

# Medicine As A Moral Practice: Reconsidering The Role Of Moral Agency In The Patient-physician Relationship

F Jotterand

---

## Citation

F Jotterand. *Medicine As A Moral Practice: Reconsidering The Role Of Moral Agency In The Patient-physician Relationship*. The Internet Journal of Law, Healthcare and Ethics. 2002 Volume 1 Number 2.

## Abstract

In this paper, I reconsider the notion of agency often neglected in contemporary moral theory. More specifically, I examine what the relationship taking place between the physician and the patient entails from a moral perspective. The discipline of medical ethics focuses mostly on the four principles of autonomy, justice, nonmaleficence, and beneficence as the foundational precepts guiding the physician through a consultation. However, the nature of medical practice, i.e., medicine as moral practice, requires a much richer vision of the reality of moral life. The physician, due to his or her special status, is de facto liable as a moral agent because of the fiduciary nature of the relationship with the patient and the kind of knowledge he or she possesses. In other words, although medicine requires scientific and technological knowledge, it is first and foremost oriented towards what Edmund D. Pellegrino calls a "healing relationship" that demands moral accountability.

In the last four decades, the progress of medicine has increasingly challenged ethicists, physicians, theologians, and philosophers to provide justifications of new medical innovations. Some very important issues, such as organ transplants, abortion, physician assisted suicide, genetic manipulation, IVF technologies, and cloning have moved to the center of political and public discussions as never before. In the 1960s, in response to the increasing social concern about the moral implications of these new enhancements in medicine, physicians turned to lay people – mostly theologians, philosophers and lawyers – to consider the morality of particular issues. This shift in prerogative gave birth to the discipline of bioethics.<sup>1</sup> Although many streams of influence shaped this new form of moral philosophy from its beginnings, today's most dominant form of moral reasoning encountered within the field of bioethics is oriented toward examining quandaries and act analysis. In the following essay I do not aim to critique such methodology per se but rather consider one aspect that is often disregarded in bioethical theory, that is, the importance of agency in moral reasoning and how it relates to medical practice. This is for one specific reason.

Moral reasoning in Western society has shifted historically from an ethic based on virtue (agent-oriented ethics) to an ethic based on principles, duties, social contract, and rules. Edmund D. Pellegrino and David C. Thomasma, in their volumes *The Virtues in Medical Practice* and *The Christian*

*Virtues in Medical Practice*, claim that the same shift occurred in the field of medical ethics. They argue that many attempts have been made to combine a virtue ethic with principle-based theories without success. However, the dominant approach to contemporary biomedical ethical problems, organized around the four principles of justice, autonomy, beneficence, and nonmaleficence, has begun to be questioned due to the "abstract nature of principles" and their "failure to capture the richness and complexity of the moral life."<sup>2</sup> Furthermore, a principle-based ethics does not satisfactorily take into account the role of the character of the moral agent.<sup>3</sup>

An important element must be kept in mind in our analysis. In the criticism formulated against current bioethical theory it is not argued that medical ethics ought to be based uniquely on the concept of virtue ethics. Rather, it is the incompleteness of moral theories within the field of bioethics that is at the core of the discussion. It is argued that the current stress in most moral theories on principles (and casuistry) is unable to give a complete picture of the moral reality of human existence. Consequently, efforts to link a virtue-based ethic with a principle-based ethic must be undertaken.<sup>4</sup> Such efforts have been unsuccessful to this point because, in the end, virtue ethics is relegated to a secondary role. The above statement of Tom Beauchamp and James Childress epitomizes this claim:

The special role of virtues in ethical theory should not be construed as evidence for a primary role, as if a virtue-based theory were more important than or could replace obligation-based theories. The two kinds of theory have different emphases, but they are compatible and mutually reinforcing.<sup>5</sup>

The tension in moral philosophy between an ethic construed in terms of principles and technical knowledge and one construed in terms of virtue-agency requires a redefinition of the quest for moral knowledge. Some scholars, such as philosopher Alasdair MacIntyre for instance, argue for the necessity of rediscovering a moral vision that would enable society to envision the moral sphere as a means of contextualizing morality rather than as an arena of the status quo.<sup>6</sup> In relation to bioethics, James Drane remarks that bioethicists in America have their own metaethical framework focused on verifiable facts, logical arguments, methodological rules, and privacy concerns. Unfortunately, he writes, character – agent related ethics – is not a clear enough concept, not objective enough, not precise enough to fit this model.<sup>7</sup>

In what follows I aim to demonstrate the importance of an “agency oriented ethic” in the healing relationship that occurs between the physician and the patient.

### Medicine and Moral Reasoning

We might be tempted to conceive medicine as a discipline the purpose of which is uniquely the advancement of the physical well-being of individuals. Medical results of a particular treatment, however, are strongly related to the healing relationship taking place between the physician and his or her patient.<sup>8</sup> Medicine, then, is more than an empirical enterprise in search of a cure; it is an art that involves humans with “a soul” and “free will.” As historian Erwin H. Ackerknecht has rightly pointed out,

Medicine is not only a science; it is also an art. Science is primarily analytic, art primarily synthetic. Medicine is likely to remain an art, however hard we may try to make it more and more scientific, and however much we may attempt to master its scientific contents. For medicine deals not with impersonal atoms, elements, plants with tropisms, or animals with instinct mechanisms, but with humans with a ‘soul’ and ‘free will.’<sup>9</sup>

It is precisely because medicine deals with human beings that morality occupies a fundamentally important place in

medicine. Indeed, the art of medicine is a practice that is characterized by “internal goods and standards of excellence that give it a moral intelligibility unlike most of our institutions....Medicine [is] first and foremost a moral practice constituted by intrinsic moral convictions that are operative even if not explicitly acknowledged.”<sup>10</sup> Hence, medical practice can be understood as a form of human activity composed of moral standards. It reflects, I will claim, the intrinsic moral property of medicine for two important reasons.

First, medicine is a form of human activity limited by the human experience as finite beings. The scientific data gathered by different medical disciplines cannot confine the healing relationship between the doctor and his patient to a secondary stage of importance on behalf of technological skills. In fact, according to Ackerknecht, “psychosomatic” diseases will form from 50 to 70 per cent of the physician’s practice.<sup>11</sup>

Moreover, medical research deals with universal phenomena, empirically tested and verifiable, but medical practice is an attempt to apply empirical data to particular patients who may or may not respond favorably to the laws of medical science. While the physician depends on scientific information for the elaboration of a diagnosis, he or she ultimately processes them according to an “internal dialogue” conformable to “the canons of the liberal arts.”<sup>12</sup>

These two aspects of medicine (relationship and interpretation of scientific data) suggest, as asserted by Pellegrino and Thomasma, that medical practice entails a moral aim as its ultimate purpose.

Medicine is a process aimed to an action taken in the interest of the specific patient. Its chief aim is not discovery of the laws of nature. The end of medicine, its justifying principle, is, in the final analysis, a moral one: the “good” of a person seeking help. The choice of what ought to be done turns on questions of value, morality, and interpersonal dynamics. These questions can be studied scientifically, to be sure, but they cannot be defined by scientific considerations alone.<sup>13</sup>

Although Pellegrino’s and Thomasma’s contention is significant in our reflection, it nevertheless raises two important issues. First, the content of the moral undertaking of medicine still remains unspecified and uncertain especially in our pluralistic society. How ought we determine which morality should be applied? On what basis

and who should ultimately decide the criteria for medical practice? Those questions are certainly at the center of the medical ethical discourse and are not easily answered. Although, I will not try to answer those important issues, I will assert that the morality of Western medicine is closely bound to Hippocratic medicine and therefore any attempt to specify the morality of our traditional medicine must be considered in the light of the Hippocratic corpus.

Second, I will argue that the two aspects of the practice of medicine – the healing relationship and the interpretation of empirical data – imply an ethic virtue, that is, an ethic emphasizing the notion of moral agency in which a person makes the correlation between agency (reasons, motives, intentions) and actions. The character of an individual is one aspect of his or her self that determines an action through “a mode of social existence.”<sup>14</sup> Hence, if this description of what constitutes the moral reality of the self is correct, it follows that the medical relationship depends on the doctor’s ability to implement scientific knowledge according to moral values inherent in his or her self. Indeed the relational and interpretative character of medicine represents the moral nature of medical practice.<sup>15</sup> Medicine “is an intrinsically interpretative practice that must always be practiced under the conditions of uncertainty [the uncertainty of each illness’ narrative]. Accordingly, patient and physician alike bring virtues (and vices) to their interaction that are necessary for sustaining therapeutic relationships.”<sup>16</sup>

The close relationship between the agency of the doctor and the act of interpretation of medical facts requires the crucial role of virtue ethics in medical practice for two main reasons. First, on the medical level, the type of relationship between the doctor and the patient implies that each participant engages his or her moral discernment (as a moral agent) in order to find the best prognosis (action) for a specific medical issue. The doctor must exercise what Stanley Hauerwas calls the “wisdom of the body” which entails the manifestation of some character traits (or virtues) intrinsic to medical practice.<sup>17</sup> Second, each illness in itself represents a kind of narrative that demands a reconsideration of the notion of virtue and character – or agency. Because each disease implicitly carries the particularities of the patient’s health history, the physician has to use moral and interpretative discernment during the consultation in order to finalize a diagnosis for the best interest of the patient.

This capacity to perceive the good for the patient in the healing relationship entails the idea that within the practice

of medicine there are certain standards of excellence inherent in such human activity. To that we shall now turn.

## **THE INTERNAL GOODS AND STANDARDS OF EXCELLENCE INTRINSIC TO MEDICINE**

Medicine as a form of human activity implies a reliance on internal goods and standards of excellence. These are “moral imperatives” that constitute an “internal morality of medicine – something built into the nature of medicine as a particular kind of human activity.”<sup>18</sup> Pellegrino and Thomasma formulate five moral imperatives that characterize the specific human relationship in medicine. They are (1) the inequality of the medical relationship; (2) the fiduciary nature of the relationship; (3) the moral nature of medical decisions; (4) the nature of medical knowledge; and (5) the ineradicable moral complicity of the physician in whatever happens to the patients.<sup>19</sup>

First, the vulnerability and inequality of the medical relationship is obvious in the sense that illness produces a mental state in which the patient becomes anxious, fearful, and dependent on others – primarily the physician. It creates a total dependence and vulnerability of the ill person who must refer to a skilled professional in order to regain control of his health and life. This inescapable situation of vulnerability “imposes de facto moral obligations on the physician. In a relationship of such inequality, the weight of obligations is on the one with the power....The physician...has the obligation to protect the vulnerability of the patient against exploitation.”<sup>20</sup> The condition on how the relationship is established logically implies the second moral imperative, that is, the fiduciary nature of this relationship. Trust and confidence are “ineradicable” for the benefit of the sick and in order to achieve the ends of the medical endeavor.<sup>21</sup>

Third, the nature of medical decisions makes the medical relationship a moral enterprise in the sense that most of the medical decisions are the combination of technical and moral components.<sup>22</sup> This means that the physician must refer to his technical knowledge in order to make a scientific assessment (diagnosis, prognosis, and choice of therapy) of the patient’s condition without undermining the ends of medicine, that is, the good of the patient. Technology and morality ought not to be dissociated but rather combined to enhance the well being of the patient.

Fourth, the characteristics of medical knowledge impose certain moral obligations on those who possess it. Medical

knowledge is not acquired primarily for its own sake but rather for a specific purpose – the care of the sick. Consequently, physicians have the obligation to be stewards of that knowledge and not the exploiters of medical techniques for reasons of self-interest or monetary gain.

Finally, by virtue of the kind of covenant established between the patient and the physician, there is an implicit moral complicity necessary for the healing process to be achieved. "The physician is therefore de facto a moral accomplice in whatever is done for good or ill to the patients."<sup>23</sup> The obligation to serve the patient's good cannot be overridden on behalf of any other party such as the hospital, the economic or fiscal policy, or the law.

## CONCLUSION

These internal goods and standards of excellence are the constitutive framework of medical practice.<sup>24</sup> They cannot, however, be separated from the element essential to the relationship between the physician and the patient, that is, from the role of the agent-physician in the healing dynamic. Because medicine involves real people, it cannot avoid considering the aspects of ethics that regulates human behavior, that is, the virtues – or the notions of agency and character. Principles, laws, and rules are part of the process but do not compose the essence of the moral self.

## ACKNOWLEDGEMENTS:

I would like to thank Professor Elizabeth Heitman who reviewed and made helpful comments on an early draft of this article.

## References

1. For a detailed account of the origins of bioethics see Albert R. Jonsen, ed., "The Birth of Bioethics." Special Supplement, Hastings Center Report 23:6 (1993).
2. Edmund D. Pellegrino and David C. Thomasma, *The Christian Virtues in Medical Practice* (Washington, D.C.: Georgetown University Press, 1996), 23.
3. Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), xi.
4. James Drane claims that current ethical theories stressing principles on behalf of agency reflect the moral status of American culture. He states that "the act analysis orientation of American medical ethics merely reflects the loss of concern about inner being and character in contemporary American culture. Modern Americans identify with science and technology, to the point of looking at their own lives through these narrow perspectives. What science identifies as real is what is physical and measurable. Acts, therefore, are real, but not a person's character or inner self....The machines which surround contemporary persons and with which their lives are so immersed also have an influence. They dictate the way we think of ourselves....Life itself is experienced as a machine: a production center moved by outside factors. Leisure, which once was time for self-remembering, has become a form of self-forgetting (not reading and reflection, but distraction and activities). The fact that the self is forgotten in ethics is not too difficult to understand. In some sense, both modern ethics and modern American medical ethics reflect contemporary life." *Becoming A Good Doctor: The Place of Virtue and Character in Medical Ethics* (Kansas City: Sheed & Ward, 1988), 140.
5. Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, 3d ed. (New York: Oxford University Press, 1989), 379.
6. See particularly *After Virtue*, 2nd ed. (Notre Dame: University of Notre Dame Press, 1984); *Whose Justice? Whose Rationality?* (Notre Dame: University of Notre Dame Press, 1988); and, *Three Rival Versions of Moral Inquiry* (Notre Dame: University of Notre Dame Press, 1990).
7. Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*, 141-142.
8. Erwin H. Ackerknecht, *A Short History of Medicine* (Baltimore: Johns Hopkins University Press, 1982), xviii.
9. *Ibid.*
10. Stanley Hauerwas, *Suffering Presence* (Notre Dame: University of Notre Dame Press, 1986), 8, 4.
11. Ackerknecht, *A Short History of Medicine*, xviii.
12. Edmund D. Pellegrino and David C. Thomasma, *A Philosophical Basis of Medical Practice* (New York: Oxford University Press, 1981), 147.
13. *Ibid.*
14. MacIntyre, *After Virtue*, 29.
15. "Virtue and Character," *Encyclopedia of Bioethics* [CD-ROM], 1995 ed.
16. *Ibid.* The idea of character in the "healing relationship" is also supported by James Drane who contends that "to insist on a place for character in medical ethics is to say that the original meaning of ethos (the inner self) is relevant to what goes on in medicine....By individual acts of selfless caring for the sick, a doctor becomes a caring self. By repeated just acts, he makes himself just....Doctors, like everyone else, or perhaps more so than others, develop certain attitudes, dispositions and character traits. Medical ethics, it seems, should be concerned with this fact." Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*, 138.
17. Hauerwas, *Suffering Presence*, 69.
18. Pellegrino and Thomasma, *The Virtues in Medical Practice*, 42.
19. *Ibid.*
20. *Ibid.*
21. *Ibid.*, 43.
22. *Ibid.*
23. Pellegrino and Thomasma, *The Virtues in Medical Practice*, 44.
24. These five moral imperative do not represent an exhaustive list of the moral constituents of medical practice but rather the background in which virtues can be manifested. Among them benevolence, truthfulness, respect, friendliness, justice, compassion, wisdom, fortitude, temperance, integrity, and the religious virtues of faith, hope, and charity. For further details see Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*, 33-131; Pellegrino and Thomasma, *The Christian Virtues in Medical Practice*, 42-98, and Pellegrino and Thomasma, *The Virtues in Medical Practice*, 51-161.

**Author Information**

**Fabrice Jotterand**

Rice University