Medicine's Goals and the Prophetic Tradition

Catholic Health Care Has an Opportunity to Help the Medical Profession Return to Its Roots

BY ROBERT J. WALTER, DHCE

Dr. Walter, who studied health care ethics at Duquesne University, Pittsburgh, is currently a senior associate, Neiswanger Institute for Bioethics and Health Policy, and a third-year student in the Stritch School of Medicine; both institutions are part of Loyola University Chicago.

An 83-year-old male is admitted to the emergency room for diffuse pain, increased lethargy and confusion, and shortness of breath. A physical exam and lab studies reveal widespread metastatic cancer infiltrating the lung, spine, and brain.

The man is transferred to intensive care for stabilization and continued monitoring while therapeutic options are considered. After surgery and radiation/oncology consultations, physicians determine that the patient requires several surgical procedures, as well as extensive chemotherapy and possible radiation therapy.

However, even with these interventions, the patient's six-month-survival probability is less than 10 percent. The alternative is to forgo invasive life-prolonging treatments and provide palliation of his pain and symptoms so that he can be as comfortable as possible in his remaining time.

It is cases such as this that raise questions about the goals of medicine and about what constitutes the proper pursuits of the medical profession. Should the prolongation of life be medicine's goal? Or should it perhaps be the alleviation of suffering and pain? If the reality is that both of these are goals, how do we reconcile them when they conflict, as they do in the case above?

The answer lies in medicine's foundation as a profession and is expressed in both its telos and ethos. However, within the last half century, the medical profession has undergone many changes, some of which have challenged its fundamental groundings. These changes have altered our conceptions of medicine's telos and ethos, and in doing so have brought with them the potential to change the face of modern medicine. While this trend has been supported by some experts, who claim that it is a necessity of the times, others have voiced their concerns that the profession has lost it roots and its ability to agree upon a common telos and ethos. These changes and uncertainties challenge Catholic health care, which necessarily exists between two worlds: the goals and values of the medical profession and the values and belief structure of the Roman Catholic faith.

To examine such issues, it is necessary to look at the practice of medicine, discern its goods, and describe the role of the medical profession. It is necessary, too, to examine the role of religious dialogue in the public forum. In this article, I will argue that the medical profession represents the organization of an act that carries with it a "special nature." This special nature is grounded in the profession's response to the human vulnerability produced by illness—the vulnerability of the ill person to whomever is trusted to restore his or her health.

Because of this special nature, the medical profession carries with it an intrinsic responsibility. This responsibility is grounded in the inescapable reality of the human condition—finitude and susceptibility to illness.* The act of medicine, therefore, must be a rightful response to this vulnerability and, as a result, can only take place within a profession.

Medicine and Its Foundations

Some critics have argued that the medical profession is in a state of complete moral decline. I do

* I use the term "intrinsic" here to mean that which has been true throughout human history and which reasonable speculation leads one to believe will continue to be true in the future.

not believe this to be an accurate depiction. Rather, I agree with Edmund Pellegrino, MD, who contends that what is being experienced in the profession is a paradigm shift: What was a vocation of healing is becoming a career of self-interest. An important contributor to this paradigm shift is a lack of a well-developed ethical and moral aspiration. According to Pellegrino, when the ethic and moral aspiration are in place, the profession is a *vocation* or calling. When they are not in place, or are unclear, the profession becomes a *career*.[1]

A vocation is a calling to serve specific ends that are beyond one's own ends. These non-self-interested ends are served according to a defined set of moral standards. "Career" is derived from the Latin word *carrus,* or "wheel" (from which also comes the English word "car"). A *carrus*—which might more broadly be interpreted as "wagon"—enables one to travel in any direction, at any speed, as long as one does not break the law; no guide other than enlightened self-interest is required.* The term "career" implies a line of work in which one may pursue any given personal end as long as it remains within the bounds of the law and the rules of the workplace. A career has no defined set of objective standards guiding actions toward specific moral ends.

INTERNAL AND EXTERNAL GOODS

The philosopher Alasdair MacIntyre suggests distinguishing between goods *internal* and *external* to a particular practice. A *practice* he defines as "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 conception of the ends and goods involved, are systematically extended." [2]

The practice of teaching, for example, allows for the acquisition of several goods, both external and internal. Assuming that a teacher is good at his or her job, the external goods realized will include an appropriate salary, social status, and positive student-faculty evaluations. The internal goods realized will include increased knowledge and analytic skill and adherence to objective standards that inform pedagogy. Any practice may facilitate the achievement of any of these goods. In a profession, however, the achievement of excellence is specifically related to the acquisition of the profession's internal goods.

In American culture, teaching offers a good example of how external and internal goods are distinct from each other. Even though teachers may not be paid adequately or given the respect they deserve, their failure to achieve these external goods does not imply the failure of the teaching profession. Indeed, the profession's excellence is measured only by the goods internal to its practice.

Unlike a profession such as teaching, a career is directed primarily by external goods that determine its excellence. Success in a career, like success in business, is determined by profit return and customer satisfaction. Internal goods, if any exist, are often secondary to the external goods and have no moral import. The primary pursuit of external goods is not just acceptable—it is encouraged and praised in the practice of a career. This is one substantial difference between a career and a vocation or profession. When a profession reorients itself in a way that gives the achievement of external goods primary place at the expense of its internal goods, or when the internal goods that once were important to the profession no longer morally define and structure the practice, the profession undergoes a substantial paradigm shift. [3]

Such is arguably the case in the practice of contemporary medicine. As a profession, medicine must be aimed towards the goods internal to its practice. These internal goods, in turn, become the basis for the professional ethic. As noted earlier, it is the acquisition of these goods for the benefit of the patient that directs the excellence of the profession.

But today a number of prominent spokespersons in the medical community believe that medicine has begun to stray from its pursuit of internal goods and is instead pursuing the various goods external to its practice. These external goods range from social status to "appropriate" salary, from commercial goods to patient satisfaction.

While all of these goods are worthwhile, they should not be the defining characteristics of medicine and should not dictate how the profession acts and develops morally. If indeed

A career has no defined set of objective standards guiding actions toward specific moral ends.

---

* *Enlightened self-interest* may be defined as the pursuit of legitimate ends for the self while respecting the rights of others. As such, it has no defined specific moral ends and is regulated primarily by law.

In distinguishing professions from careers, I do not mean to portray careers in a negative light. The self-interest inherent in the notion of a career is not necessarily selfish. One who pursues a career is not expected to profess his or her willingness to forsake (or at the very least temper) personal ends for larger ones. There is nothing morally wrong in pursuing a career.

medicine has begun to shift its primary focus toward external goods, then it is undergoing a substantial paradigm shift away from the practice of medicine as a response to the vulnerability of illness.

Illness, Profession, and Medicine

The medical profession must attempt to rediscover its internal goods. It will do this through an orientation of its practice towards a response to the fact of illness, an ontological attack upon the human person resulting in a vulnerability to which only medicine may respond in an attempt to restore the full dignity of the patient.

Medicine, when understood as a response to the patient's vulnerability, develops a profound ethic from this central theme. Both this ethic and its implications for the practice of medicine can be seen, in part, in Pellegrino's notion of three phenomena he sees as specific to medicine: *the fact of illness, the act of profession,* and *the act of medicine.*[4]

An examination of the ethic may begin with the *fact of illness.* Medicine exists because humans become ill. Illness, Pellegrino writes, may be defined as "a subjective state, one in which a human being detects some change, acute or chronic, in his/her mode of existence based in anxiety about the functions of body or mind."[5] Perceiving this altered state of existence, an individual becomes a patient, "one who bears some disability, some deficiency or concern, one who is no longer 'whole,' one who perceives special limits on his or her accustomed activity." Pellegrino argues that this is nothing less than an ontological assault on the unity of body and self. It hinders or impedes the person's ability to choose and enact choices and actions. He or she is no longer able to pursue what Pellegrino calls "transbodily purposes" (e.g., knowledge, friendship, justice, love).[6] Illness, in essence, erodes the self-image the patient has shaped throughout his or her life.

In this state, the health normally perceived as a means toward freedom and other primary values is no longer present. Because the patient is compromised in his or her ability to pursue important goals, he or she becomes vulnerable, experiencing a state of "wounded humanity."[7] This existential change in the patient lends a special dimension to the state of illness.* The existentially vulnerable state in which the patient comes to the physician requires that the latter publicly "profess" his or her intention to try to heal the former. This is what entering into a profession implies. The *act of profession* (the word "profession" is taken from its Latin root *profiteri,* "to profess") is "an active, conscious declaration, voluntarily entered into and signifying willingness to assume the obligations necessary to make the declaration authentic."[8] The act of profession is a promise made to the existentially vulnerable patient (and to the community) to restore health.

Each profession possesses a central act of commitment that is the "vehicle of authenticity and the bridge which joins the need of the one seeking help with the promise of the one professing help."[9] In the medical profession, this is the *act of medicine,* in which the ethical obligations of the healer are grounded. This is the enactment of the promise that the physician publicly makes to the patient and society. To detail the act of medicine, one must first consider the end of medicine, which, as Pellegrino says, is "a right and good healing action taken in the interests of a particular patient."[10] This right and good action constitutes the act of medicine. It is a combination of technical and moral decision making that affords it the status of a "moral enterprise" of a special kind, due to the fact that a medical decision consists of a "complicated interplay of several value sets—those of the physician, of the patient, and of society."[11]

Medicine's Telos

Given an understanding of the three phenomena (the fact of illness, the act of profession, and the act of medicine), one must consider the implications for the profession. It will be helpful to focus on medical practice in terms of its *telos,* or ultimate end. It is clear that a professional ethic grounded in internal goods is the most appropriate ethic for any profession. Defining biomedical ethics as a simple application of traditional theoretical ethics is both inappropriate and insufficient.

I believe that one overarching telos governs the professional ethic of medicine—serving the best interest of the patient through some action that promotes his or her right and good healing. All other ends or goods of medicine (intermediary ends or goods) are aimed toward *this* telos.

Under this ultimate end, Pellegrino subsumes four, more focused goods.[12] Each of the four presupposes an ethic of beneficence and is consistent with the focus of medicine as a response to the vulnerability of the patient. The four goods' primary purpose is to articulate the telos more concretely so that the professional ethic can be understood and accomplished in a clinical setting. The four goods are internal to the practice of

* It is this special dimension, this woundedness, that should warn us not to classify medicine as a commodity like any other. The restoration of health is fundamental, because through it all other goods may be realized.

medicine. As such, they help guarantee medicine's excellence and integrity as a profession.

The Medical Good This is the use of medicine's scientific and technological knowledge to cure, contain, ameliorate, or prevent illness. It is the judicious application of this knowledge determined in the clinical situation by "medical indications" (which Pellegrino defines as "a statement of those clinical characteristics that make the application of given therapeutic modality worthwhile in certain classes of patients"[13]).

The Patient-Preference Good This second good is expressed in preferences—in what the patient considers to be in his or her own best interest. As Pellegrino puts it, the good "summates many values: the kind of life the patient would like to live, the risks he wishes to take and for what benefit. Each of us has a life plan and a set of values arranged in some order of preference, some set of things we wish to achieve and things to avoid. These values are based in culture, ethnicity, age, sex, occupation, family, and dozens of other facets of our individual lives."[14] In essence, these are the patient's quality-of-life decisions.

The Autonomy Good Autonomy may be defined broadly as "the [free and uncoerced] choice of a person among moral values and his accountability for the choices made."[15] This is a generic good proper to all humans and is grounded in the "human capability for reason, choice, and judgment and in the capacity to express those choices in speech."[16]

The "Last Resort" Good The fourth good is "the good of last resort." In essence, this is an ultimate good that, all else considered, predominates for a patient. Whatever the patient defines as his or her ultimate good is the principle that ultimately grounds and justifies the moral choices that he or she makes. This "good of last resort" is similar to the patient-preference good in that it is a concrete value; but it differs in ascribing a hierarchical structure to the individual's value system. That is, when it becomes impossible to accomplish all of the patient's wishes, the physician, following the telos of the medical practice, should try to accomplish them in the order that the patient ranks them.

These goods, together with the telos of medicine, dictate the manner and context in which the physician and patient reach a medical decision. The physician is obliged to pursue whatever is the good and right act, according to the situation of the particular patient, as that act pertains to the ends (internal goods) of medicine as dictated by the profession.

However, it is often the case that, in particular situations, the intermediary ends of medicine (although oriented toward and subsumed under its ultimate end) conflict. For example, the prolongation of life and the alleviation of pain, both aspects of medical good and usually elements of the patient's best interest (and autonomously chosen as such by the patient), can be mutually exclusive goals. Pellegrino suggests no method for responding to such dilemmas, fully recognizing his inability to do so as a possible objection to his argument, although he does mention the possibility of a supplemental ethic that would address it.[17]

Beyond Pellegrino

Although lack of space forbids delineating all of medicine's possible intermediary ends, it may help to return to the hypothetical 83-year-old man with metastatic cancer with whom I began this article.

Often, in the clinical setting, there comes a point at the end of a patient's life in which treatment may proceed along one of two paths. Physician, patient, and family must decide whether to continue treatment that aims at the end of *prolongation of life;* or, on the other hand, to terminate that treatment, which might be burdensome, and instead provide palliative care that aims at the end of *alleviation of pain and suffering.* It is at this point that a problem arises in Pellegrino's argument: Which of these intermediary ends of medicine are to be pursued? Pellegrino holds that nothing within the study of medicine, the practice of medicine, or medicine's professional ethic is capable, in and of itself, of answering this question.

However, I suggest that a consideration of the second, third, and fourth goods of the patient's best interest may help solve the dilemma. If the profession fails to consider these three goods, it exposes itself to several risks (such as threats to the patient's autonomy and degeneration of the profession into a career), as well as to the corruption of its telos: to act in the "right and good healing action taken in the interests of a particular patient." When a physician, patient, and family try to determine which course of action is *most* right and good, the patient's preferences should be the deciding factor. As Pellegrino notes, these preferences will be the fruit of the patient's life plan and values, as revealed in a narrative of his or her life.[18] Thus it will be the narrative—in whose patterns the patient's life plan and values will be seen—that determines the appropriate course of action. That being the case, it appears that medicine needs a narrative ethic to supplement its professional ethic.

The manner in which the patient decides on a course of action will ordinarily exemplify one type

The prolongation of life and the alleviation of pain can be mutually exclusive goals.

of moral theory or another. The patient's personal moral theory will, of course, differ from the specialized, professional ethic of medicine. But if the physician is to understand the patient's moral reasoning, there must be some dialogic relationship between the professional ethic and the varieties of moral reasoning found in a society at large. Without this dialogic relationship, the professional ethic risks becoming disassociated from the society and the people it professes to serve.

Moreover, unless the physician understands the manner in which a patient reasons morally, he or she cannot fulfill Pellegrino's third good, *patient autonomy*. To genuinely respect the patient's autonomy, the physician must believe that the patient has, using a coherent moral process, reasoned thoroughly and carefully in coming to a decision. This may at times require the doctor to directly challenge the patient's reasoning, which can be unpleasant for both. Still, the physician would be failing a professional obligation if he or she were to support a patient in a decision (and then to participate in the chosen course of action) that he or she did not believe was in the patient's best interest and based on the patient's own values.

The Prophetic Voice of the Catholic Tradition

I've said that medicine's professional ethic is based on its claim to be a response to vulnerability resulting from injury or illness. How can the Catholic tradition, through dialogue with the larger medical community, inform this claim?

I believe that three key interrelated elements of the Catholic tradition are invaluable additions to the professional ethic of medicine. These elements are:

- The preferential option for the poor
- Social justice in the context of the common good
- Healing in light of the ministry of Jesus

However, before discussing the three elements, I must say something about the role of the prophet. In the Judeo-Christian tradition, the prophet is one who bears witness to the community and seeks to call it back to its true foundation. In witnessing, a Christian professes the truths of the faith and calls others to a life in Christ. The prophet, however, not only witnesses; he also seeks transformative actions. The prophet does so because he or she understands faith to be a public reality, not a cloistered, private one. Faith requires, even demands, action that attempts to bring about the fruits of faith. As Fr. John C. Haughey, SJ, has pointed out, "One of the great contributions of the Second Vatican Council was to put the church squarely back into the world . . . committed to assisting the world in making each of its systems and institutions function according to the ethical principle of the common good. . . . It is encumbent, then, on followers of Christ and their communities to assist in perfecting 'the temporal order in its own intrinsic strength and excellence' so far as they are able."[19]

Both witness and transformation must be integral aspects of Catholic health care's ministry, thereby helping the larger medical community orient itself toward the common good.

How may this prophetic discourse be enacted by Catholic health care?

The Preferential Option for the Poor People who come to the medical profession for aid are in a state of vulnerability. Although care must be provided to all who need it, special attention must be paid to those who are the most vulnerable. As Paul Farmer has noted, "most often, diseases themselves make a preferential option for the poor. . . . [Studies] show the poor are sicker than the nonpoor."[20] The poor come to the medical profession more vulnerable than the nonpoor, in need of more aid, and usually in a greater state of despair (because they believe they cannot, or will not, be helped). In response to such vulnerability, the Catholic health ministry has a long-standing tradition of outreach to the poor, providing them with care they cannot get elsewhere.

Such a response enacts the prophetic tradition. First, it witnesses, showing special care to the disadvantaged. Second, it transforms, both by attempting to rectify a social injustice (lack of health care for the poor) and by setting an example and calling others—particularly the larger medical community—to act similarly. In essence, the ministry's concern for the poor is a symbol of potential.

Justice in Light of the Common Good The Synod of Bishops states: "While the Church is bound to give witness to justice, she recognizes that anyone who ventures to speak to people about justice must first be just in their eyes. Hence we must undertake an examination of the modes of acting and of the possessions and lifestyles found within the Church herself."[21]

If the church is to be a beacon for justice, it must first examine its own practices and set an example that is just for others to follow. Advocating a preferential option for the poor is one means of being just (and some would say it is the defining characteristic of social justice), but the Catholic health ministry must be just in other ways as well. It must also, for example, ensure the community's access to health care through outreach programs; show proper respect for its own employees; develop policies that safeguard

patients' and employees' dignity; and ensure that billing for services rendered is done in a just manner. In this way, the Catholic health ministry bears witness to social justice, acts on behalf of the common good, and encourages the larger medical community to do the same.

Healing in Light of the Ministry of Jesus How may the Catholic tradition inform an understanding of the goals and ends of medicine? The answer lies in how one views the healing act in light of the ministry of Jesus.

The Gospel reveals a healer who desires not only a return to physical health but also restoration of the whole person: body, mind, and spirit. What is seen in Jesus' ministry is a fundamental respect for human dignity and the goal of restoration of unity between the body and self.

Seen in this way, Jesus' work ministry provides an orientation to the goals of medicine and the context with which those goals should be pursued. To return to the hypothetical patient with metastatic cancer, simply prolonging his life is one potential course of action. And it may be an appropriate intermediate medical goal. But it will not fully answer to medicine's telos unless it seeks in its completion the dignity of the patient and the restoration of the unity of his body, mind, and spirit. The example of Jesus' ministry reminds contemporary medicine of its profoundest goals.

An Opportunity for the Ministry

Catholic health care has a major opportunity to raise a prophetic voice, calling the larger medical community both to reform and inform the discussion through the Catholic tradition's dedication to the preferential option for the poor and to social justice. To respond to this opportunity, however, Catholic health care must look to its foundations and apply those values in the hope of further informing the discussion of medicine's goals. If the medical profession is to respond appropriately to the vulnerability of illness and the needs of the patient and the community, it must address the issues here and come to a common consensus regarding its telos and ethos. ■

NOTES

1. Edmund Pellegrino, "Professional Ethics: Moral Decline or Paradigm Shift?" *Religion and Intellectual Life,* vol. 4, Spring 1987, pp. 21-22.
2. Alasdair MacIntyre, *After Virtue: A Study in Moral Theory,* University of Notre Dame Press, Notre Dame, IN, 1984, pp. 187-188.
3. MacIntyre, pp. 187-195.
4. Edmund Pellegrino, " Toward a Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness," *The Journal of Medicine and Philosophy,* vol. 4, no. 1, March 1979, p. 44.
5. Pellegrino, "Toward a Reconstruction."
6. Pellegrino.
7. Pellegrino, p. 45.
8. Pellegrino, p. 46.
9. Pellegrino, p. 47.
10. Pellegrino.
11. Pellegrino.
12. Edmund Pellegrino, "Health Care: A Vocation to Justice and Love," in Francis A. Eigo, ed., *The Professions in Ethical Context: Vocations to Justice and Love,* Villanova University Press, Villanova, PA, 1986, pp. 106-108.
13. Pellegrino, "Health Care," p. 106.
14. Pellegrino.
15. Pellegrino, p. 107. Ethicists often put the principles of autonomy and beneficence at odds with one another. However, Pellegrino here proposes a broader understanding of the principle of beneficence, one that includes the requirement that the patient remain autonomous.
16. Pellegrino, p. 107.
17. Pellegrino, "Toward a Reconstruction," pp. 33, 47-48, 52.
18. Pellegrino, "Health Care," p. 106.
19. John C. Haughey, "Connecting Vatican II's Call to Holiness with Public Life," *Proceedings of the 55th Annual Convention,* Catholic Theological Society of America, San Jose, CA, 2000, p. 1.
20. Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor,* University of California Press, Berkeley, CA, 2003, p. 140.
21. World Synod of Bishops, *Justice in the World,* 1971, para. 40, available at www.osjspm.org/cst/jw.htm.