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Medicine as a Goal-Directed, Moral Practice

Physicians and other health care professionals face many challenging decisions, and for this reason they need practical wisdom. Practical wisdom is a virtue, or character trait, that allows those who have it to respond well to a challenge of decision making – that is, to respond with realistic appreciation for the objective features of a situation and with sensitivity to the moral values it involves. Practical wisdom is ends-oriented, which is to say that knowledge of what *ends* are worth pursuing ought to precede consideration of what *means* are most likely to achieve those ends. Because practical wisdom is directed toward an end, it is a purpose-driven pursuit, one that seeks the best means to fulfill an end or achieve a goal. In the absence of ends or goals, practical wisdom ceases to carry the meaning it otherwise implies. As an ends-oriented virtue, practical wisdom is therefore *teleological* because it is directed toward, and guided by, an end (in Greek, *telos*). The relationship between wisdom and ends is of central importance in this book, and to understand what practical wisdom means in medicine, we must first understand what the practice of medicine accepts as its ends or goals. In Chapter 3, practical wisdom will be discussed in much more detail.

I. INTERNAL AND EXTERNAL GOODS RELATED TO MEDICAL PRACTICE

Any discussion of medicine's ends will reveal that there is wide agreement about what kinds of goals the practice of medicine should pursue. But if discussions probe deeply and broadly enough, it will also become apparent that people disagree about some of the goals that may be associated with the practice of medicine. One source of disagreement stems from divergent beliefs about whether the goals of medicine are properly viewed

as intrinsic or extrinsic to the practice of medicine itself. *Intrinsic ends* concern those aspects of medical practice that relate most closely, and respond most directly, to the human experience of illness and the bodily and mental effects of disease. Medicine's intrinsic ends would include the well-known goals of healing, comforting, and preventing disease – ends that are so easily taken for granted that it may seem strange to suggest they could be otherwise. These intrinsic ends may be said to represent the *internal goods* of medical practice, on the grounds that these goods are inseparable from the practice of medicine as we currently understand it. The claim that such goods are internal implies that their validity is independent of, and prior to, other considerations such as professional standards, patient preferences, public policies, social conventions, and historical circumstances.

By contrast, *extrinsic ends* concern those uses to which medicine may be put in the service of goals that do not relate directly to purposes such as healing, comfort, and disease prevention. Extrinsic ends correspond to other goals that justify and guide medical activity. Examples of extrinsic ends in medical practice are not hard to find. A team physician can use his skills to stabilize an athlete's injury and minimize her pain in order to enhance her team's prospects for victory. A general internist can perform a physical examination and laboratory testing to determine a prospective employee's health insurance risks. A psychiatrist can determine an accused person's competence to stand trial. A military physician can use vaccinations to enhance national security by lessening soldiers' vulnerability to biological agents of warfare. A pediatrician can prescribe growth hormone to treat a young boy's short stature and thus improve – according to parental estimations – his prospects in life. Such examples illustrate how extrinsic ends arise from circumstances, preferences, or priorities that motivate people and organizations to employ medicine as a means to ends other than, or beyond, direct healing, comfort, or disease prevention for individual patients.

The distinction between intrinsic and extrinsic ends, or internal and external goods, has both advocates and critics. One advocate, Edmund Pellegrino, argues that the basis for the distinction is real and vital, maintaining that the ends of medicine can and should be derived from values internal to medicine (what he calls the *essentialist* position) rather than from values externally imposed on medicine by society (what he calls the *socially constructed* position). The essentialist position derives its ends from the nature of medicine itself, whereas the socially constructed position derives its ends from an external social source "arrived at by

social dialogue, consensus formation, political process, or negotiation."[1] With colleague David Thomasma, Pellegrino offers a phenomenological justification for an essentialist position within a philosophy of medicine that provides a teleological account of medical practice based on its internal goods.[2] Within this account, the ends of curing, caring, helping, and healing form a valid *telos* of medicine because these ends are derived from the internal goods of medicine. But conceptions of medical practice based on traditional notions of internal goods have their critics. Those who view the practice of medicine as a socially constructed enterprise offer a competing perspective, claiming that medicine's social organization is more determinative than its proposed philosophical foundations or perceived ethical norms, at least as far as predicting the behavior of medical professionals is concerned.[3]

In contrast to the essentialist and socially constructed views, a third alternative can be called the *professionally constructed* perspective, according to which professionals impose their own values on the practice of medicine. This view suggests that medical professionals are the authors of their own practice, that they develop and maintain their own concepts of health and disease, which are value-loaded rather than scientifically objective, and that they use these concepts to justify and achieve professionally determined goals. Critics of a professionally constructed perspective of medicine may offer contrasting views in which patients and physicians are supposed to negotiate the terms of the medical encounter. One such approach recommends that patients bring to medical professionals any problem that concerns them and then negotiate the terms of interpreting the problem in a way that allows both the patient and the professional to participate in the process of interpretation. One advocate of this approach claims that, after such dialogue, "a patient is usually quite ready to change his view of what his problem is from purely a symptomatic one to one that ties the symptoms, present and possible, to a disease, and the physician, for his part, is often quite ready to adapt his notion of a problem, diagnosed in terms of a particular disease, to what it will mean to

[1] Edmund D. Pellegrino, "The goals and ends of medicine: how are they to be defined?" in *Physician & philosopher: the philosophical foundation of medicine – essays by Dr. Edmund Pellegrino*, ed. Roger J. Bulger and John P. McGovern (Charlottesville, VA: Carden Jennings, 2001), 59.

[2] Edmund D. Pellegrino and David C. Thomasma, *A philosophical basis of medical practice: toward a philosophy and ethic of the healing professions* (New York: Oxford University Press, 1981).

[3] Eliot Freidson, *Profession of medicine: a study of the sociology of applied knowledge* (Chicago: University of Chicago Press, 1970), 5.

the patient in the short run and in the long run."[4] On such an account, the practice of medicine is a process of consensus about what is allowed to count as a medical problem, and the patient–clinician relationship is an interpretive partnership that is entitled to make this determination.

Given the predictive powers and interventional techniques that have been achieved through biomedical science and clinical investigation, some may find it strange that anyone would suggest that patients ought to be empowered to influence the definition of what constitutes a medical problem. They might suggest that a more objective status should be granted to the patient–physician encounter, one that is less dependent on the subjective perspectives of patients and professionals. But critics of professionally constructed views of medicine are right to draw our attention to the ways in which subjective values can affect how our concepts of health and disease are defined and how goals of medicine are derived from these concepts. Such critics also remind us of the importance of patient–physician dialogues that acknowledge and engage the particular beliefs and needs of patients, without denying the validity of the knowledge and skill that professionals gain from training in biomedical science and through clinical experience.

II. DIVERGENT CONCEPTS OF HEALTH AND DISEASE

Unsettling as they may be, questions about the degree to which medicine is an objective endeavor encourage us to examine assumptions that may be embedded in our basic concepts. Common meanings of *health* and *disease* are largely taken for granted in the practice of medicine, by physicians and patients alike, and we do not usually pause to discuss their meanings when we hear phrases such as "Smoking is bad for your *health*," "Cardiovascular *diseases* kill many Americans," "the National Institutes of *Health*," "the Department of Public *Health*," or "the Centers for *Disease* Control and Prevention." Indeed, it would be a rare event to hear a patient and physician discuss the meanings of health or disease during a clinical encounter. But these observations about common practice should not cause us to conclude that consideration of the meanings of our basic concepts is unimportant.

[4] John Ladd, "The internal morality of medicine: an essential dimension of the patient–physician relationship," in *The clinical encounter*, ed. Earl E. Shelp (Dordrecht: Reidel, 1983), 228.

Questions prompted by philosophical, historical, and sociological observations readily reveal the extent to which the meanings of health and disease can be debated and how their various interpretations carry implications for the way medicine is conceptualized and practiced. Consider, for example, how concepts of disease have evolved over thousands of years, with competition between perspectives that view disease as a reality existing separately from the persons it affects and perspectives that view disease as a deviation from whatever society considers normal.[5] In addition to the fascinating variability in the way diseases have been classified (nosology) from one historical period to another, observers also point out how values are active in identifying undesirable conditions (that are judged bad and are therefore considered diseases) and desirable conditions (that are judged good and are therefore considered manifestations of health). Such observations support the conclusion that concepts of health and disease are determined by a mixture of scientific, statistical, and cultural norms, resulting in a definition of disease as "the aggregate of those conditions which, judged by the prevailing culture, are deemed painful, or disabling, and which, at the same time, deviate from either the statistical norm or from some idealized status."[6] By correlation, health is the absence of disease.

But not everyone agrees that concepts of health and disease are derived only from some mixture of scientific, statistical, and cultural norms. Leon Kass, for example, observes that the English and Greek origins of terms pertaining to health signify "wholeness" (English, *health*) and "living well" (Greek, *hygeia*) and that these terms have a standing that exists independent of their linguistic associations with disease.[7] His Aristotelian conclusion is that health is "the well working of the organism as a whole" and this "well working" is a natural norm characterized by specific excellences of the human body,[8] not a value judgment imposed by a society or culture onto a "value-neutral condition of the body."[9] H. Tristram Engelhardt offers an assessment that resonates with Kass's view by suggesting that health serves as a unifying regulative ideal that represents the common

[5] Henry Cohen, "The evolution of the concept of disease," in *Concepts of health and disease: interdisciplinary perspectives*, ed. Arthur L. Caplan, H. Tristram Engelhardt, and James J. McCartney (London: Addison-Wesley, 1981), 209–19.
[6] Lester S. King, "What is disease?" in *Concepts of health and disease*, ed. Caplan et al., 112.
[7] Leon R. Kass, "Regarding the end of medicine and the pursuit of health," in *Concepts of health and disease*, ed. Caplan et al., 15.
[8] Ibid., 18.
[9] Ibid., 13.

direction away from all the various diseases. However, he differs from Kass in holding that both disease and health are simultaneously descriptive *and* normative concepts, as both involve explanation and evaluation.[10] In contrast to the approaches of Kass and Engelhardt, a sociological perspective of health may focus on the individual's ability to participate in society, as evidenced by Talcott Parsons's description of health as "the state of optimum *capacity* of an individual for the effective performance of the roles and tasks for which he has been socialized."[11]

For the purposes of this book, I acknowledge the shifting currents of nosology in the history of medicine and the normative implications for medical practice of the malleability of the concept of disease. But with Kass, I also assume that health has an objective aspect that need not be in conflict with its subjective interpretation and experience for individual patients.[12] I further assume with Parsons that there are features of health and illness that are common to all human beings on the basis of their shared constitutions, features that would also be expected to vary as a function of social and cultural circumstances.[13] Finally, I acknowledge the implications of George Engel's warnings against reducing health and illness to a set of narrow biomedical parameters, as well as his call for a biopsychosocial model of illness that takes account of the multidimensional ways in which the biological substratum of disease affects and is affected by an individual's psychological, behavioral, and social contexts.[14] Together, these assumptions constitute a perspective that recognizes objective features of human biology, subjective features of human valuing, and contextual features of human society.

Our diverse concepts of health and disease, and the extent to which their meanings are believed to be either objectively verifiable or socially constructed, indicate why the goals of medicine can be viewed as having an intrinsic or extrinsic justification. Significant implications flow from these divergent sources of justification and their potentially contrasting values. The importance of this intrinsic–extrinsic dichotomy was

[10] H. Tristram Engelhardt, "The concepts of health and disease," in *Concepts of health and disease*, ed. Caplan et al., 31–43.
[11] Talcott Parsons, "Definitions of health and illness in the light of American values and social structure," in *Concepts of health and disease*, ed. Caplan et al., 69.
[12] Kass, "Regarding the end of medicine and the pursuit of health," 12.
[13] Parsons, "Definitions of health and illness in the light of American values and social structure," 57, 61, 62.
[14] George L. Engel, "The need for a new medical model: a challenge for biomedicine," in *Concepts of health and disease*, ed. Caplan et al., 589–607.

addressed by a group of international scholars convened by the Hastings Center to identify goals that should guide the practice of medicine.[15] They labeled the two sides of this dichotomy the *inherentist* and *social construction* views. The inherentist position holds that "medicine's proper ends are constituted as a response intrinsic in medicine's practice to the universal human experience of illness."[16] By contrast, the social construction position holds that the great variability of medicine's goals over time and across cultures – due to variable interpretations of disease, illness, and health – makes it difficult to identify a single set of inherent values that would determine a common and enduring set of goals. Medicine on this view is seen as "an evolving fund of knowledge and a changing range of clinical practices that have no fixed essence" and are characterized by "scientific and social malleability."[17] Notably, these scholars were unable to achieve full consensus on whether the goals of medicine should be derived from inherent features of medical practice or from socially constructed features. Instead, they affirmed both perspectives, concluding that "medicine has essential ends, shaped by more or less universal ideals and kinds of historical practices, but its knowledge and skills also lend themselves to a significant degree of social construction."[18] They also believed, however, that the medical profession should rely on its historical traditions and its "inner direction and core values" in order to avoid being misused by society.[19]

Acknowledging the need to come to terms with questions about our concepts of health and disease is an important first step in appreciating how our understanding of medicine as a moral practice depends on beliefs about what medicine's purposes should be. Practical wisdom in medicine depends fundamentally on goals derived from these purposes. An understanding of practical wisdom in medicine will be shared only to the extent that there is consensus about medicine's goals. Before discussing specific goals considered appropriate for medicine, it will be helpful to pursue a bit further the question of medicine's internal features by appropriating insights from Alasdair MacIntyre's analysis of the relationship between virtues and the notion of a *practice*. In the process, the

[15] Mark J. Hanson and Daniel Callahan, eds., *The goals of medicine: the forgotten issues in health care reform* (Washington, DC: Georgetown University Press, 1999).
[16] Ibid., 15.
[17] Ibid., 16.
[18] Ibid.
[19] Ibid.

difference between medicine's internally and externally derived goods, or ends, will become clearer.

III. MEDICINE AS A PRACTICE AND THE POTENTIAL FOR TENSION BETWEEN INTERNAL AND EXTERNAL GOODS

In *After Virtue*, MacIntyre describes moral virtue as it relates to the concept of a *practice* and the way in which different goods, or ends, may be internal or external to a practice. His definition of a practice is, admittedly, not simple: "any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended."[20] The length and substance of this definition indicate how significant a human endeavor a practice is, on this view. And if one reads this definition with health care in mind, it is not hard to see how directly it applies to the practice of medicine.

For MacIntyre, internal goods are a necessary feature of a practice and a prerequisite for understanding how virtue functions in the context of a practice. The ability to recognize the internal goods of a practice is gained by participating in that practice, such that those who lack the relevant experience are incompetent to judge a practice's internal goods.[21] Moreover, because a practice involves standards of excellence and obedience to rules, those who enter a practice necessarily submit their professional performance and attitudes to the authority of those standards.[22] Finally, the achievement of the internal goods of a practice is not the individual accomplishment of an independent practitioner, but rather represents a success for all who participate in that practice.[23] On MacIntyre's account, medical practice entails an intimate relationship between the internal goods pursued by individual professionals to the benefit of patients – such as healing, comfort, and disease prevention – and the overall good that sustains the community of medical professionals.

[20] Alasdair MacIntyre, *After virtue* (Notre Dame, IN: University of Notre Dame Press, 1984), 187.
[21] Ibid., 189–90.
[22] Ibid., 190.
[23] Ibid., 190–91.

There is therefore an interdependence between the internal goods, the individuals who make up the community of practice, and the community of practice itself. Such an account places the question of medicine's internal goods at the center of any discussion of how virtue ethics and practical wisdom should be understood in medicine.

To view the medical profession as a community of practice – in which internal goods are definitive and standards of excellence authoritative – is to view medical professionals as members of a moral community who are defined not only by a technical practice, but also by ethical standards that are constitutive of their professional identity. MacIntyre's account relates *practice* to *ethics* by defining virtues as those qualities of professionals that are essential to achieve the internal goods of a practice.[24] Virtues – such as compassion, benevolence, justice, courage, and honesty – not only shape the character of interactions between medical professionals and patients, but also are the means by which professionals define their relationships to each other.

MacIntyre distinguishes between internal and external goods to draw a contrast between *practices* and the *institutions* that sustain them. As an illustration of this internal–external distinction, consider in medicine the internal goods of healing and benevolence and the external good of financial compensation. For instance, hospital-based physicians know that their professional responsibility is to implement excellent diagnostic and therapeutic strategies so that a hospitalized patient recovers as quickly as possible and disease-related suffering as well as the risk of hospital-associated complications are thereby minimized. However, they are also aware that by limiting the length of a patient's stay in the hospital (i.e., by discharging a patient from the hospital sooner rather than later), more revenue will be received by the hospital due to the nature of diagnosis-associated payment mechanisms. In such a context, how do physicians stay focused on the health-centered needs of patients when they are also aware of the finance-centered needs of hospitals? Similarly, clinic-based physicians are aware of their professional obligations to promote health and minimize burdens for their patients. But they are also aware that under fee-for-service reimbursement mechanisms, more revenue comes from more return visits to the clinic, since clinic visits are billable. By contrast, follow-up provided by telephone or email communications may be medically appropriate and very convenient for patients, but they may not be compensated. How do physicians stay patient-centered in their

[24] Ibid., 191.

practice strategies in the midst of such financial incentives? These examples illustrate how real and relevant the distinction between internal and external goods can be.

The distinction between internal and external goods reminds us that tensions can arise whenever internal and external goods are pursued in tandem, which – MacIntyre reminds us – they always are. Institutions like hospitals are necessarily concerned with external goods. In the course of sustaining the *practice* of medicine, hospitals acquire, organize, and distribute external goods such as money, power, and status. These external goods pose challenges for a practice, but they are also necessary as the practical means by which practices are sustained over time.[25] The interrelationship of practices and institutions is intimate and tense:

> Indeed so intimate is the relationship of practices to institutions – and consequently of the goods external to the goods internal to the practices in question – that institutions and practices characteristically form a single causal order in which the ideals and the creativity of the practice are always vulnerable to the acquisitiveness of the institution, in which the cooperative care for common goods of the practice is always vulnerable to the competitiveness of the institution. In this context the essential function of the virtues is clear. Without them, without justice, courage and truthfulness, practices could not resist the corrupting power of institutions.[26]

The contrast MacIntyre draws warns us against the risk of confusing practices, and their internal goods, with institutions, and their external goods. This is a warning we should hear. But he presents the contrast so starkly that he runs the risk of implying that institutions are so focused on external goods that they cannot also be devoted to the internal goods of the practices they sponsor and sustain. We should therefore qualify MacIntyre's assessment by recognizing that institutions can be, if their leaders and members choose, genuinely devoted to the internal goods of the practices they sustain, even while they are also busy pursuing goods external to those practices. Good institutions, we might say, are those that place the purpose of a practice at the heart of their mission and allow that purpose to pervade and guide the entire organization and its activities. At their best, good institutions organize human endeavor in ways that promote valuable ends. They do so by setting expectations, maintaining standards, and creating structures and procedures that not only help achieve those ends but also support the moral values and integrity of

[25] Ibid., 194.
[26] Ibid.