

Medicine's Interest in Abortion

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ABSTRACT: Using the distinction between purposes and ends as developed by American philosophers Francis Slade and Robert Sokolowski, this paper asks what interest medicine or the profession of medicine has in the practice of abortion. The argument of the paper recognizes that in the practice of medicine, a medical professional's purposes or the wishes of her patients may conflict with the ends of medicine. If the end of medicine is the patient's health and wholeness, what weight does it hold when weighed against the variety other interests one might take in the practice of abortion?

AS A WAY TO CLARIFY what interest doctors or the profession of medicine might have in the practice of abortion, I would like to discuss a philosophical distinction between purposes and ends.¹ To give some idea of what I have in mind, let's first look at a couple of scenarios that have nothing to do with abortion.

Most states in America that permit capital punishment execute their capital offenders with an injection of a fatal dose of drugs that causes the immediate death of an otherwise healthy human being. Must a doctor, precisely in virtue of being a medical professional, refuse to cooperate in an execution, even though, as a citizen and faithful Christian, that individual has no moral objection to capital punishment? Is there a reason from within the logic of medicine that justifies the American Medical Association's Policy E-2.06?

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¹ Cf. Francis Slade, "Ends and Purposes" in *Final Causality in Nature and Human Affairs*, ed. Richard Hassing (Washington D.C.: The Catholic University of America Press, 1997) pp. 83-85; "On the Ontological Priority of Ends and Its Relevance to the Narrative Arts," in *Beauty, Art, and the Polis*, ed. Alice Ramos (Washington D.C.: The Catholic University of America Press, 2000), pp 58-69.

That text reads: “A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution.”

Consider a second case.² Imagine that a father brings his young son to a doctor and explains that his family, as part of an extended clan, makes a good part of their living by begging and playing off the sympathies of the larger public. Because his son is slow of mind and clumsy of body, he plans to make him a professional beggar. The clan’s long-time experience indicates that the boy will be more effective in the long run if he is both blind and lame. The father asks the doctor to remove one leg and to blind him in one eye. Even if the doctor were in sympathy with the family’s concern that the boy be a productive member of his community, would there be any reason for a member of the medical profession *not* to accede to the father’s request? Regardless of the doctor’s personal feelings about the matter, is there any reason from within the logic of the profession of medicine and her vocation as a doctor that she should refuse to perform the procedures?

In both of these scenarios, a doctor is asked to accede to a prospective client’s request to perform medical procedures for which the physician is properly qualified. Let us grant that, so far as one can calculate consequences, the effect of the doctor’s services would bring about the very *purposes* intended: the criminal is swiftly and painlessly executed, and the child’s pathetic condition makes him an effective beggar. The medical techniques have been flawlessly executed and the variety of purposes and intentions have been effectively achieved. Can we, however, avoid the suspicion that there has been some miscarriage of medicine?

I set out these two scenarios in order to highlight the question whether medical professionals must have as one of their purposes a care for the *good* of medicine. Is medicine’s interest being served? Are these actions consistent with the ends of the medical profession?

Purposes and Ends

The general context for distinguishing purposes and ends is the sphere of human action and the attempt to make it count, to make it meaningful. In

² Cf. Nora Groce, Marie Loeb and Barbara Murray, “The Disabled Beggar – A Literature Review: Begging as an Overlooked Issue of Disability and Poverty” (Geneva: International Labor Organization, 2014), available at <http://www.ilo.org/public/libdoc/ilo/2014/486143.pdf>.

human activity, we are often moved by wishing and desiring, and in this context we strive for various goods, sometimes hitting them, sometimes missing them. “Purposes are wished-for satisfactions in view of which an agent deliberates and acts.”³ By contrast, an end is “what the thing is when it has reached its best state, its perfection and completion in and for itself.”⁴ The difference between ends and purposes needs to be drawn out. In distinguishing purposes and ends, I shall be simply recapitulating the ideas of Francis Slade and Robert Sokolowski.

Purposes. We have our wishes. We anticipate our lives being better. Blending our desires and imaginations, we project ourselves into the future possession of some good, some thing, or some condition that would lead to greater fulfillment in life. Some of our wishing transports us to conditions that are outright impossible or at least practically unrealistic, and we know it. But in many cases, what we wish for can be achieved. In such cases, our wishes become our purposes as we begin to get practical and to apply our intelligence to the task of realizing our wished-for goods. When we deliberate by calculating which means are feasible, with options and alternatives, and then setting our wills to a particular course of action, we move from wishing to choosing. As we employ deliberation and choice, our wishes become our purposes. Purposes are mental realities that arise with human intention. They are goals or focus points for human actions. Purposes are like targets for the sake of which we plan and, stage by stage, deploy our resources. For example, it was my purpose to deliver this lecture, and with this purpose in view, I arranged my affairs for sufficient research, composition, and travel. To take another example, one might encounter a neighbor named Al at a local home supply store. Were we to ask him what he’s doing, he would not say he’s purchasing lumber – that much is obvious. Rather, he might say that he intends to build a storage shed. In our planning, our purposes hold first place, and the means descend from them. The very idea of reckoning means with no purpose in mind is nonsense. Wouldn’t it be surprising if Al had no ulterior purpose in mind? What would we think if Al were seriously to tell us that he was buying lumber because he likes to buy lumber? It simply gives him great satisfaction to buy lumber!

³ Robert Sokolowski, *Christian Faith and Human Understanding* (Washington D.C.: The Catholic University of America, 2006), “What is Natural Law? Human Purposes and Natural Ends,” pp. 214-36 at p. 216.

⁴ Sokolowski (2006), p. 215.

We should note that the chain of means and purposes can be stacked or entrained, so that what at one stage is a purpose becomes at another stage a means to some further purpose.⁵ For example, imagine that Christina works extra hours to earn money in order to fly to Nepal to assist her sister in a time of trouble. In this scenario, working overtime, saving money, and traveling to Nepal may each be considered a purpose, from one point of view, but from another, a means to something else. In each of our imagined cases – Al’s shed, Christina’s generous visit, my lecturing – the purposes for which we act are held firm in mind by the intellectual power of foresight as goals or targets. Notice that purposes are mental realities. They are intentions that come into existence as the result of our practical deliberations. Purposes are real and alive because we were unsatisfied with the mere wish and started thinking practically.

Ends. Ends are like purposes in that they are a kind of good that belongs to a thing. But unlike purposes, they are not things of the mind. Many things have ends, even though they do not and cannot wish’ they do not and cannot deliberate or choose. Sokolowski says that there are three sorts of things that have ends.⁶ First, there are organisms such as *plants and animals*. Given good seed and suitable conditions of soil, nutrients, moisture, and sunshine, and barring the ravages of parasites, we commonly speak of plants as thriving. They become good instances of their kind. Much the same sort of thing can be said of an insect, or a reptile, or a mammal. If the animal has all of its parts, and its nutritive, reproductive, perceptual, and locomotive powers function well, it will thrive in its proper environment. If one wants to know what a butterfly or giraffe is, then one examines excellent specimens of the type, fully alive at work in their environment, for instance, “doing the giraffe-thing” well.

Secondly, there are works of human artifice such as *tools and social institutions*. Ink pens are made for handwriting, and schools are made for learning. It is true that pens may serve as book marks, door stops, or status symbols, but it is no less a pen for serving those purposes badly. But if it does not fit the hand or does not distribute ink evenly or does not adapt to both straight and curved lines, then it is not a good pen, because it does not serve well its end. Similarly, an elementary school as an operating institution may well feed students, provide them clothing and medical care, and keep them safe

⁵ Robert Sokolowski, *Moral Action: A Phenomenological Study*, reprinted (Washington, D.C.: The Catholic Univ. of America Press, 2017), pp. 23-27.

⁶ Sokolowski (2006), p. 216.

in the late afternoons while their parents work, but it is not a better school for all that. Its excellence as the sort of institution that it is shows in its inspiring desire and communicating abilities for understanding, judgment, decency, and creativity in thoughtful engagement with the world.

Thirdly, *human beings* are said to have ends. Many philosophers from different cultures and for almost three millennia have agreed that human beings have an end that they have called “happiness,” even if there is little agreement on just what that happiness is. Common wisdom seems to agree that some lives end well and other end poorly. What is it about some human lives that, in the final reckoning, we find in them something to honor and to emulate? Typically it is not determined by health, wealth, status, power, or physical beauty – many an unhappy person possesses these goods. Such material goods do not lie at the core of our judgment. We admire good men and women for something more spiritual, more ethical.⁷

Crisscrossing purposes and ends. We do not need much imagination to see how the differences between wishes and purposes and ends as they crisscross in our practical lives. First of all, our capacity for wishful thinking can short-circuit our deliberative judgments regarding what is practically achievable. When this happens our wishes do not rise to the status of purposes; our efforts at deliberation are unhinged from what is realistically practical. Our apparent choices are in fact little more than wishes. And when our wishes are not tailored by deliberation and choice, then we are much more victims of our wishes and desires and events than we are agents of self-control who marshal the means to the purposes we have targeted.

We can also mistake our purposes for our ends. Human experience, history, and literature are replete with the stories of men and women who successfully sought power, fame, or wealth but in the end were unhappy. We would say that they mistook their purposes for their ends. We ourselves determine our purposes, but our ends are given to us: they are part of the way we are. I do not choose my inclinations to truthfulness (to know and share the truth) nor my inclinations to sociability (to live with others, to care for and be cared for by others in justice and in love). The ethical drama of individual human lives turns on whether and how we achieve our given ends. Have we pursued our purposes to the neglect or even the frustration of our happiness? Or have we managed to shape and direct our purposes in accordance with the

⁷ Robert Sokolowski, *Phenomenology of the Human Person* (New York NY: Cambridge Univ. Press, 2008), esp. pp. 186-89, 238-70.

good of our ends?

Medicine as Art and Science

For the purposes of this discussion, let us understand medicine as a species of knowledge that has both theoretical and practical dimensions to it. It is both science and art. As science, it includes knowledge of the principles, parts, and causes of organic health and sickness. It understands the flourishing of the human organism and the manifold threats and impediments to that flourishing. As an art, medicine is the mastery of the techniques for restoring and maintaining health.⁸

On a first look, we might think that medicine belongs to the individual doctor. It is the doctor who understands the medical condition of the patient; it is the doctor who makes the diagnosis, offers a prognosis, and directs the treatment. However, each individual doctor has possession of only a part of medicine. The manifold specialties of the medical field make it evident that medicine more adequately belongs to the community of doctors, to the medical profession taken as a whole.

The primary experience of medicine – the medical act, if you will – occurs in the personal and professional exchange between the doctor and the patient. One controlling fact in medical activity is that people get sick. They experience in their bodies deficiencies, impediments, and failures that are not normal. They need interventions or supplements in order to bring some fragile or immature development to its perfection. Some aspect or quality of organic life that is part of the normal expectation for an individual human being is absent: it fails to mature or once possessed has subsequently been diminished or lost. Medicine aims at the restoration and well-functioning of the whole organism in the particular conditions of the given individual. In this context, it is worth noting that the English word “health” derives from an Indo-European root meaning “whole,” and the Greek words for “health,” namely, *hygeia* and *euexia*, literally mean “living well” and “good habit of body.”⁹

A second controlling fact is that doctors know how to heal. They have a developed capacity for diagnosis, prognosis, and treatment. This means that they know what counts as wholeness and as well-functioning parts and systems

⁸ Sokolowski (2006), “The Art and Science of Medicine,” pp. 237-49 at p. 237.

⁹ Leon Kass, M.D., *Toward a More Natural Science: Biology and Human Affairs* (New York NY: Free Press, 1985), “The End of Medicine and the Pursuit of Health,” pp. 157-86 at p. 170.

of the human organism in the particular cases of their individual patients. They can also recognize deficiencies and privations, and sometimes they also know the causes. They employ techniques for restoring the normal conditions of wholeness and well-functioning.

Let us now apply our earlier distinction between ends and purposes to the instance of medicine. What *purposes* motivate doctors in their practice? If engagement in medical action is conceived of as a means to the doctor's purposes, what purposes does she have in mind in doing what she does? Here are some likely possibilities: alleviate suffering, earn income, enjoy the honor and esteem of colleagues, the joy of healing the sick, gratitude of patients, intellectual interest in the challenges of diagnosis and treatment, minimize liability, maintain social status and self-esteem. Any or all of these (and no doubt there are more), in whatever combination, can function as the purpose(s) of a doctor's being involved in the practice of medicine. We have spoken about purposes; how about the end of medicine itself?

Does medicine, as a science, an art, a profession, have its own *end* or *ends*? Let me, without much elaboration, introduce the thesis that the primary and governing end of medicine and therefore of the medical profession is the health of individual human persons. As formulated by Leon Kass: "Medicine is constituted by the task to assist living nature in human bodies to the work of maintenance and function and perpetuation."¹⁰ Further, he notes: "Health is a natural standard or norm..., a state of being that reveals itself in activity as a standard of bodily excellence or fitness, relative to each species and to some extent to individuals, recognizable if not definable, and to some extent attainable."¹¹ Most strictly, health refers to the individual organism. In actual clinical conditions, health is a matter of more or less, pegged to the particularities of individual person's age and given physical conditions. Health is a positive good, not just the absence of disease or injury.

The doctor's knowledge is aimed at taking the measure of a patient's health. It is not, at least not primarily, focused on the patient's feelings, wishes or purposes. The healthy human being is the end of medical art. As an end, health needs to be distinguished from the doctor's pleasure in satisfying patients' desires, their social adjustment, their desired alteration of an otherwise

¹⁰ Kass (1985), "Professing Medically: The Place of Ethics in Defining Medicine," pp. 211-23; "Is There a Medical Ethic? The Hippocratic Oath and the Sources of Ethical Medicine," pp. 224-46 at p. 235.

¹¹ Kass (1985), p. 173.

healthy human body, experimental research for scientific truth, and the simple prolongation of life (insofar as we distinguish being healthy and being alive). The doctor, by virtue of medical art and the science that supports this art, knows the signs and conditions and possibilities of health. Her judgment as an expert in medicine is the measure of truth in matters of health. The patient's wishes and purposes need to be checked by the doctor's medical knowledge and practical competence. The variety of purposes and of interests that can be brought to bear in the solicitation and provision of medical care, whether on the part of the patient, the doctor, or other parties, must be consistent with the health of those who are treated.

We often desire what is not good for our health, wittingly or unwittingly. What we want or desire as our good is not always what is truly good for us. Medicine is one of the preserves of objectivity in our culture of relativism. It is a field where the distinction between objective truth about what is good is defended against the subjective truth about what we want to be good. Science also maintains a commitment to objective truth. The sophisticated knowledge of mechanisms and processes at work in the structuring and functioning of the human organism that makes up the body of medical knowledge is understood as embedded in an overarching dynamic condition of maintaining, losing, and regaining wholeness. The whole, the healthy, cannot be utterly lost sight of. It is an overarching form, rather like the rules of the game, within which all of medical information, observations, and techniques make sense.

Medicine and Abortion

In considering the announced topic of medicine's interest in abortion, I have thus far said little about abortion. I have spoken about purposes and ends, and I have spoken about health as the end of medicine understood as a profession that is both an art and a science.

What, then, is medicine's interest in abortion? In the practice of abortion, there are two distinct human organisms that are the immediate focus objects or targets of medical technique. An abortion surgically or chemically interferes with the otherwise healthy functioning of a woman's reproductive system in order to terminate the nascent human life developing in the womb. In cases where abortion serves no one's *purposes*, and so is not at issue, standard medical care looks after the health of both the mother and the child *in utero*. And medical science is remarkably good at this. The well-functioning of reproductive organs and the whole development of new life fall within the *ends*

of medical art.

How is it, then, that the practice of abortion falls within the *ends* of medicine? By virtue of an abortion's procedures the mother's reproductive system fails to reproduce and the fetus dies. Whatever and whoever's *purposes* are served by the practice of abortion, it seems that the *ends* of medicine are inevitably *not* served.

What interests are being served? Whose purposes? The mother who carries a child in her womb will have interests of her own that we can easily imagine. There are the interests of the father as well as those of the child's grandparents and the mother's friends. Third, the practice of abortion can serve a society's interests in population control and in checking the decline of the standard of living among a population that cannot be expected to care properly for its young. Fourth, abortion is a vital concern in the area of law and politics. At issue is whether the constitution protects the right to abortion as essential to a woman's ability to seek her own meaning and self-fulfillment in life. Fifth, closely associated with the social-political concerns are the interests of a society's moral and religious authorities, which invest considerable talent and resources to the shaping of public opinion and personal consciences on the morality of abortion. Sixth, there is the largely commercial interest of the biotechnology and pharmaceutical industries involved in research, development, and marketing of instruments and resources for abortion services.

It is easy enough to recognize in our experience, directly or indirectly, involvement in abortion at any of these levels of engagement. For the purposes of this discussion, however, I wish to put aside all such considerations with regard to the involvement in abortion at any of these levels of concern.

Medicine's Interest in Abortion

To what extent ought a practicing physician or nurse have a care for the ends of medicine? For the moment, we can stand back from the charged issue of abortion and pose the question from a more generic point of view by wondering about what ethical obligation the possession of the art of medicine and of the science that supports it carries for the doctor or nurse. Need the care for the maintenance and restoration of the health of the physically infirm or suffering be an active purpose that motivates the acting health professional? And if care for health ought to be an active interest on the part of working medical professionals, where does this care for the inherent *ends* of medicine fall among a ranking of the variety of personal and institutional *purposes* that

will inform a doctor's or nurse's professional engagements?

One way to assess the claim that the good of health has upon the decisions and judgments of a medical professional's practice is to pose the following questions. On what basis might a medical doctor refuse care to a patient in just those circumstances in which she has adequate medical knowledge, resources, and opportunity to restore or stabilize health of an individual whose medical condition would otherwise deteriorate? What purposes might the doctor have in mind that this refusal would serve? Would we estimate the doctor differently as a woman of moral character depending upon whether she would or would not refuse medical care?

These considerations seem to push one to the view that the doctor's care for the health of others – restoring it and maintaining it, when it is within his or her capacity – is of no inconsiderable weight in her personal practice. It is hard to imagine that the doctor does not feel from within her understanding of herself as a medical professional the special obligation that she has to the service of health. This summons to the good of health would seem to be of a piece with the power and distinction conferred on one simply by the possession one's portion of the art and science of medicine. The power to restore health gives essential meaning to the doctor's professional identity. That health is a great human good should need no argument. What becomes of medicine when its inherent ends are frustrated by putting its knowledge and techniques in the service of other purposes? What internal conflict must a doctor or nurse endure when in the direct use of her medical knowledge and competency she would intentionally jeopardize someone else's health in order to achieve other purposes?

Earlier we recognized that people take stances with respect to the practice of abortion from within a variety of spheres of interest, among them, mothers, fathers, friends, citizens, legislators, ethical and religious leaders, and medical professionals. We strictly restrained our focus to the interests of medicine and its professionals. Even within this narrowed focus we recognized a manifold of interests that divide into either purposes or ends. In the conclusion, we encountered an incoherence or conflict between health as an *end* of medicine and the various *purposes* that might effectively be served by the practice of abortion.

To conclude, let's put into one of the pans of a balance a doctor's care for the *ends* of her profession. Into the other pan we place the variety of *purposes* served by the practice of abortion. The purpose of this essay has not been to tilt

the balance to one side or the other, but rather to be sure that the claim of the ends of medicine is felt with its just weight in the deliberations of medical professionals.