Target Article

Toward a Reconstruction of Medical Morality*

Edmund D. Pellegrino, Georgetown University

At the center of medical morality is the healing relationship. It is defined by three phenomena: the fact of illness, the act of profession, and the act of medicine. The first puts the patient in a vulnerable and dependent position; it results in an unequal relationship. The second implies a promise to help. The third involves those actions that will lead to a medically competent healing decision. But it must also be good for the patient in the fullest possible sense. The physician cannot fully heal without giving the patient an understanding of alternatives such that he or she can freely arrive—together with the physician—at a decision in keeping with his or her personal morality and values. In today's pluralistic society, universal agreement on moral issues between physicians and patients is no longer possible. Nevertheless, a reconstruction of professional ethics based on a new appreciation of what makes for a true healing relationship between patient and physician is both possible and necessary.

Open Peer Commentaries

Robert M. Veatch, p. 72

Denise M. Dudzinski and Wylie Burke, p. 75

Rosamond Rhodes, p. 76

Nuala Kenny, p. 78

Joel D. Howell, p. 80

Gail Geller, p. 82

Loretta M. Kopelman, p. 85

Angelo E. Volandes and Elmer D. Abbo, p. 88

Katherine Wasson and E. David Cook, p. 90

One of my major concerns, in recent years, has been what I perceive as the need to rebuild a basis for medical ethics and medical morality. This was in fact the central theme of my recent book, *A Philosophical Basis of Medical Practice.* To establish such a basis in some philosophical conception of the physician–patient interaction is necessary, I believe, for a number of reasons. The first is that if you look at the history of medical ethics and medical morality you will find, by and large that it consists of a series of *a priori* statements of what ought to be done, statements of moral principles. Nowhere, however, in the first documents, the scripture so to speak, of medical ethics—the Hippocratic corpus or collections those 70-plus books, the Hippocratic Oath included—do you find an attempt to put a philosophical, rational justification under the obligations that are deduced.

Now you might say, What difference does that make? I think it makes a very significant difference if you look at what has been happening to the interpretations of the physician–patient encounter over the past several hundred years. What is unique about the medical encounter is the interaction between someone who is ill, on the one hand, and someone who professes to heal, on the other. What we think about that relationship in large measure determines what we regard as the obligations patients and physicians owe each other. In short, medical ethics is based in our philosophy of the healing relationship.

Medicine is a moral enterprise, and has been so regarded since Hippocratic times: that is to say, it has been conducted in accordance with a definite set of beliefs about what is right and wrong medical behavior. Only in recent years, however, has it been ethical in the strict sense of that term.

Let me clarify that point. Ethics is a branch of philosophy; it is not a set of visceral sensations arising somewhere in the solar plexus and suffusing the frontal lobes with "good" or "bad" feelings. Ethics is a formal, rational, systematic examination of the rightness and wrongness of human actions. It comes into existence only when a moral system becomes problematic and is challenged. Ethics was born when Socrates began to raise those perplexing questions which so vexed his contemporaries that they offered him the cup of hemlock. He passed onto the next world as a consequence with his irritating questions still unanswered. It is when the claims of morality put forward in any given time are made problematic subjects for critical inquiry that ethics begins. And if you examine the history of medical morality, you will find that most of it is the history of moral statements without very much in the way of formal philosophical justification.

Why is that of concern? For one thing, the 2,500-year-old image which emerges from the

*Originally published in *The Journal of Medical Humanities*, 8(1), Spring/Summer 1987. Reprinted with permission from Springer Science and Business Media.

The American Journal of Bioethics, 6(2): 65–71, 2006

ISSN: 1526-5161 print / 1536-0075 online
DOI: 10.1080/15265160500508601

Hippocratic corpus and which still has wide uncritical acceptance today, is the very image being most seriously questioned in our democratic, pluralistic society in which more and more people are being educated about matters of bodily and mental health. That image is of the physician as a benign, benevolent, all-knowing authoritarian figure who decides what is best for his patients. That conception served humanity well in a time that was simpler and when medical decisions did not involve, as they do increasingly today, a host of new questions of values and morality it more easily fulfilled expectations in a society in which there were very few educated people who would say, "Just a moment—I would like to understand what is happening! I want to have a say in what you are going to do."

Today the traditional image is being fractured. It is being challenged and drastically revised in some of the more recently proposed professional codes. That great canon of medical morality, the Hippocratic Oath is being honored more in the breach than in the observance. Each one of its prescriptions has been questioned by some physicians and violated by others. Thus, it is almost impossible today to define a common set of medical moral principles to which all physicians subscribe.

A further point is that we have competing interpretations of the physician–patient interaction to contend with. The first, as I have said, was a paternalistic one, the Hippocratic notion of the benign, all-knowing physician. The second is based on the philosophy of John Locke: the idea of two autonomous individuals entering a contract for service. Then a third model is the commercial one being eagerly propounded by some of my colleagues today. In this model, medical knowledge is held to be a proprietary possession of the physician. He makes it available, as the baker would make bread available, when he pleases, in what manner he pleases, for those who can purchase it if they please. If they don't like the bread they can go on to another baker.

Another viewpoint is that there is no real difference between the medical transaction and the transaction between you and your auto mechanic, discussing the health of your automobile—whether he should or should not operate on the carburetor. This analogy may seem fanciful, but it is seriously and boldly argued. Other models—the hieratic, holistic, psychosociobiologic, and biological models—all have an effect upon some facet or facets of the physician–patient relationship. Each, when applied logically and completely, results in a different kind of ethics and practice and a different educational schema.

It seems self-evidently important whether you think the physician–patient relationship is a contractual relationship between two autonomous individuals, whether you think one individual has proprietary right over the knowledge he has and can purvey it for a price on his own terms, or whether you prefer some other model. A philosophical understanding of that relationship therefore becomes the first step in any reconstruction of medical morality. The obligations of physician as physician, the first step in medical morality, must depend on what we think of the healing relationship.

Personally, I would reject all of the notions I have cited and would rather put forward another one. It is of interest to know that what I am proposing was attempted a long time ago. This was the attempt to derive the obligations of a physician from the nature of medicine, made in the first century AD, by the physician to the Emperor Claudius, Scribonius Largus. In a rather brief disquisition on medications, Scribonius put forward the notion that we should determine the responsibilities of the physician by examining the nature of medicine itself. He said that the aim of the physician, the end of medicine, was *humanitas*.

That was the first time, as far as we know, that a word with that precise meaning was used in this connection. Humanitas—humanity, a love of mankind, was not the same as *philanthropia*, the Greek concept which expressed rather a kindliness towards the patient that would enable the physician to have a good practice and a good reputation. Scribonius Largus also used the word *misericordia*, mercy. *Misericordia* and *humanitas*, in his conception, were the aims of the physician in the same way that justice was the end and aim of the judge and the lawyer.

There has been no real attempt since Scribonius to build a concept of medical practice on such a philosophic foundation. I propose to make such an attempt—to examine the nature of the physician–patient relationship, and to draw from this some of the obligations of the physician.

It is important to note that while I am speaking of the physician the same approach is applicable to the nurse, dentist, psychologist—any of the professions that offer themselves as healers. There are three phenomena that we must consider: the first is the fact of illness; the second is the act of profession; the third is the act of medicine.

Consider first the fact of illness. When one becomes ill, one undergoes a change in existential

states. Let's say that one experiences a sudden pain in the chest. Most people today are well enough educated to know that this could be the beginning of a heart attack. That realization leads very quickly to the conclusion that one is no longer healthy, but is ill. Illness is a subjective definition made by the patient, not solely by the physician. The latter determines what is a disease, which is not the same as illness. It is the patient who determines that his or her customary balance the sense of wellness has been disturbed to the point where it is necessary to consult someone else for assistance. Recognition of that disturbed balance initiates the state of illness.

What happens to someone who is in that state of illness? First of all, some of the things we associate most closely with being human involve the capacity to use our bodies for transbodily and outwardly directed purposes. In a state of illness the body is no longer our ready instrument; it becomes, instead, the center of our concern. It begins to tyrannize, to make demands; it has to be listened to, taken somewhere for help. In a sense, there's a split between the self and the body: one steps back, as it were, and begins to look at one's body; the unity of body and self that had previously existed is fractured somewhat.

Secondly, the person who is ill has lost some of his freedom. He does not have the knowledge personally to discern the answers to three fundamental questions that occur to anyone in a state of illness: *What's wrong? What can be done?* and *What ought to be done?* Since the patient cannot make his own decision unaided, he must put himself in the hands of another person. He becomes dependent upon the person and therefore vulnerable.

Being ill is a radically different state of affairs from being well. To those who argue for the auto mechanic version of the healing relationship, I would suggest that, as distressed as we may be with the carburetor and the perverse things automobiles do to us in cold weather, the illness of our autos doesn't have the kind of impact on our very existence that illness does. The underlying thought in illness for most persons, even with trivial and certainly with important symptoms, is: *Is this the beginning of the end of my existence?*

The fragility of our human existence comes before us bluntly when we experience illness. We have therefore, in the fact of illness, a wounded state of humanity. We haven't changed human nature ontologically, but the operations we usually regard as human are impaired.

In that particularly vulnerable state we confront the second fact of the physician–patient relationship: the act of profession. The word *profession* comes from the Latin word, *profiteri*, which means to declare aloud. But how do we declare aloud? When you come to a physician, his question is, How can I help you? Implied in that question is his promise, the promise to help. Thus, in the presence of one vulnerable human being who is ill we have another human being who promises to help, to heal, to restore the balance insofar as scientific knowledge will allow.

Implicit in the act of profession are two things. The first implication is that the physician possesses the necessary knowledge—that he is competent. The second is that he will use that competence in the patient's interest and not his own, for the patient's good. What we mean by the patient's good today increasingly raises questions about values, about what is the good life. To act in the patient's interests implies the promise that the physician will act in such a way that the patient's interpretation of the good life will be protected and that he will have an opportunity to make the value choices that so often underlie the decisions about what should be done.

The relationship between someone who is ill and someone who promises to help is perforce a relationship of inequality. I am not justifying the inequality. I am defining what is, not what ought to be. The physician–patient healing relationship is of its nature an unequal relationship built on vulnerability and on a promise.

The third element of the physician–patient relationship is the act of medicine. The act of medicine involves those actions on the part of the physician that will lead to a correct healing decision. A healing decision is one that will make the patient whole again, restore bodily harmony if that is possible, and perhaps even make it better than before the illness occurred. A healing decision is consistent with the knowledge that we have of scientific medicine—in other words, a medically competent decision.

But it must also be a good decision. A good decision will fit this particular person, at this age and situation in life, with this person's aspirations, expectations, and values. We are all closely identified with our values; they are the things we think are important, the things that define us as persons. The contemporary emphasis on holistic or whole-person medicine derives from the notion that to protect the whole person we must not only heal the organ—a point so obvious that we don't need to make it any more, even though it is violated time and again—but we must also make the decision that is good for this person in the fullest sense.

The choice of how we want to live our lives when we face serious illness, whether we want to reject the indicated treatment or run substantial risks of discomfort for even a small chance of benefit, are value decisions no one can make for us. The complexities of a "good" decision are such that we cannot deduce them automatically from what may be a scientifically correct decision.

It is in the moment when physician and patient together decide what should be done that medicine as medicine comes into being. This is the moment of clinical truth—an exercise in practical judgment, in prudence, and ultimately in ethics. Indeed, it is in the relationships involved in the triad of the fact of illness, the fact of profession, and the act of medicine that the obligations of the physician and the patient to each other are born. A few examples of the way these obligations derive from the nature of the healing relationship are in order. But they must be limited for want of time.

One of the realities of illness is the gap in information that separates the patient and the physician. Certainly one of the physician's obligations is to close that gap, to enhance the patient's capability to act and make truly human decisions. Therefore, the patient needs to understand the nature of the illness and the alternatives being offered—to understand them well enough to be able to make an authentic personal decision. There are, in truth, very few complex and abstruse notions in medicine that can't be communicated in plain English terms. Physicians need to be reminded that what's required is the information and the understanding to make this decision, not all decisions in medicine. There is no question that the person who is ill has the most exquisite interest in that decision. Disclosure of medical fact becomes a first moral imperative: the physician cannot really heal unless he enhances the patient's moral agency, his capacity to make his own moral and value decisions based on a knowledge of alternatives.

Consent then, becomes not a legal but a moral notion. Set aside the question of whether a piece of paper has been signed or not. All too frequently a signed permission is testimony of a superficial transaction. True consent (the word comes from the Latin *con* and *sentire*, meaning both to know and to feel together) implies that the patient and the physician together must know what they are dealing with, and what the alternatives are. They have come to a conclusion together about what it is they wish to do. We cannot have a morally valid consent when information is withheld or manipulated, when freedom is lacking, when there is insufficient reflection on the values at issue. The physician has a responsibility to underscore the moral questions so that the patient can act in a way consistent with his or her belief systems. Clearly he must avoid imposing his own values on the patient.

In this view the ancient and traditional notion of the benign, authoritarian physician who decides what is best for the patient needs revision. Instead, we must think of two moral agents, the patient and the physician, interacting over the value questions. The medical decision very frequently reflects an intersection of value decisions. So when a patient who is a Jehovah's Witness says he or she does not want a transfusion and regards that value as overriding—overriding life itself—the physician has to respect that decision. The same is true of the Catholic for whom abortion is anathema. Remember, however, that the physician too is a moral agent. Therefore, the patient cannot ask the physician to override his values. To respect the patient's moral agency does not mean submitting to whatever he wishes if it violates the physician's moral beliefs.

It is obvious that we are talking about a much more mature, open relationship than has existed in the past: a relationship in which two individuals interact as moral agents, recognizing that one is in a more vulnerable position than the other. The weight of the obligations therefore rests on the person with the greater degree of power and authority, and the one who has made a promise to help. In this view we have an ethics of responsibility, imposed upon the physician by virtue of his own freely made promise to the one who is ill. The emphasis is on obligations and responsibilities mutually incurred by both physician and patient and not on their mutual rights.

A serious question today for conscientious physicians is how to deal with conflicts between what is good for the patient and what is good for society—between individual and social obligations. Take the cost of medical care. Should the physician act as an instrument of social and economic policy and decide who shall receive care and who shall not? Should the physician enter into quality-of-life determinations or even raise the questions? Here, I would hold, the patient has to express his or her view, the physician his or hers. If they are in concordance they can move ahead together. The optimal decision is one which arises between them rather than too directly from either the doctor or the patient. This kind of interaction takes time. Inevitably there is the objection: "But we don't have time!" Nevertheless, we cannot so easily escape the

fact that moral considerations take precedence over all others. Unless delay means a positive danger for the patient, we are obliged to take the time needed for a morally defensible decision-making process.

We have in the medical relationship two interacting moral agents, each of whom most respect the dignity and values of the other. A logical consequence is that at times the physician is morally impelled to remove himself or herself from the relationship when he or she differs on a matter of moral principle with the values the patient expresses. We are very likely to see the emergence, in the not-too-distant future, of the expectation that physicians will announce in advance their positions on the more crucial human life decisions. These decisions may involve such things as abortion, artificial insemination, withholding of treatment prolonging life, or using socioeconomic determinants in allocating scarce medical resources.

It is abundantly clear that in a morally pluralistic society universal agreement between physicians and patients on fundamental moral issues is no longer possible. It is more than ever imperative, then, that patients and physicians recognize where their value systems coincide and where they diverge. In the vulnerable state of illness, patients must be protected against submersion of their value systems without, on the other hand, expecting the physician to sacrifice his own. The triad of phenomena inherent in the healing relationship—the fact of illness, the act of profession, and the act of medicine—provides a sound foundation for defining relationships of physicians and patients necessary to preserve the moral agency of each.

These concerns raise some interesting questions about the education of physicians. A remarkable thing has happened in medical schools in the past two decades. In 1963 the number of medical schools that taught medical ethics was perhaps a dozen. Today in a national survey we have just concluded we have found that of the nation's 126 medical schools, 114 teach medical ethics. I would not imply that medicine has become more ethical by virtue of that statistic; but at the very least, ethical questions are being examined in a critical fashion. What is more important in a pluralistic society is that medical students and young physicians today are being educated in some of the skills of ethical discourse. They are learning how to analyze ethical dilemmas—how to recognize, analyze, and understand their own value systems and those of their patients, and how to resolve conflicts in values. Moreover, these questions are occurring in medical rounds at the bedside and in the clinic. This would have been unthinkable twenty years ago.

The capacity to recognize, analyze, and resolve ethical issues at the bedside is just as important as knowledge of the basic and clinical sciences. This judgment follows inescapably if you accept the idea that the end of medicine is a right and good healing action for a particular human being. This capacity is at least one of the more tangible elements of compassion. Compassion has a moral quality; it is not just a fine bedside manner or a capacity to have a physiological or psychological empathy with the patient. These are not to be deprecated. But compassion is something more. It means (to go back once more to the Latin) "feeling with," "suffering with," the patient.

Every human experience is unique, especially the experience of illness. No one can fully experience another person's experience of illness. Nevertheless, if we are to arrive at a medical decision that fits as closely as possible a patient's experience, we must penetrate that unique experience to some degree. That's what compassion means. To feel something of what it is to be ill: not in general, not in society, not in one's family, but in this person here and now. Compassion becomes a moral requirement because a truly healing action requires some comprehension of what this illness means to this person. Objectivity required by medical science is a stepping back, which is absolutely necessary for the technical decision. But with compassion we step back into the patient's experience in order to make a good, morally defensible decision.

To summarize, I think we need to reconstruct medical morality on a sound philosophical base—the base that is unique to medicine: the physician–patient relationship. It makes a great deal of difference whether you look at it as a healing relationship in the terms I have been describing, as a contract between two persons who are on an equal footing, or as a commercial transaction. We are now in an era in which competition may become a new salvation theme in medicine: unleashing the competitive spirit, it is ventured, will save us all by driving costs down. Well, even if it does reduce costs, what will it do to the healing relationship?

Ask yourself, as you all must eventually, as physicians must: is there something about illness that is unique and that puts it into a different category of human relationships from that of your relationship with our auto mechanic or grocer? I think our answer must be, "Yes." If we can establish that point we may hope for fairly wide agreement

amongst us on what constitutes an ethical relationship between the healer and those who are ill.

Even with this agreement there remain broad areas in which there is no consensus. A philosophy of the physician–patient relationship is not the whole of medical morality. One cannot have a complete medical morality unless one has taken a stand on several levels of medical–moral discourse. First, the one I have been talking about: What are the obligations of a professed healer, simply by virtue of making that profession? We can come to a common agreement at this level because the phenomena of illness, medicine, and the act of medicine have foundations we can observe.

This will not tell us how we should act in the face of specific medical moral dilemmas—what to do in the case of abortion, euthanasia, the prolongation of life, the care of the infant with multiple deformities, behavior control, genetic engineering, and all the other medical–moral problems of the day. On these important issues we are not likely to agree unless we are in agreement at two deeper levels. One level has to do with what we think man is, what his nature is—our philosophy of man: Is he genetically determined in a certain way?; are ethics and science the same thing?; is ethics swallowed by science, by neurology? The other level has to do with our opinions about a source of morality outside of man, a transcendental source, that stands over and beyond man. Do we believe in God?; what do we believe about Him?

Most of the difficulty and emotion in ethical discourse arises from the great differences of opinion at the last two levels: the philosophical and the theological. In a pluralistic society we cannot expect uniformity on these last two levels.

But I do think agreement is both possible and necessary at the first level, at the level of a philosophy of the physician-patient relationship, the focus of my remarks. I and some others are working toward a reconstruction of medical morality that might extend what Scribonius Largus started in the first century AD. We certainly have the insights today to go somewhat further, in a somewhat more sophisticated way, and to develop a viable professional code that will fit the requirements of our times better than some of the older ones do. We are trying to challenge both physicians and patients to ponder these issues because professional medical ethics is no longer an enterprise to be pursued solely by physicians, for physicians.

Finally, I believe, the elements of the healing relationship and the obligations derivable from them are common to all health professionals. We must therefore look towards the reconstruction of not just medical ethics but an ethics for the health professions, for all who profess to heal. There will be some clashes arising from the differences between, let us say, the act of medicine and the act of nursing, but these will be minor and subsidiary to those things that are common to all of us.

Difficult as a reconstruction of professional ethics will be in a pluralistic society, with so many health professions vying with each other, I think the construction of a common ethic is possible and necessary. But for it to be successful we must start with the phenomena we all share—patients, physicians, nurses and all professed healers: the phenomena of the healing relationship. ■

REFERENCES

Ba-Sela, A., and H. E. Hoff. 1977. Isaac Israeli's fifty admonitions to the physician. In *Legacies in ethics and medicin*e. New York: Science History Publications.

Bernarde, M., and E. W. Mayerson. 1978. Patient–physician negotiation. *Journal of the American Medical Association* 239: 14–15.

Burns, C. 1977. American medical ethics: Some historical roots. In *Philosophical medical ethics: Its nature and significance*, ed. S. Spicker, and H. T. Engelhardt, Jr., Dordecht: D. Reidel.

Cabot, R. 1977. The use of truth and falsehood in medicine: An experimental study. In *Ethics in medicine*, ed. S. Reiser et al. Cambridge, MA: M.I.T. Press.

Cassell, E. 1977. Autonomy and ethics in action. *New England Journal of Medicine* 6: 333–34.

Cicero, G. 1967. *Cicero on moral obligation: A new translation of Cicero's ''De Officiis.''* Introduction and notes by J. Higginbotham. Berkeley, CA: University of California Press.

Deichgraber, K. 1950. *Professio medici zum Vorwort des Scribonius Lagos.* Wiesbaden: Franz Steiner Verlag.

Edelstein, L. 1943. *The Hippocratic oath: Test, translation and interpretation.* Baltimore: Johns Hopkins Press.

Edelstein, L. 1967. The professional ethics of the Greek physician. In *Ancient medicin*e, ed. O. Temkin, C. L. Temkin. Baltimore: Johns Hopkins Press.

Gert, B. 1973. *The moral rules.* New York: Harper Torchbooks.

Hippocrates. 1923. Hippocrates I–IV, Trans. W. H. S. Jones. Cambridge, MA: Harvard University Press.

Hooker, W. 1849. *Physician and patient: A practical view of medical ethics.* New York: Arno Press.

Jones, W. H. S. 1946. *Philosophy and medicine in ancient Greece.* Baltimore: Johns Hopkins Press.

Jonsen, A. F., and A. E. Hellegers. 1974. Conceptual foundations for an ethics of medical care. In *Ethics of health care*, ed. L. Tancredi. Washington, DC: Institute of Medicine.

Levey, M. 1977. Medical ontology in ninth century Islam. In *Legacies in ethics and medicine,* ed. C. Burns. New York: Science History Publications.

Marcus Aurelius. 1960. *The meditations of Marcus Aurelius*. Trans. G. Long. Garden City, NY: Doubleday & Co.

Nortell, B. 1978. AMA Judicial Activites. *Journal of the American Medical Association* 239: 1396–1397.

Owens, J. 1977. Aristotelian ethics, medicine and the changing nature of man. In *Philosophical medical ethics: Its nature and significance* (Vol. 3), ed. S. Spicker and H. T. Engelhardt, Jr. Dordecht: D. Reidel.

Pellegrino, E. D. 1973. Toward an expanded medical ethics: The Hippocratic ethic revisted. In *Hippocrates revisted*, ed. R.J. Bulger. New York: MEDCOM Press.

Pellegrino, E. D. 1977. *The anatomy of clinical judgments: Some notes on right reason and right action*. Paper presented at the Fifth Trans-Disciplinary Symposium on Philosophy and Medicine: Clinical Judgment, University of California School of Medicine, Los Angeles, CA.

Pellegrino, E. D. 1979. *Humanism and the physician*. Knoxville, TN: University of Tennessee Press.

Pellegrino, E. D., and Thomasma, D. C. 1981. *A philosophical basis of medical practice: Toward a philosophy and ethic of the healing professions.* New York and Oxford, UK: Oxford University Press.

Pellegrino, E. D. 1979. Toward a reconstruction of medical morality: The primacy of the act of profession and the fact of illness. *Journal of Medicine and Philosophy* 4(1): 32–56.

Percival, T. 1975. *Medical ethic*s. Huntington, NY: Robert Krieger.

Scribonius Largus. 1887. *Compositions*, ed. G. Helmreich. Stuttgart, Germany: B. G. Teubner.

Spicker, S. 1977. Medicine's influence on ethics: Reflections on the putative moral role of medicine. In *Philosophical medical ethics: Its nature and significance* (Vol 3), ed. S. Spicker and H. T. Englehardt, Jr. Dordecht: D. Reidel.