, then the physician's attention is drawn to the patient's experience of illness as more than a locational index for diagnostic inquiry because the patient's story communicates what the patient can no longer take for granted, but wants to recover. While the patient may not be able to recover his or her former way of being in the world, the physician can help the patient recover a way of being in the world that allows the patient's sense of integrity or wholeness to be renewed. In this way, the patient is healed.

The connection between trust and healing leads to a concern Zaner raised about Pellegrino's phenomenology of the clinical encounter in his comments on chapter 1 of this dissertation. Zaner to Rosen, e-mail, November 24, 2008, 11:48 a.m. Zaner noted that the fact of illness establishes the origin of medicine in two senses: there is "the fact of 'getting sick'" on the side of the patient and, on the side of the physician, there is the "wanting to help those who are sick." Zaner to Rosen, e-mail. According to Zaner, Pellegrino does not distinguish these senses (or sides). Hence Zaner asks whether Pellegrino's identification of the fact of illness as the origin of medicine is phenomenologically sufficient: "must there also not be some sort of wish, desire, plan, aim, to want to help those who are sick?" Zaner to Rosen, e-mail. Zaner addresses this question when he points out that patients want "to know that those who take care *of* them also care *for* them." Zaner, "Trust and the Patient-Physician Relationship," 49-50.

Contrast between Zaner and Pellegrino

After the foregoing discussion of Zaner's concern about Pellegrino's approach to the question of trust, I want to show how Zaner's work captures key insights that were mentioned in the two previous sub-sections (on whether physicians can appreciate their patient's experience of illness and whether patients and physicians can deliberate together). By doing so, I will be able to bring into focus the common ground between Zaner and Pellegrino. It is against this common ground, I submit, that the differences between them become significant. For their differences do not go to the question of whether the phenomenology of the clinical encounter makes a significant contribution to medical ethics: both agree that it makes a decisive contribution. Their differences go to the question of how that contribution can be fully articulated.

Zaner often raises the question of trust as he considers what it means when the patient asks the professional, "put yourself in my shoes," Zaner shows that the appeal for compassion calls for a certain kind of dialogue:

What is obvious about any human encounter is even more fundamental to the clinical situation: one enters or is party to them *with 'what I am'* and there is no getting around or belying that. To dialogue with another, there is nothing for it but to *be oneself*, and in that (hopefully) to *enable the other to be himself* as well, with all that is entailed. To 'put yourself in my shoes' does not in the least require that you somehow deny, do without, get rid of (even momentarily), anything of what

Zaner also grapples with this issue when he takes up the story of Gyges' ring from Plato's *Republic*. See Zaner, "Physicians and Patients in Relation," 232-4 and Zaner, "A Meditation on Vulnerability and Power," in *Health and Human Flourishing: Religion, Medicine, and Moral Anthropology*, eds. Carol Taylor and Roberto Dell'Oro, eds. (Washington, DC: Georgetown University Press, 2006), 147-9. In contrast to the anti-Hippocratic position developed by Veatch, Zaner thinks that the question of trust is central to the Hippocratic ethic. In particular, Zaner argues that the Hippocratic ethic is meant to protect patients from being harmed by their exposure to physicians. See "Physicians and Patients in Relation," 230-231, "Meditation on Vulnerability and Power," 146-7.

you are (what “values” are definitive to that most of all). Even to attempt that is to fail, and moreover it is to practice a sham of a dialogue.⁹⁷

Zaner gets at the work of healing in this passage: it is to enter into a dialogue with the patient in a way that enables the patient to recover him- or herself. As Zaner makes clear, such a dialogue cannot take place unless the professional is present as him- or herself. However, Zaner also makes it clear that the professional needs to be present in a way that enables the patient to come forward, with his or her vulnerabilities, as him- or herself. After all, patients cannot be healed (become whole again) unless they feel free to be the persons that they are *here* and *now*: suffering from illness, uncertain of the future, and unable to count on those things that were taken for granted before the onset of illness.

Zaner expands upon this insight in a subsequent essay. “To experience things as the patient experiences them,” he writes in “Trust and the Patient-Physician Relationship,” “requires helping the patient understand and talk about just what this patient believes, desires, aims for, values, and the like.”⁹⁸ This is hard work:

Not only are we in our daily lives rarely called on to engage in this kind of reflection and self-inspection, but it is a quite difficult act to undertake and sustain. At the same time, for the professional to provide that kind of help, disciplined self-knowledge by the professional is clearly required—that is, frequently practiced, disciplined reflection intended to delineate the professional’s own feelings, moral beliefs, social framework, etc., along with a rigorously disciplined suspension of it, in order to understand what things are like for the other person. This can be understood as a kind of ongoing practical distantiation that undergirds the act of compassion or affiliative feeling. This difficult act, I believe, turns out to be crucial for establishing a basis for patient trust; hence, it seems to me integral to the patient’s appeal for the professional’s responsiveness.⁹⁹

⁹⁷ Richard Zaner, “Medicine and Dialogue,” *JMP* 15 (1990): 321.

⁹⁸ Zaner, “Trust and the Patient-Physician Relationship,” 59.

⁹⁹ *Ibid.*

In this passage, Zaner suggests an important, but subtle, difference from Pellegrino's position. Pellegrino's phenomenology shows that the clinical encounter is a deliberative inquiry and the focus is on the end (*telos*): a right and good healing action. Zaner's phenomenology stays longer with the origin (*arche*). This shift in attention calls upon the professional to attend to the patient differently so as to elicit from the patient who the patient is as an agent: the professional is not yet looking toward the end of healing; instead, the professional seeks to understand the experience of the person who asks for help. As our examination of Pellegrino has shown, this kind of listening is required for the physician to be a healer. However, before the end of healing can properly order the encounter of patient and physician, the origin of their encounter must be understood; for this understanding to be achieved, the patient must appear as him- or herself, and the professional must register who the patient is, as *this* person. This achievement cannot happen without a dialogue that seeks to uncover the patient's predicament, his or her vulnerability, uncertainty, and need to trust.

The initiation of this dialogue and the work of developing the dialogue for the sake of healing does not require extraordinary sensitivity or an inordinate amount of time. Instead, it requires of the professional three items that are typically in short supply: disciplined self-awareness, a readiness to be available to the patient, and a willingness to be vulnerable because one is aware of oneself as one makes oneself available to the other.¹⁰⁰ Cassell and Charon have written about how physicians can learn to become

¹⁰⁰ Herein lies the importance of professional detachment. The physician is not available as *this* person who is also known to (or remembered by) parents, children, friends, and acquaintances, but as the *doctor*. Cassell makes this point in respect to the physician's

available to their patients in this way.¹⁰¹ What Zaner adds to their work is the careful articulation of this intersubjective possibility in *Ethics and the Clinical Encounter* where he lays out his own phenomenological approach to medical ethics.¹⁰²

Zaner's medical ethics builds on an earlier study in which he pursues the question of how one becomes a self in the first place. In *The Context of Self*, Zaner describes the thoroughly intersubjective dynamic whereby one self *enables* an other to become a self through an empowering mutuality.¹⁰³ Although Zaner is primarily concerned with the growth or development of the self, his discussion the dynamic encounter between an enabling self and an enabled self provides much needed insight into the clinical encounter. To be ill is to no longer be the self one was prior to the onset of illness because one can no longer take for granted whatever allowed that earlier self to be itself. The upshot of illness is a profound uncertainty: one cannot know whether or how one can be oneself again; and if one cannot be oneself again, then who will one be in the future? And who is one now, between past and future selves? When illness is framed in this manner, the need for healing becomes a need to be enabled to become oneself again, but in a new way imposed by the experience of illness. This need calls for the help of someone who knows what is

need for personal detachment so as to be self-aware and available to patients in need of help: "It may seem threatening to you at first, as though your defenses were down. Remember that you are working. It is you, the doctor, doing and being this way, not the personal you." Cassell, "Diagnosing Suffering," 534.

¹⁰¹ See Cassell, *Doctoring and Charon, Narrative Medicine*.

¹⁰² Zaner, *Ethics and the Clinical Encounter* (Englewood Cliffs, NJ: Prentice-Hall, Inc.: 1988). Zaner has refined his approach to clinical ethics in numerous essays published since 1988.

¹⁰³ See Richard Zaner, *The Context of Self: A Phenomenological Inquiry Using Medicine as a Clue* (Athens, Ohio: Ohio University Press, 1981), 199-241.

required to enable persons who are ill to become themselves again, namely the physician *qua* healer.

In my view, the dialogue that Zaner emphasizes should not be interpreted as an alternative to the deliberative model presented by Pellegrino. It is, instead, a description of the deliberative process that happens within the clinical encounter. Zaner's description has been shaped by his work as a clinical ethicist: he knows what it takes to initiate the dialogue and to keep the dialogue going so that the end of healing can be discerned.

Pellegrino aptly summarizes Zaner's approach in his foreword to Zaner's *Troubled Voices: Stories of Ethics and Illness*. Pellegrino writes about Zaner:

In his narration of each case, [Zaner] makes it clear that he is immersed in a common quest with those who seek his help. His aim is not to display his technical proficiency as an ethicist, but through questions and responses to enable others to see what course of action is best for them. Zaner strives to put himself in the other person's shoes—a simple way to express the aim of his finely honed and sophisticated use of dialogue.¹⁰⁴

What Pellegrino says about Zaner's work as an ethicist also expresses Pellegrino's view of the physician's task as a healer: a "finely honed and sophisticated . . . dialogue" that seeks to determine a right and good healing action for this patient must "enable [patients] to see what course of action is best for them."

In closing, I would suggest that Zaner's work demonstrates the lasting influence of Pellegrino's philosophy of medicine. The phenomenology of the clinical encounter he presented in "Toward a Reconstruction of Medical Morality" in 1979 will continue to

¹⁰⁴ Pellegrino, foreword to *Troubled Voices: Stories of Ethics and Illness*, by Richard Zaner (Cleveland: The Pilgrim Press, 1993), xii.

provide fertile ground for future developments in the ongoing task of grounding the ethics of medicine in the meeting between a person who is ill and a person who professes to heal.

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