

The Physician-to-Patient Relationship in Virtues-Based Ethical Analysis

J.L.A. Garcia

ABSTRACT: Here I first summarize some elements of Edmund Pellegrino's approach to bioethics by characterizing it as an internal, bottom-up approach, in contrast to the externalist, top-down one found in mainstream principlism. Second, I sketch an understanding of the moral life that centers on role-relationships, focuses on moral patients (rather than agents), is driven in its evaluation of actions by their motivational inputs rather than their outcomes, and treats virtues as fundamental. Third, I use this approach to provide a virtues-based grounding for a bioethics like Pellegrino's. Fourth, I acknowledge and reply to Pellegrino's own reservations about such grounding. My fifth and sixth sections relate and compare this approach both to mainstream principlism and to recent "progressive bioethics" by indicating that, properly conceived, the ethical practice of medicine faces constraints that militate against the progressive agenda. Lastly, I use this virtue-based grounding in summarizing, analyzing, and rebutting some objections that have been raised against Pellegrino's views.

Patients care how much you know
only after they know how much you care.
– a saying among physicians

DR. EDMUND PELLEGRINO rooted bioethics – especially, clinical medical ethics – in a philosophy of medicine. His approach, neglected in the current literature, offers a stark contrast with mainstream bioethics as represented, especially, in Beauchamp and Childress's influential "principlist" understanding of the foundations of

bioethics.¹ Its riches, however, need to be situated within a strong and explicitly articulated ethical theory in order to clarify their contents, fortify them against attacks, and illuminate their advantages over rivals. It is this work my essay begins.

Here I begin by sketching some of the main parts of Pellegrino's fundamental philosophy of medicine and then the approach to medical ethics that he builds on it. Next I turn to philosophical theory of normative ethics and briefly develop an approach that is virtue-based, role-centered, respondent-focused, and input-driven, while trying also to motivate and defend that approach. My third section shows how that approach accommodates Pellegrino's understanding of medical ethics. In the fourth section, I note and respond to his own misgivings about grounding his medical ethics in a comprehensively virtue-based conception of morality. My fifth section turns briefly to the widely influential alternative approach of Beauchamp and Childress. I argue that its principles can be better understood when analyzed in terms of the moral virtues. The sixth section sketches how to apply to some live controversies such a view of medicine and ethics as grounded in virtues. I close by examining how thus basing Pellegrino's substantive medical ethics in virtues helps his defenders respond to some difficult challenges that have been posed to his thinking.

1. Pellegrino's Philosophy of Medicine

Dr. Pellegrino's philosophy of medicine² involves three main elements: the fact of illness, the act of profession, and the encounter in (especially, clinical) medicine. We can begin with what he calls the (1) universal fact of human illness. By this phrase he means our inevitable deterioration from aging, genetic predisposition or birth defect, accident, disease, violence, and so on. This fact stems from our (1a) vulnerability to harm from nature, environment, happenstance, oneself, other persons,

¹ Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, 6th edition (New York NY: Oxford Univ. Press, 2009).

² See Edmund Pellegrino, *Philosophy of Medicine Reborn: A Pellegrino Reader*, ed. Tristram Engelhardt and Fabrice Jotterand (Notre Dame IN: Univ. of Notre Dame Press, 2008); Edmund Pellegrino and David Thomasma, *For the Patient's Good: Restoration of Beneficence in Health Care* (New York NY: Oxford Univ. Press, 1988).

and the like. Because of this and our human limitations, Pellegrino observes, we all stand in a relation of (1b) dependence on other persons for health maintenance, restoration, and improvement.

A second element is the physician's self-defining (2) act of profession, which (2a) follows from a period of specialized formal education, a period of apprenticeship, and lifelong learning, (2b) attests to personal devotion, deep and lasting internal commitment, and (2c) occurs as a dated act of public pronouncement, which stands never repudiated. Here he allows us to see anew, the root of the now too familiar classification of medicine as a profession. As a professional, the physician professes something, makes a public proclamation and self-dedication.

Pellegrino's final element is (3) the clinical encounter, which requires the physician's (3a) attentive listening, (3b) examination, (3c) testing, (3d) and diagnosis, as well as (3e) recommendations, (3f) supervising regimens of treatment, (3g) follow-up listening, and much else. Thus conceived, the physician and patient stand in what Pellegrino designates a relationship of "shared intentionality," with both of them collaboratively aimed at maintaining or restoring the patient's health.

From this philosophy of medicine, by which he means its historical and conceptual analysis, Dr. Pellegrino (sometimes collaborating with Dr. Thomasma) developed a medical ethic "from the bottom up." He locates its foundation in the clinical encounter between a needy patient and a medical professional. Pellegrino begins this part of his analysis by identifying medicine's ends (that is, its appropriate objectives) for the physician (and wider medical team) as including (e1) healing the patient, (e2) helping her, (e3) curing her, (e4) preventing her future illness, and (e5) promoting her future health.

What we can call Pellegrino's "internal" medical ethics centers on the physician's virtues, that is, excellences in the calling to serve others as a physician, which include (v1) compassion (closely related to what Pellegrino and Thomasma elsewhere call "beneficence"), (v2) fidelity-within-trust,³ (v3) practical reasonableness, (v4) justice, (v5) courage,

³ In Pellegrino's later telling, compassion and fidelity-within-trust seem to replace what, in Pellegrino and Thomasma, was combined under the title "beneficence-in-trust." See Edmund Pellegrino and David Thomasma, *Virtues*

(v6) temperance, (v7), integrity, and (v8) self-effacement.⁴ Pellegrino also identifies various related duties or obligations that medical doctors have. Prominent among these are (d1) technical competence, (d2) ensuring (realizing) the patient's agency through both providing appropriate information and securing her consent, and (d3) respect for the particularities of each given physician/patient relationship.⁵

From the standpoint of this philosophy of medicine, Pellegrino further distinguishes various obligations that the patient incurs as patient, including (p1) trust in the physician's (and medical team's) competence, (p2) respect for the physician's own moral agency, (p3) truth-telling about her illness, (p4) caution in what she requests of either her physician or the larger medical team, and a (p5) willingness, within reasonable limits, to participate in medical research.

Dr. Pellegrino's substantive, "bottom-up" medical ethics contrasts with usual top-down, "applied ethics" model found, especially, in the principlism of Beauchamp and Childress, as well as with formalistic, contractual models of medical ethics. Still, even bottom-up ethics needs guidance from ethical theory on what kinds of things can matter morally. And it is ethical theory that makes sense us of why it is that physicians should be concerned with these matters, strive for those objectives, constrain themselves by particular considerations, and make certain decisions.

2. Virtues-Based Ethical Theory

Recently, Michael Slote and Linda Zagzebski have stressed broadly virtues-based approaches to ethical theory – what he calls agent-based virtue ethics⁶ and she "motivation-based."⁷ Both highlight caring for persons, thus helpfully tying virtue ethics to the so-called "care ethics"

in Medical Practice (New York NY: Oxford Univ. Press, 1993), ch. 5.

⁴ The list appears not meant to be exhaustive; the physician's virtues may thus include other excellences. See Pellegrino and Thomasma (1993), pp. 11-13.

⁵ Edmund Pellegrino and David Thomasma, *Philosophical Basis of Medical Practice* (New York NY: Oxford Univ. Press, 1981), ch. 9.

⁶ Michael Slote, *Ethics of Care and Empathy* (New York NY: Routledge, 2007).

⁷ Linda Zagzebski, *Virtues of the Mind* (New York NY: Cambridge Univ. Press, 1996).

that philosophers devised largely under Carol Gilligan's influence.⁸ This has manifest relevance to the caring professions, healthcare in particular.

Trying to go both a bit deeper and somewhat broader than they, here I propose a new approach, built on four *structural* (i.e., concerning the arrangement of moral features) or *dynamic* aspects of morality (i.e., concerning the emergence of and dependence-relations among such moral features as duties to act, virtuous traits, and valuable states of affairs) – in short, morality's meta-features.⁹ First, I introduce the concept of virtues-basing, which builds on the commonplace that virtues are good-making features of people, traits, character, responses, decisions, actions. Within an ethical theory that is virtues-based, the central virtues are conceived as stable, deep-seated orientations of desire, affection, and will, including dispositions to want, feel, and intend a certain state of affairs. Virtues-basing means analyzing in terms of the virtuous all true claims about what states of affairs are impersonally or intrinsically valuable, and what actions and omissions are morally obligatory, permitted, forbidden, wrong, etc.

So conceived, each of the principal good-making character traits within those person-to-person role-relationships that are morally determinative can be seen as a form of benevolence or love, i.e., the willing and wishing of certain goods to, for, and of the person we can characterize as the "role-respondent," i.e., the person to whom the role relates the contextually focal moral agent or subject. These are the moral virtues, and it illuminates all the principal moral virtues to conceive them as forms of goodwill (i.e., instances of willing some person to have certain goods). So understood, we can say with Slote that these virtues are forms of "caring," but, against Slote and following Darwall, that caring is itself better conceived as benevolence than as empathy.¹⁰

Role-centering is our second structural/dynamic feature of a moral

⁸ See Michael Slote, *Morals from Motives* (New York NY: Oxford Univ. Press, 2003) and Zagzebski.

⁹ J.L.A. Garcia, "Virtues of the Natural Moral Law" in *Natural Law in Modern Society*, ed. Holgar Zaborowski (Washington, D.C.: The Catholic Univ. of America Press, 2010), pp. 99-140.

¹⁰ Slote, *Ethics of Care*, passim; contrast Stephen Darwall, *Welfare and Rational Care* (Princeton: Princeton Univ. Press, 2003), ch. 3.

theory. A theory is role-centered when it holds that all moral statuses are held in, and with respect to, certain role-relationships, such as those of friend, spouse, parent, offspring, partner, co-citizen, fellow, and so on. In this way, anyone's moral virtues make someone good within a certain role as filling that role (understood as one of a certain group of role-relationships). These role-relationships are modes of person-to-person connection, which hold a special place in human flourishing so that normally one person's fully flourishing as a human person includes there being someone else who is a good friend to the first person, someone else who is a good parent to that person, and so. (It is for this reason that such role-relationships can properly be called morally determinative.)

For an ethical theory to include our third feature, patient-focus, is for it to hold that when someone has moral virtues, then that person has features that tend to make her good within (i.e., as occupying) a certain role-relationship with someone who is the moral patient (that is, the person on the receiving/object end of the moral agent's actions or the moral subject's attitudes). The virtues make the moral agent/subject a good role-relationship for and relative to the moral patient. More specifically, a theory is patient-focused if and only if it is the needs and interests of the moral patient that ultimately determine which responses by or in the moral subject are virtuous and which vicious.

Input-drive, as an account of the moral status of actions – including their being morally good or bad, virtuous or vicious, but also their deontic status as morally required, forbidden, permitted, right or wrong, and so on – means any such status of actions derives from their agents' psychological input, i.e., the motives from, and intentions with which they are done.

In ethical theory that is, in these ways, virtues-based, role-centered, patient-focused, and input-driven, it is the moral subject's (and moral agent's) response to *each* of her role-respondents (i.e., the persons with whom she stands connected in certain central and morally determinative role-relationships) that shapes the moral quality of her life. In this way, it is the *depth* of response within a role that matters morally, while the *breadth*, i.e., the mere number of those affected by her actions, may prove morally irrelevant.

There are signal advantages to ethical theory that has the features of being virtue-based, role-centered, patient-focused, and input-driven.

First, human action is *humanized* (as the exercise of personal, rational agency) rather than *instrumentalized* and *mechanized* as a mere device for producing desired outcomes. Second, the range of moral luck is helpfully restricted, excluding from moral relevance mere good or bad fortune in the results of someone's actions. Third, the morality status of an action is intimately connected with its *meaning* and thus with the person-to-person relationship in which it occurs. Fourth, moral "norms" are helpfully "transparent," so as to indicate not only *what* is or isn't to be done, but *why*. Fifth, moral life is better *unified*, with the moral goodness/badness, virtue/vice, obligation/prohibition of moral subjects and their responses all given a *common basis*. Sixth, because of the unique ultimate importance it assigns on the psychological input to the agent's actions, part of the grounding is put in place for defending an intentionalist ethic of right action, including the form of reasoning called "double effect."

3. Relevance for Dr. Pellegrino's Account

An ethical theory that is virtue-based, role-centered, patient-focused, and input-driven is well positioned to provide foundations for an understanding of medical ethics along the lines that Dr. Pellegrino has championed. Within it, medicine is seen as a special kind of relationship, one that emerges in a professionalized, institutionalized, and specially targeted form, from the deeper virtue of comprehensive willing of goods for or to another. The physician is thus, for the most part, restricted in her strictly medical capacity to attending to her patient's medical interest and health needs. Patients, but also physicians, are conceived as persons. They are individuals of a rational nature, in that it belongs to their nature to develop a rationality that extends beyond inference to pervade their desires, feelings, choices. Thus, medicine itself is inherently a mode of person-to-person connection.

Dr. Pellegrino's stress on the clinical engagement can now be seen as akin to Levinas's conception of "the face" as the intimate engagement wherein we deeply encounter the Other.¹¹ The personhood of the physician and the patient both ground and limit their relationship and its

¹¹ Emanuel Levinas, *Basic Writings*, edited by A. Peperzak, S. Critchley, and R. Bernasconi (Bloomington IN: Indiana Univ. Press, 1996).

internal ethics, as well as such values or principles as freedom, equality, autonomy, and beneficence. The vision of Thomasma and Kissell,¹² explicitly derived from Dr. Pellegrino, of the physician as “friend and healer” is thence vindicated. Moreover, we gain insight into being a physician as both a role and an identity. As a profession, being a physician is socially constructed, but medicine is still not therein arbitrary in its configuration and content, nor dispensable. Rather, medicine is rooted in the core needs, life-situations, and relationships of human beings: our natural and inherent vulnerability and carnality (on the patient’s side), and in our inherent sociality and rationality (on the physician’s side).

More specifically, each of the virtues, ends, and duties that Dr. Pellegrino identifies for and within medical practice is revealed as an excellence-making feature that the physician has in person-to-person relationships with various patients as shaped by the medical interests of each patient. Here we should recall and examine each of Pellegrino’s “virtues [of the physician] within medical practice,” taking them in order.

Compassion. The structural moral theoretic features of being role-centered and input-driven both show an important epistemic role for the physician’s experiencing something close to what the patient feels, in order to determine what the latter needs, in keeping with the demands of being patient-focused.

Fidelity-within-trust. Being input-driven demands that the agent act with the intention of doing what the patient properly trusts her to do her best to achieve.

Integrity. Properly understood, being virtues-based requires that each motivational input should be operationalized in ways consistent with others doing their work of helping make the agent good in her role. Thus, even if they lack the stronger unity that some philosophers have ascribed to them, there is a kind of consistency among the virtues that, in the agent, constitutes a kind of internal consonance, which is the root idea behind the concept of integrity.

Self-effacement. This virtue reflects being patient-focused in that

¹² David Thomasma and Judith Kisell, eds., *The Healthcare Professional as Friend and Healer* (Washington, D.C.: Georgetown Univ. Press, 2000).

the physician should not be focused on showing off her virtuosity at or in diagnosing, devising a treatment plan, performing surgery, etc., but should remain focused on the patient's medical welfare.

Practical reasonableness, justice, courage, and temperance. The remaining physician virtues that Pellegrino enumerates are, of course, the traditional cardinal virtues from Plato and Aquinas. Here I will not try to show how to elaborate them within this ethical theory, save to say that, plainly, prudence, courage, and temperance are often useful, and sometimes needed, in the self-regarding role of self-stewardship, as well as within many other-regarding ones. Justice also easily fits such ethical theory, because it is a matter of the moral agent respecting every other person as a person.

Likewise, each of Pellegrino's "ends" are vindicated on analyzing medicine as a narrowly focused, professionalized derivation from the morally determinative person-to-person role-relationships. Helping is the generic operationalizing of goodwill with respect to any dependent person, who is as such a being of limited powers. Healing and curing are the past-looking forms of helping people attain, retain, or regain their medical good/welfare. Preventing illness and promoting health are future-looking forms of helping get (maintain and improve) the medical good.¹³

Finally, this approach reveals each of the "duties" that Dr. Pellegrino identifies for and within medical practice as a matter of a physician's achieving, maintaining, and using technical competence. In this way, however, duty points to the difference between mere skill and virtue, because a good physician must not only possess skills but be *motivated* properly to use them. The physician's so conducting herself as to remain concordant with such a trait is obligatory insofar as the physician's failure to gain, maintain, and act from such competence, when she treats her patient, is such an egregious departure from the role-virtue of seriously willing her patient's medical welfare that it is a vicious (and therein a bad-making) response to her. Thus, we can validly

¹³ These ends are not only ends for the institution of medicine but, more important, each such medical end is also a proper object of the individual person's purposes and intentions, insofar as the physician is operating *qua* medical professional.

call such behavior her duty, something that is obligatory for her, meaning that it is necessary for her being virtuous *qua* physician.

What Pellegrino deems the physician's duty of enabling or facilitating (that is, ensuring) a patient's agency by providing her information and securing her consent is a principal mode of the physician's respecting her patient as a person capable of and entitled to (have others will that she enjoy the good of) self-direction. Acting in ways consistent with that trait is mandatory insofar as the physician's failure so to regard her patient is such a flagrant deviation from the role-virtue of respect for the patient as a person that it too is vicious, tending to make the professional care-giver a bad physician. So, again, it is obligatory in that it is required, needed, for any physician to be a good physician.

The duty of respecting the particularities of relationship between each patient-and-physician pairing likewise is a principal way for the physician to treat her patient as unique, unrepeatable, irreplaceable, inexhaustible, infinite, and unfathomable in her personhood.¹⁴ This permits a sort of theoretical reconstruction of the concepts of obligation and duty in this sphere: behaving in ways harmonious and consonant with that trait is required insofar as the physician's failure so to regard her patient is so abhorrently distant from the role-virtue of respect that it is likewise vicious.

Probably, the traits that Pellegrino deems virtues of the patient within the clinical context – i.e., trust in the physician's (and medical team's) competence, respect for the physician's own moral agency, truth-telling about her illness, caution in what she requests of the physician (and medical team), and willingness, within limits, to participate in medical research – could also be accounted for within this ethical theory. However, our focus here is on the physician, so I won't pursue that claim.

4. Dr. Pellegrino's Misgivings

Despite all these advantages we have shown in grounding a "bottom-up" medical ethics such as Pellegrino's in a certain kind of

¹⁴ It is Levinas who did most, among the past century's philosophers, to stress these points about "The Other."

virtues-based ethical theory, we should acknowledge that he himself explicitly criticizes the adequacy of virtue ethics as a full account of medical ethics.

He worries that virtue ethics must scant the importance of duty, and that there is more to medical ethics than the physician's own excellence, or self-fulfillment. Against this, I note that importance is *not* the same as *independence*. Some recent theorists show how and that we can reduce claims about duty, etc., to claims about what is virtuous.¹⁵ Following Aristotle (*Metaphysics* IV.5), we can construe moral duty, i.e., the morally necessary, as what is needed, what must be, in the sense that, without it, something is (will/would be) bad. Thus, right medical action, within my proposed ethical theory is not output-determined, not aggregative across persons, non-maximizing, but derived from goodness (*qua* virtue), grounded in relationality and personhood from features of the medical actor's personal agency and her patient's needs as an incarnate person (patient-focused); and responsive especially to goods that are proper to medicine: the patient's physical, mental, and emotional functioning.

It is also true that, contrary to what I here propose, Dr. Pellegrino extends the physician's responsibility to pursuing her patient's comprehensive good, including her spiritual good, and even her merely perceived good. Yet this seems to me too broad a focus for any profession, neglecting both the specialization characteristic of any profession as such, and medicine's own peculiar concern for health, i.e., medical well-being.

5. The Principlism of Beauchamp and Childress

Contrary to the principlism of Beauchamp and Childress, each of their four principles – beneficence, non-maleficence, justice, and autonomy – can be best understood as rooted in a virtue-based, role-centered, patient-focused, input-driven ethical theory.

Medical *beneficence* is morally important insofar as the physician, *qua* moral agent, puts into action her good will for the clinical patient. It is the physician's willing the patient a certain crucial subset of what

¹⁵ See Slote, p. 5, Zagzebski, p. 235, and Rosalind Hursthouse, *On Virtue Ethics* (New York NY: Oxford Univ. Press, 1999), p. 28.

is good for a person. Thus conceived, the morality of beneficence, doing and causing good, derives from the deeper moral matter of benevolence, willing what is good.

Medical *non-maleficence*, likewise, matters morally chiefly insofar as the physician strives not to cause or allow harm to her clinical patient, especially such serious harms as death.

Classical Greek thinkers deemed justice the tendency to give each her due and the recent philosopher T. M. Scanlon's recent emphasis on "what we owe to each other" shows that our basic understanding of it has not much changed. For the medical agent, it consists in responding with due deference and respect to the patient's personhood. That especially means the physician's willing her patient the goods that are peculiar to persons, those that involve bringing the rationality internal to, and definitive of, her being a person to bear on her life. One chief theater for doing that is when her doctor advances and protects the patient's ability to live her life according to her own considered plan. That brings us to the topic of self-direction, autonomy.

Autonomy deals specially with the peculiar personal goods of self-direction and self-management as the individual's own responsibility and authority. How best to live, but not whether (nor how long) to keep living, is within a person's proper purview, and thus also within her steward's. Autonomy is thus to be respected in the physician, as well as the patient, and reconceived as law rooted not merely in the self, but in reason's discernment of natures.

Beauchamp and Childress's most recent treatment of the physician/patient relationship centers on the doctor obeying rules of veracity, privacy, confidentiality, and fidelity. However, these are also best understood from within a virtue-based theory. For most supposed moral rules, specific divine commands aside, can be understood as summary statements of what it would be vicious to do (or omit) in the situation. Moreover, the importance of veracity in medical ethics derives from the fact that it is a good to and for a person that person's hold true beliefs. Similarly, the significance of privacy and confidentiality within medical ethics reflects the physician's regard for the personal good of managing information about oneself, thereby acknowledging one's own dignity or that of another person. Likewise, the importance of fidelity in medical ethics derives from the importance of trust and the related virtue

of trustworthiness, within interpersonal relationships, especially those dealing in intimate matters.

6. Limits to Medical Intervention

A conception of medical ethics consistent with, suggested by, and even emergent from, an ethical theory that is virtue-based, role-centered, patient-focused, and input-driven helps us to see not only the proper focus of, but also needed limitations to, medicine. In contrast, progressive bioethics, recently proclaimed by prominent contemporary bioethicists hewing to the current line, aims to harvest the fruits of bio-research, without the suspicion, worry, and misgivings manifest in so-called conservative bioethics. Instead, constrained chiefly by liberal commitment to freedom and equality, it is guided only by the “progressive [political] values” of “critical optimism [about biotechnology], human dignity [reduced to autonomous decision-making], moral transparency [treating ethics as an aid to people’s realizing their own supposed values rather than a search for unchanging moral truths], [and] ethical practicality [i.e., dismissal of slippery-slope reasoning and even logical conclusions of technological rationales].”¹⁶

Yet the concepts of freedom and equality are crucially incomplete (freedom to do or be what? freedom from what? equality in what?) and in need of justification. A deeper ethical theory is needed to inform, give substance to, limit, clarify, and restrain these vague concepts’ application. As Kant saw, it is the freedom of persons *in their rationality* that matters morally, so freedom to follow mere appetites or perverse desires merits no special protection. Further, a genuinely human bioethics must always be wary of the technological temptation to use new capabilities beyond the constraints of moral virtue. Moreover, several of these supposed values presuppose controverted and dubious metaethical positions, most notably the self-proclaimed progressives’

¹⁶ See: Jonathan Moreno and Sam Berger, “Bioethics Progressing” in *Progress in Bioethics: Science, Policy, and Politics*, ed. Jonathan Moreno and Sam Berger (Cambridge MA: The MIT Press, 2010), pp. 3-22. Alberto Giubilini and Francesca Minerva, “After-Birth Abortion: Why Should the Baby Live?” in *Journal of Medical Ethics* 39 (2013): 261-63. Walter Sinnott-Armstrong and Franklin Miller, “What Makes Killing Wrong?” in *Journal of Medical Ethics* 39 (2013): 3-7.

smug abandonment of deep moral truths about the human person in favor of an imagined imperative to operationalize temporarily fashionable preferences.

Our approach also enables us better to counter some recent radical proposals in medical ethics, such as so-called “after-birth abortion” (infanticide) and efforts to set aside the “dead donor” rule to equate “total disability” with death, and thereby justify harvesting for transplantation vital organs from the living. Against this, I observe that in their justified attention to the patient’s abilities and capabilities as goods to her as a human person, these approaches scant the elevated status and dignity of the person herself and her life as transcendently valuable and uniquely irreplaceable.

7. Some Critical Questions for Dr. Pellegrino

I conclude by showing how grounding a Pellegrino-style medical ethics within virtue-based, role-centered, patient-focused, and input-driven ethical theory positions us to respond to several pointed challenges that have been posed to his views.¹⁷ Since these have probably blocked some open-minded thinkers from accepting his insights, I hope thus to open the way for a broader appreciation of what he accomplished.

First, then, there is this pointed question: why should we think there is a special, internal ethics for medicine (but not for policing or ballet)? I respond that being role-centered allows many roles to have internal virtues, while also showing how central role-virtues are usually forms of good will (willing of relevant goods for the role-respondent).

Second, we face the query, isn’t Dr. Pellegrino’s approach excessively focused on the physician (professing, virtues, duties), and not enough on patient? Here, my retort is that being virtue-based and patient-focused combine to make the physician’s virtues *qua* physician derive from, and depend on, the medical well-being of the patient.

¹⁷ For a summary of these, see Daniel Sulmasy, “Essentialist Medical Ethics of Edmund Pellegrino: Analysis and Critique” in *Physician and Philosopher: The Philosophical Foundations of Medicine: Essays by Dr. Edmund Pellegrino*, edited by Roger Bulger and John McGovern (Charlottesville VA: Carden Jennings Publishing, 2001), pp. xvii-xxx.

Third, some wonder whether Dr. Pellegrino's approach isn't arbitrary, narrow, and old-fashioned, in excluding (or marginalizing) preventive medicine, and public health. Does it neglect medicine's attention to the common good, social needs, and patient's varying and sometime idiosyncratic wishes, subordinating all that to the ways of olden days, ways in which he accords the honorific of "tradition"? Against this, I contend that being role-centered and patient-focused combine to direct the virtuous physician's attention to the narrowly medical needs and interests of each patient encountered, leaving servicing social needs largely to others, or to physicians acting outside their specifically medical role.

In a pertinent way, a physician's involvement in public health is like her practice of elective cosmetic medicine though, to be sure, the cases are also importantly different. In cosmetic medicine, she draws on her knowledge of the human body, biochemistry, and so on, in dealing with her patient, but she doesn't put this knowledge to work for the distinctively medical purposes of restoring or maintaining the latter's health. In public health, her objective is health, but it is not the health of any specific person who is her patient. Genuinely to practice medicine is to provide healthcare, but there can be no such providing that is not providing it to a specific individual. Since in public health she has no patient, what she does is again using her expert knowledge, but not really in practicing medicine. She may serve as expert, bureaucrat, informed citizen, or whatever, but not exactly as a physician acting in her professional calling.¹⁸

Fourth, it is asked why should we think medicine, or any human practice, has a universal, unchanging, necessary, and detailed essence? And how could we human beings come to know such an essence? Shouldn't Dr. Pellegrino's universalist philosophy of medicine be replaced by a more culture-relative conception of local medicines (in the

¹⁸ Pellegrino, I think, had a related point in mind when he called some of his own work, and in naming his Georgetown University center for "clinical medical ethics." But this terminology is somewhat too restrictive. For a physician treating someone on a battlefield, or in a roadside emergency, or in the wake of a natural disaster, is not in a clinical setting, but nonetheless has determinate patients, even if they are hers only temporarily. She is thus practicing medicine at those sites, in those settings.

plural)? There are several apposite replies. There are internal, conceptual limits to what might be, or be part of, medicine. Distinguishing medicine's essential and core, from its merely peripheral, practices, e.g., elective cosmetic surgery, is therefore both valid and important. Still more vital, as we saw, is protecting medicine's essence as a healing professional from the *soi-disant* progressives' degrading and homicidal agenda of abortion, infanticide, mercy-killing, physician-assisted suicide, and so on. Additionally, a more general understanding of medicine's point and nature is important for our ability both to judge its current state, proposed changes and impending future.

Fifth, Robert Veatch worries that any "internal" medical ethics, all versions of which he traces to A. MacIntyre on "practices," must scant a morality rooted not in human purposes, practices, etc. but in God's (legislative) Will.¹⁹ In rebuttal, I remind the reader that MacIntyre himself, in the second edition of his classic *After Virtue* requires that any social practices relevant to defining human virtues fit a larger human teleology. God's creative will, which is inscribed in our natural human socialization, desires, etc. and not only his legislative will, can be morally normative.

Finally, Jeffrey Bishop, in conversation with me at the University of Notre Dame's 2012 and 2013 medical ethics conferences, opined that we cannot effectively argue to a substantive bioethics from premises about *the* nature and intrinsic purpose of medicine, because medicine has different purposes, etc., in different cultures, epochs, and places. Again, I must point out that there are necessary limits to variation beyond which what remains are no longer medical practices, physicians, nurses, treatments, etc., but only simulacra. (Compare a teacher who lies to her students. Can that genuinely be teaching?) Of course, someone could argue that what comes to replace medicine is better, and that the distinction is merely verbal/semantic. But, of course, this *novum* would not be better medicine, so how is it better? Better *for* people? Arguably so, but remember that, as Pellegrino has reminded us, medicine itself developed from basic human vulnerabilities, interdependence, etc. The new thing that replaces genuine medicine may be better at getting people

¹⁹ See Veatch, "Internal and External Sources of Morality for Medicine" in Thomasma and Kitchell, pp. 75-86.

what they have come to want. Its being *better at satiating our whims and velleities* doesn't make this practice *better as medicine*, and, in any case, we then need to evaluate those wants themselves as ones that do or don't promote human flourishing. Moreover, the distinction is anything but verbal, since it is an essential difference in the semi-technical, Aristotelian sense of "essential": it gets at what is of medicine's nature, and at its very core.