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THE GOOD OF PATIENTS AND THE GOOD OF SOCIETY: STRIKING A MORAL BALANCE

ABSTRACT: The relationship between the good of individual patients and the special good is examined when they are in conflict. The proposition is advanced that the ethical resolution of such conflicts requires an ethic of social medicine comparable to the existing ethic of clinical medicine. Comparing and contrasting the obligations clinicians incur under both aspects of the ethics of medicine is propaedeutic to any ordering of priorities between them. The suggested partition of obligations between patient good and the common good is applicable beyond medicine to the other health professions.

KEY WORDS: clinical ethics, social ethics, patient good, social good, ordering priorities

I. INTRODUCTION¹

In previous works we have held that an authentic ethic of clinical medicine must have its roots in a philosophy of medicine in which the good of the patient determines the obligations and virtues of the health professional.^{2,3,4} In this essay we extend the same line of reasoning to the medicine of society. We contend that an authentic ethic of social medicine must have its roots in a philosophy of society in which the common good determines the obligations and virtues of the health professional. We deem a parallel development of the ethics of individual and social medical ethics to be a requisite for any ordering of priorities between, and among, them when they come into conflict in decision making.

Though the ethics of medicine has traditionally centered on the obligations of physicians to individual patients, there has always been a need to recognize the ethical issues arising from the fact that medicine is always practiced within a social context. The factual basis for the recognition of this fact was late in coming in the history of medicine.⁵ It is, however, especially pressing today for several reasons.

Physicians and nurses today practice within organizations, institutions, and systems; they are members of interprofessional health care teams and professional associations; access, availability, and distribution of health care has become a question of justice, and fairness; the economic, societal, and political impact of medical decisions have ethical significance, as does the conduct of health care organizations; potential

and actual conflicts between the good of individual patients and the good of society are realities in managed care and in proposed systems of health care reform. As a result of all this, some bioethicists even suggest that the focus of the physician's ethics should be society, not the individual patient.

One of the more important questions raised by this recent recognition of the social context of medicine is the resolution of conflicts that may arise between the individual patient and the social common good. Can physicians serve the good of both? Can clinicians preserve their dedication to the primacy of their patient's good and still take the common good into account? Is some ordering of priorities possible when two good ends come into conflict? Is there some way to achieve moral balance between ends? Are those bioethicists who urge displacement of the physician's obligations from his own patient to the good of society, or entrust the good of the patient to institutions rather than physicians, to be heeded?

Responding to such questions requires a philosophy and ethic of social medicine comparable in development to that of clinical medicine. This essay approaches some of these questions in the following way: first, we examine the nature of social medicine and its dependence on a philosophy of society; then we digress to discuss the philosophy of ends, since our approach to the answers we suggest is teleological; we then move to an analysis of the composite nature of the good of society as the end of social medicine with a reemphasis on the distinctions between the functions of the clinician and public health physician; we close with a suggested ordering of the physician's obligations both to patients and society when these are in conflict.

II. THE MEDICINE OF SOCIETY WITHIN A PHILOSOPHY OF SOCIETY

The term "social medicine" has had a troublous history. It has been equated with the diseases of civilization, an anti-modernist ideology, and the study of the effects of lifestyles, culture, and environment on health and disease. As Porter points out, these themes are often intermingled.⁶ For this reason we prefer the term the "medicine of society" for what others might today subsume under "social medicine" but will use them interchangeably.

By the medicine of society we mean simply the use of medical knowledge to the advance the health of society, of humans living collectively in households, families, communities, and nations. This is distinct from clinical medicine, which is the use of medical knowledge to help, heal, and relieve the sufferings of individual patients. We shall use "social medicine" and the "medicine of society" interchangeably in this limited sense without denying the importance of the many other dimensions that might

be included under the same rubric.

The ethics of the medicine of society, to be properly delineated, should be located within a broader context of a philosophy of society. We prefer this term to a social philosophy, which is currently used too diffusely for our purposes.⁷

By a philosophy of society we mean a study of the nature, being, and existence of humans living and working together. It is studies of the organisms humans generate to fulfill their essential nature as social and political beings, beings who need society and social instruments to attain their good as humans. The locus of study of a philosophy of society may be the family, community, state, nation, profession, or even the global community. A philosophy of society begins with the question—"What is society, what is its nature, to what does it tend, and what is its telos or end?" The telos of society is ultimately the good of the persons who constitute that society, the good essential to their fulfillment of their potential as humans. This is a good that cannot be fully achieved by humans living isolated from each other.

Within such a philosophy of medicine the medicine of society has a specific function. That function is the use of medical knowledge to cultivate the health of the social organism by treating illness and preventing disease in its members since a healthy society cannot thrive without healthy citizens. An ethic of the medicine of society is directed to the good of the social organism, to the common good, the good shared by all and owed to all.

To be sure, the ethic of the medicine of society will be shaped by the philosophy of society within which it exists. In a libertarian society conceived as a voluntary association of free individuals (*gesellschaft*), the ethics of social medicine will be constructed in terms of free markets, individual choice, and little or no government involvement. In a communitarian society (*gemeinschaft*) in which the individual is defined by the group, the ethic would emphasize just distribution of goods, controlled markets, limitations on individual freedoms, and government involvement. In each case, the well functioning of society and its members is sought.

The philosophy of society that provides the framework for the ethic of the medicine of society that we espouse lies between these extremes. It is rooted in the social philosophies of Aristotle and Thomas Aquinas. This social philosophy holds to a reciprocal view of the relations of the good society and the good person. Neither has sovereignty over the other. It avoids totalitarianism, which exalts the common good above the individual as it avoids anarchism of exalting the good of the individual over the good of the whole. A truly dynamic philosophy of society recognizes the necessity of a continuously negotiated struggle to balance individual and common good.

Within this dynamic relationship of individual and common good, health and

health care can be seen as societal goods because health is a good of human life, an essential component of human flourishing. In his *Politics* Aristotle speaks of the special care that should be taken of the inhabitants of a society.⁸ In establishing a city he lists health as a first necessity.⁹ His reference here is not just to providing individual care but to the public health as a common good.

Aquinas, likewise, takes the function of the State to be the promotion of the common good which he specifies in terms of preservation of peace, promotion of moral well being, and ensuring a sufficient supply of the material necessities of life.¹⁰ According to Aquinas the State, like society, is necessary for the development of human potentialities and its function is to provide the conditions for the good life.

Clearly, the conception of society set out by Aristotle and Aquinas is incompatible with the extremes of a libertarian, laissez faire conception of society or, on the other hand, with a Marxist, all-consuming state-controlled economy. For both Aquinas and Aristotle the good for humans and the good for society are not determined by social preference. Rather, the good is defined by natural law that sees societies and life in communities as essential for humans if humans are to develop their full potentialities as human beings.¹¹

Neither Aristotle nor Aquinas could imagine the enormous capabilities of today's medicine, which when properly used, can enhance social and individual flourishing. But it is not unreasonable to assume that they would regard health and medical care as among the responsibilities of a good society toward its citizens, but not their highest good. Health would be at the least a material and instrumental good for both the individual and the society. At best it would be a material necessity that the State should assure for all. Health care could not be a privilege to be enjoyed only by those fortunate enough to afford it. It could not be left to the fortuitous interplay of commerce, the competitive marketplace, and the medical entrepreneur.

In a good society health care is a common good as well as an individual good. Herein lies the tension that is of such growing concern today when health care resources are generally regarded as limited relative to the potential benefit they offer if used optimally. That tension brings commutative and distributive justice into conflict.¹² Traditionally the physician has felt ethically bound to commutative justice, i.e. the obligation to be faithful to a promise of trust that he or she will act primarily in his or her patients' best interests. But, in recent years, increasing pressure from governments, health plan administrators, ethicists, and the public have tended to add distributive justice, i.e. the preservation and conservation of social resources to the physician's ethical obligation.

Some ethicists and policy makers suggest that a "new" medical ethic is neces-

sary, one in which the physician's ethical concern should be transferred from the primacy of the patient to the primacy of the society.¹³ A further extension of this trend is to move the patient's trust relationship away from doctor to the institution. The health "system," not the physician, in effect becomes the patient's healer, advocate, and guarantor of safety.¹⁴

Our line of argument rejects these calls for a "new" ethic of medicine. It also resists trends to establish societal duties as primary for clinicians. We acknowledge that medicine as a practice, and physicians and health professionals within that practice, do have social obligations. Nonetheless, these obligations can, and must, be served without sacrifice of the trust relationship inherent in the clinical encounter. We therefore distinguish the obligations of the clinician that are dictated by the ends of clinical medicine and those of the public health physician or nurse dictated by the end of the common good.

The clinical relationship centers on a vulnerable, anxious, dependent, often suffering individual person. By offering to help, the clinician "professes" to possess medical knowledge that she will use for the patient's good. The clinician serves the common good by her dedication to the good of individual patients. Clinicians, physicians, and nurses are *de facto* advocates for the good of their patients.

For public health physicians and nurses the relationship is with the whole society. The end or purpose of the relationship is the good of humans as a collectivity, the common good. Public health physicians act for the good of all to the extent that medical knowledge can serve that good. They are the *de facto* advocates for the common good. Their "patient" is society and its ills. They serve the good of society's individual members secondarily by assuring a healthy community in which the individual can flourish.

Clinical medicine and public health medicine having different immediate ends cannot be conflated. They remain in a dynamic relationship with each other since the end of each is essential for human well-being. This is consistent with the social philosophy we have espoused above. Clinical medicine and the medicine of society, however, can in exercising their obligations, each within its own domain, conflict with each other.

That conflict may be generated on either side of the relationship. In the one case the undeviating commitment of the clinician on the good of his patient can conflict with societal attempts to conserve resources, impose standards of clinical care, or provide tort relief for medical error. By the same token, the efforts of those who practice the medicine of society may conflict with the pursuit of patient good by over-regulation of bedside decisions, limiting hospital access, or providing inadequate mental

health care for the poor, or overburdening clinicians with paperwork that takes time from care of patients. On the social philosophy we have espoused practitioners of clinical medicine and of the medicine of society both serve a human good, each from its own perspective. When they do conflict in fact, there is need for some ethical priority setting.

Such a setting of priorities requires a framework in which the ethical foundation for both clinical and social medicine can be interrelated. Much of the history and literature of ethics and bioethics consists of elaborations of the ethics of clinical medicine and individual patient care. Similar frameworks for the ethics of the medicine of society are still in a state of development. In the next section of this essay we offer a philosophy and ethic of the medicine of society based in a definition of the ends of social medicine.

First, a word about ends is necessary because we ground individual and social ethics of medicine in the ends that distinguish them.

III. A WORD ABOUT ENDS

Today's confusion about the ends of medicine and the need for their redefinition lies in the erosion of the Classical-Medieval notion of ends, their relation to the good, and the relation between the idea of the good and ethics.¹⁵ The good is the end or *telos* of human activity, and the end is that for which a thing exists, that which an act is designed to bring about. Ends are rooted in the nature of things themselves. They answer the question "What for?"¹⁶ We do not impute ends to things; things are not good because we desire them. We desire them because they are good. We may put things, like medicine, to certain goals and purposes, but whether these are good or bad uses depends upon whether they fulfill the ends for which medicine exists and that define it *qua* medicine.

Aristotle and Aquinas, whose line of reasoning we follow here, were concerned chiefly with the larger conception of the good for humans as the end of human activity. Both structured their moral philosophies on the good as the end of human life. That end in its ultimate sense was, for Aristotle, a life consistent with the natural virtues, which led to happiness. For Aquinas, it was a life lived in accord with the natural and spiritual virtues that led to the beatific vision and fulfilment of the spiritual nature of humans.

Both Aristotle and Aquinas used medicine as an example of a human activity with a definable end and good, a lesser good, of course, than the ultimate good of human beings as such. They defined the final end of medicine as health, toward which

the activity of medicine tended, that which made it what it was, and distinguished it from other human activities. Yet health was for them a subsidiary end, oriented toward the life of an individual in society an enhancing as many of that individual's powers of fulfillment as possible.

Thus, in determining the ends and good of human life, and in the realm of lesser good in everyday life, ends and the good are intimately related. Today, discussion of ends has been replaced by discussion of values and choices. The rights to choose and to value have become the warp and woof of bioethics, rather than a search for the good of individuals and society. Iris Murdoch put it this way: "The philosopher is no longer to speak of something real and transcendent but to analyze the familiar activity of endowing things with value."¹⁷

The shift from consideration of ends to consideration of "value" choices lies at the root of confusion about social medicine and its philosophy as well. On the modernist view, social medicine should be aimed at whatever people value or choose among the sentiments of liberal society. The continuing debate about prescribing growth hormones for healthy, but smaller than average children, is an example of how social mores about size and its importance directly influence clinical medicine and public policy. The debate about the proper use of this and other capabilities of modern medicine, like so many others, will be interminable if it is not anchored somehow in a notion of the good for humans as it relates to the powers of modern biotechnology. The ongoing debates about "enhancement" versus "treatment" are an example of our society's confusion about the proper ends and uses of medical knowledge.

IV. THE GOOD OF SOCIETY—A QUADRIPARTITE END OF MEDICINE

In one of our books we defined four levels in the complex notion of the good of the patient in the clinical encounter.¹⁸ In an analogous way we can develop a quadripartite notion of the ends and good of social medicine: 1) The first and lowest level is the medical good of society, that can result from the application of medical knowledge to cultivate the health of society as an organism; 2) The second level is the good of society as society perceives it; 3) The third level is the ontological good of society *qua* society; and 4) The last level is the spiritual and non-historical good, that which fosters the flourishing of the human spirit. Taken together, these four levels of social good anchor the ends of medical knowledge when it is applied in a social context.

The medical good of society relates most closely to the *techné* of medicine, nursing, dentistry, etc. It is the good determined as indicated by the current state of medical knowledge, by what is subsumed under the rubric of the standard of care. The

good of social medicine is aimed at the medical good of the social organism as a whole: Prevention of disease and disability, assuring a healthy environment, containing and ending epidemics, public education in matters of health, advising appropriate agencies on such matters as occupation health, safety of food and water supplies, occupational health and safety, responding to natural or man-made catastrophe, etc. In short, all those domains subsumed under the title of public health and social medicine are dedicated to the medical good of the social organism.

On this view, then, the medical goods of society differ from the medical goods of clinical medicine only in scope, not in kind. The training of the health professionals at this level focuses especially upon dealing with the larger forces operating in groups and communities. The associated moral problems of medicine at this level center on the difficulties involved in adjudicating the proper balance between providing these goods for the sake of the entire community, based upon its needs, and the other levels of social goods and services beyond health, such as education, housing, etc. Even in nations that provide access to health care for all, elements of distributive justice must be considered so that the health budget does not compromise the resources available for other social goods not related to medicine.

In clinical medicine the medical good can actually become harmful. If it is provided solely on the grounds of clinical or physiological effectiveness, it may result in harm, overtreatment, etc. So too, the medical good of society cannot be allowed to overmaster other social goods that may matter more to communities. A good example was provided in the public discussions leading to the Oregon “experiment,” when senior citizens covered by Medicaid chose to put resources into home visits by health professionals to check medications rather than into access to emergency room care. This was their perception of their good (our second level). Yet, were they to experience a medical emergency, like a stroke, heart attack, hemorrhage, etc., emergency care might well be their first choice.

In this case, the good defined by purely medical criteria conflicted with society’s perception of its medical good. It is arguable whether or not this was socially the best choice. Yet in the allocation of resources, the final decision rests with society and not the physician. We would argue that in this case the medical good of society was compromised. Robert Veatch, however, might argue that whatever society decides is a good, should be provided by health professionals. Social consensus, he contends, determines the good, not the physician.¹⁹

We think this is an error of delegation. Health professionals are trained to determine the medical good of individuals and society. Society may reject their choice but this it does at its own peril, just as the patient does who rejects effective antibiotic

treatment from an infection. The task of the health professional is to provide information necessary for a rational policy choice. Society's perception of its own good may differ for many reasons, especially in the allocation of its resources. While the final decision is a social one, the health professional must retain a personal and professional integrity as a critic of the scientific and technical content of that decision.

The Good as Perceived by Society—Examples of a Conflict

Society is, thus, not the final arbiter of the medical (scientifically indicated) good of society, just as a Jehovah's Witness patient does not determine the clinical medical good of receiving a blood transfusion. She deems the medical good to be a spiritual harm. However, the religious patient accepts or rejects the scientifically-based medical good for the sake of her perception of the good at a higher level. Similarly, society may balance provisions of social medical good based upon higher values.²⁰ For example, in the current world epidemic of Corona virus infection (SARS), rights of privacy are seen by some as endangered by certain quarantine regulations.

Thus, like individual patients, society may not perceive the medical good, as defined by health professionals, as "good." "Society" may prefer other good things it perceives as preferable to the health care – economic growth, the ability to compete economically with other nations, military service, public safety, liberty in personal choice and risk taking, education, housing, recreation, etc. Seat belts, car seats for infants, safe driving, restrictions on hand guns, abstinence from tobacco and addictive substances, etc., have been widely promoted by the medical profession as good for the social organism as a whole. They have often been neglected in favor of freedom of choice, economics, or lifestyle preferences.

We have just mentioned and given examples of how patients and societies may perceive other goods to be more important than the medical good being suggested or recommended to them, and how this dynamic is also part of the social dynamic in health care. The social medical good serves the many complex facets of what individual societies may perceive as their own good. At this level a social philosophy of medicine would be concerned with political choices, preferences, and concerns that may distinguish one society from another. Here society determines the balances it wishes to provide its citizens, and its political processes should facilitate to public dialogue and decisions about that balance.

Although medicine is a universal discipline and is practiced world-wide, it is not the duty of the physician to make these social choices except as he or she functions as a citizen, an invited consultant, or as an agent of the government in carrying out its social policies about health care. Since each country and society is unique in its

demographics and customs, they will balance the social medical good in different ways. These choices are determined by interactions between and among citizens, their specific economic and natural environments, and their cultural and religious histories. Just as individual patients might decide how a specific treatment fits into her life-plans, so too, society decides what elements of health care fit into its own plans for human development.

The Good of Society qua Society

All social good must ultimately be related to the general good for human societies. Humans are social animals and need a healthy society to sustain their flourishing; similarly, a healthy society is not possible without healthy citizens. Clinical medicine and social medicine intersect in preserving the dignity of the human person. To do so, each must respect human rationality and freedom in decision-making. To serve the good for society as society, health professionals must foster the inherent value of the person independent of wealth, prestige, education, and social position. In clinical medicine the patient is a fellow human being alongside the health professional. They are joined together at this level by bonds of solidarity, trust, and mutual respect. At the societal level, doctor and patient are united by the same bonds with the whole of society and ultimately with all humanity.

It is at this third level that many of the familiar principles and concerns of biomedical ethics are philosophically rooted, such as respect for autonomy, beneficence, non-maleficence, and justice. These are principles which a society, concerned with preservation of the dignity of its citizens as humans, must assure. At this level, the qualities of justice are to be observed with respect to health care. Justice here is understood as the equality of treatment of all human beings who are equally vulnerable with respect to illness and death. One of the axioms of moral medicine is that each individual person must be treated as a class instance of the human race. This axiom is applicable to both clinical and social medicine.

Denial of care to the poor or devaluing the lives of handicapped persons, for example, violates their inherent dignity as human persons, not just their “share” of the health care marketplace. Intentionally putting some members of society at risk presumably to help others, without their consent, as was done in radiation experiments in our country, is a violation of fundamental human rights.²¹ The newly-developing efforts in bioethics to reintroduce global, environmental, and international human rights concerns would also be placed at this level.²²

Thus, the first and second level, i.e. social medical good and perceived goods, must be related to the third, the good for human beings as human beings. At this level,

both clinical medicine and social medicine intersect in the good end of preserving the dignity of the human person, by respecting his and her rationality and decision-making. They recognize, especially, the inherent value of the person as independent of wealth, prestige, education, social position, and other characteristics that so often serve to separate rather than unite human beings. As in clinical medicine, the patient is a fellow human being with the health professional. They are bound together at this third level of good by bonds of solidarity and mutual respect.

In a more classical sense, the *prima facie* principles of contemporary bioethics and the universal rights of humans, as enunciated by the United Nations, come together in the natural law. The good of society and the good of each person in that society are mutually re-enforcing. They link the good of man (and woman) with the good of society in a dynamic tension. They underlie the characters of the good society and the good person.

At this level, justice requires that health care be treated as an obligation of a good society – as a moral obligation of a good society to its citizens. This is because health care is a universal human need – a need all humans experience if they are to lead fulfilling lives and be cared for when they are ill. Each citizen, thus, has a claim on his fellows – not to health, but to care when he or she is ill. Health care is in essence an obligation a good society owes its citizens in justice.

Spiritual Good of Society

The fourth and highest level of good for clinical encounters, between patient and health professional, is the spiritual good of the patient, as we have noted.²³ This is the good of the patient as a spiritual being who transcends ordinary material concerns. Analogously, there is a spiritual dimension in the community itself, though it is more difficult to define. This dimension is always present, but it becomes more visible in times of crisis, for example, after a terrorist attack like that of September 11, 2001. For some thinkers, the social ethic of medicine stands or falls on the adequacy of its articulation with deeply embedded spiritual values inherent in the very notion of the community.^{24 25} For Loewy, the spiritual dimension is compassion that must emerge from the fact of suffering of all creatures;²⁶ for Welie, it is the intersubjectivity of suffering and shared values that grounds the clinical encounter;²⁷ for Jensen, it is the brotherhood of a common culture and concern;²⁸ and for still others, it is the solidarity with the sick and the potential for human development. For Christians, generally it is the solidarity of all humans as children of the same Creator.

The spiritual good of a society encompasses the transcendent principles of the culture. It gives ultimate meaning to human lives. It is that for which humans will make the greatest sacrifices of other good things to preserve. From the perspective of

the structures of human existence, the spiritual destiny of the human being is the highest and ultimate good.

For many cultures this will mean the religious beliefs of their citizens. For example, despite the physical need to examine a pregnant woman in clinical medicine, a different method of examination might be required in some Islamic societies where privacy is a religious value. Or, even though a respirator may be appropriate for a patient suffering from severe trauma, for the Navajo American Indian, this may violate a profound religious belief about God and nature and be proscribed.²⁹ This is not to assert that all cultural practices should be tolerated simply because there exists a religious tradition to support them.³⁰ At the very least, however, efforts must be made to understand and if possible accommodate the lower order of medical good to the higher order of the spiritual good of individuals and societies.

V. METHODOLOGICAL REFLECTIONS

Thus far we have argued that the public aspects of medicine, and the social ethics of medicine that results, may be interpreted within the same framework as that of the clinical encounter. By keeping the anchor in the clinical encounter as we have in this chapter, we tried to avoid the contemporary tendency to over-medicalize all of society's problems. Physicians need not be, indeed, should not be social engineers, as the Nazi experience so clearly taught us.³¹

For example, domestic violence contributes enormously to emergency room admissions. Clinicians have a duty to address this violence within the realm of their expertise and the clinical case. Nonetheless, not all physicians need take on the public health features of this violence. Otherwise their time would be consumed and their other responsibilities to those in immediate need, would be neglected. Therefore, there is need for clinicians to observe a certain economy of pretension with respect to the frequent and obvious social dimension of their practice.

For us this "clinical parsimony," means that a social ethic of medicine might address itself to the social issues encountered clinically. But the "patient" is now society, and the good is the public's health. The duties and obligations, the characteristics and virtues, of public health physicians are, if not the same as those that engage individual patients are at least analogous. This is not to deny that many illnesses experienced by individuals are caused by social problems, such as poverty, ignorance, poor hygiene, lack of access to safe water, and the like.³² Indeed, these broader causes of illness and disease quite rightly are the subject matter of public health and social medicine, and reflect the adequacy of the provision of health care in

any society. Thus, in the model of a social ethic of health care we are using the causes and effects of health and disease include social and even cultural conditions.

Other methodologies are clearly possible in deriving a philosophy of social medicine. Some are based upon the idea of limiting clinical pretensions that has guided our thinking. But there are other methodologies that tilt the balance between individual and social concerns in favor of the latter. For many European thinkers, the focus of a philosophy of social medicine is less on its analogies with clinical medicine, and more on the power it engenders in its public relationship to both society and individual patients.³³ The starting point of these models of a philosophy of social medicine is social power, its dominance and frequent arrogance, and the need to reign it in.³⁴ Foucault's empirical philosophy of the clinic fits this model. It is a heuristic theory that not only describes current practices, but also relates these in theory to one's own experiences of illness and repair.³⁵

Feminist bioethics might also be seen as another form of this view, insofar as it focuses upon the power relation of gender within medicine and the vulnerabilities that arise from differences in the social status of genders. Similarly, philosophies of medicine that concern the rise and power of technology would be examples of this kind of philosophy of social medicine.³⁶

VI. CLINICAL AND SOCIAL MEDICINE: SOME FURTHER DISTINCTIONS

In commenting on Aristotle's *On Sense and the Sensed Object*,³⁷ Aquinas grapples with the distinction between the particular and individual in medicine and the more universal causes and effects of medicine. He notes:

...it is for the physician to consider their [universal principles of health and disease] particular principles; he is the artisan who causes health and like any art his must concern itself with the singulars that come under this project, since operations bear on singulars.³⁸

Clinically-oriented physicians are primarily oriented to particularities. Nonetheless, the "universal principles of health and disease" are discoverable, analyzable, and manipulatable by persons other than those professing to heal individuals. Basic scientists, for example, are charged with, or have taken on, the laudable goals of improving the health of all human beings. Furthermore, examining the structures of illness and healing are at least in part the goals of a philosophy of medicine. The individualities pursued by physicians arise from more general causes and return back, *mutatis mutandis*, to existential structures of human existence through the individual.

A good philosophy of social medicine, then, will not neglect the centrality of the clinical encounter as the origin of questions about general causes of illness and disease, as well as the social effects of their neglect or their alteration.

In this regard, Aquinas notes further:

Health can only be found in living things, from which it is clear that the living body is the proper subject of health and disease...since it pertains to natural philosophy to consider the living body and its principles, it must also consider the principles of health and disease.

...the study of health and disease is common to philosopher and physician. But since art is not the chief cause of health, but aids nature and assists it, it is necessary that the physician take from natural philosophy the more important principles of his science, as the navigator borrows from the astronomer. This is why physicians practicing medicine well begin from natural science.³⁹

Since the time of Aquinas, of course, “natural philosophy” has developed into the whole panoply of physical and social sciences, as well as philosophies of nature and science. Yet the insight about general principles arising from the living body and returning through it to common features of human existence is important if we are to avoid the trap of making medicine responsible for all social causes of health and disease. An interdisciplinary and international effort can effect eradication of certain diseases. But medicine alone cannot assure human rights in health care. It must work with other disciplines, playing its restricted role in the clinical arena while articulating its efforts with politics, law, sociology, etc., to guarantee international human rights in health care.⁴⁰

*Clinical and Social Duties of Physicians and Other Health Professionals:
Conflict and Resolution*

By *clinical medicine*, then, we mean the use of medical knowledge and skill for the healing of sick persons, here and now, in the individual physician-patient encounter. Clinical medicine so defined is the activity that defines clinicians qua clinicians and sets them apart from other persons who may have medical knowledge but do not use it specifically in clinical encounters, like the basic scientist or public health physician. Clinical medicine is the clinician’s *locus ethicus*, whose end is a right and good healing action and decision for individual patients. Similarly, nursing at the bedside, dentistry, clinical psychiatry, social work, etc, each has its own *locus ethicus*.⁴¹

Moreover, clinical medicine is the instrument through which many public poli-

cies come to affect the lives of sick persons. No matter how broadly or socially-oriented we take medicine to be, illness will remain a universal human experience. Its impact upon individual human persons is the reason why medicine and physicians exist in the first place.⁴²

Using clinical medicine as the paradigm for a philosophy of social medicine does not neglect the other branches of medicine, each of which has its own distinctive end. Thus, for basic scientists the end is the acquisition of fundamental biological knowledge of health and illness. This knowledge becomes a part of clinical medicine specifically when it is applied to the needs of a particular human being here and now. Similarly, preventive medicine has as its defining end, i.e., the cultivation of health and avoidance of illness. Hence, social medicine has its end in the health of the community or the whole body politic. When the knowledge and skills of any of the other branches of medicine are used in the healing of a particular person, then the ends of that branch fuse with the ends of clinical medicine. In clinical medicine, clinical nursing, etc., the good of the patient is the end, *primus inter pares*.⁴³ In social medicine, it is the good of society.

VII. SOCIAL RESPONSIBILITIES OF THE CLINICIAN

Throughout we have emphasized the primacy of the clinician's ethical responsibilities to be located in the good of his or her patient. Under what conditions may this responsibility be balanced by ethical obligations to the good of society?

First of all, in situations of natural disaster, just war, epidemics, and overwhelming emergency the clinician's knowledge and skill must be directed to the common good, the larger issue of social and community survival. Similarly, when a patient is a threat to the community, e.g. when the patient has a contagious disease and continues to place others at risk, the autonomy of the patient is no longer inviolable. Autonomy is limited when it results in the identifiable, probably, grave harm to others. The same is true of patients with HIV infection who refuse to tell their sexual partners, or an airline pilot, locomotive engineer, or crane operator whose condition poses a threat to the safety of others. In short, whenever the good of the patient, as perceived by the patient, poses a definable, grave, or probable risk to identifiable third persons, the physician's covenant with her patient is superseded by her duty to avoid a greater threat to third parties or to society at large.

In ordinary circumstances the physician's implicit promise to serve his own patient is a primary obligation. But within that obligation the physician is bound to consider societal good when both good ends can be sensed simultaneously. Thus,

physicians are obliged to use the less expensive treatment if it is equally effective to the more expensive, even if there is some slight marginal benefit to the latter. Even more crucial is the obligation to avoid misuses, abuse, or overuse of treatments or diagnostic procedures. This is a violation of the obligation of competence, which requires the use of modalities of medicine that are effective, beneficial, and not disproportionately burdensome. In the long run, the best contribution the physician can make to conserve societal resources is to practice rational, effective, scientifically evaluated medicine. This happens also to be in the interests of the individual patient as well.

This does not mean that the physician should accept or assume the role of rationer or self appointed guardian of society's resources. To do so is to be in a morally unacceptable role of divided loyalty. Rationing should be explicit, not implicit. It should be determined by societal and institutional authority. The physician must still inform his patient about what is appropriate treatment. She must try by all legitimate means to obtain what is needed. But the final allocation of resources at both the micro and macro levels is a social not a professional decision.

When not joined in a covenant of trust with a particular patient, the physician has several obligations related to the common good. For example, physicians, nurses, and other health professionals are obliged to provide accurate, up to date unbiased technical information to policy makers, institutions, and administrators. They are required to avoid the kind of conflict of interest inherent in misleading exaggerations of benefit to advance one's favorite treatment procedure. Conversely, policymakers must be wary of one expert's depreciation of a competitors claims. The expertise of health professionals must be available as a sound factual basis for the decisions of policy and law makers. Without it political and economic considerations may distort good standards of care.

The requisite objectivity is difficult to achieve in our health care system that is, today, commercialized and market oriented to an alarming degree. Academic scientists and physicians are no less susceptible to self interest than their commercial counterparts. It is a rare research scientist who is totally free of conflict between his duties as physician and scientist, and his personal pursuit of self-interest, prestige, and power.

Yet, without reliable, verifiable, and accurate technical information, health care policy in the interest of the common good is impossible to design. Recovery of moral, as well as scientific, credibility has become a major task for today's health professionals. The moral high road is, of course, extremely difficult to follow. Without it, however the profession of medicine and the other health professions will lose what-

ever moral credibility they still retain.

Society, in the end, will be the loser. First, because it will be denied reliable technical information upon which to base public policy. Second, it will lose the example of one of the few remaining groups among which there is a substantial number who are dedicated to something other than their own self-interest. A society without an island, or two, of morally motivated professionals is a morally deprived society.

This takes us to the third level at which the professional may fulfill his or her societal duties and that is a member of a professional association or society. A medical or nursing association is defacto a moral community. Its members are united by a common public oath or commitment to act primarily for the benefit of those they purport to serve. They share in addition some set of moral precepts expressed in a moral code. Unless these moral dimensions are explicitly rejected, society assumes that they are the ethical signatures of the professions.

That professional societies today do not behave as moral communities does not erase the fact that their major ethical justification for existence is to advance the ends and purposes of the professions. If those ends and purposes are no longer moral in nature, professional associations become unions, guilds, or even the conspiracies against the public that George Bernard Shaw took them to be.⁴⁴ While not conspiracies, professional organizations today have become corporations, public relations agencies, and profit making organizations. Their size, capital holdings, and budgets are sometimes far in excess of what is required to function as moral communities, that is, as associations of professionals acting collectively to advance the purposes of medicine or the other health professions. Those purposes are focused upon the needs of sick persons or societies and not the propagation of self-interest.⁴⁵

When they behave as moral communities, professional associations provide effective means whereby health professionals could fulfill their societal responsibilities. These associations should above all be advocates for the sick. They should act collectively via public education and political action to promote a just health care system, one in which the obligation of a good society toward its members to assure access, availability, and just distribution of health care could be realized.

Associations of health professionals have enormous latent moral power if only they choose to use it. They can influence public opinion, and raise public moral sensitivity to injustices, but only if they are genuinely acting for the good of society and not their own profit. We appreciate how far this notion of professional associations as moral communities is at present from the realities. However, as with all things in the moral realm, we can hope that what ought to be, may in fact, come to be.

Finally, health professionals can fulfill their social obligations as citizens. Here

they can be advocates for what they believe to the elements of a just society or health care system. Here they can and, of course, will differ. It is here that they can express their own preferences apart from those of their fellow professionals. But here too, their votes and political participation should be guided by a sense of social good that transcends their own selfish self interest.

SUMMARY

Medicine has always existed within a social context in which the uses of medical knowledge and clinical decisions have impacted the good of society as well as the individual patient. In recent centuries the factual foundations for these interrelationships have been demonstrated. As a result, it has become clear that the social repercussions of medicine have serious ethical implications for both physicians and society.

We have, therefore, examined the relationship between the good of the individual patients and the common good in an effort to define a morally sound relationship between them, especially when they come into conflict. The proposition has been advanced that a philosophy and ethic of social medicine (or the medicine of society) is required that is comparable to the existing philosophy and ethic of clinical medicine. By comparing and contrasting the ethics and functions of clinical and social medicine some order of priority can be established when they come into conflict. The implications for clinicians in the partition of their ethical obligations to both patients and society are spelled out in terms of both an ethic of clinical and social medicine. While the physician is used as the example, the implications for all other clinicians are essentially the same, within the specific ethical framework of each profession.

NOTES

- ¹ Note: This paper was being written when Dr. Thomasma died unexpectedly. I have retained him as co-author although I have revised the text substantially. Nonetheless, I believe he would have no objection to the changes. His imprint on most of the text remains untouched.
- ² E.D. Pellegrino and D.C. Thomasma, *A Philosophical Basis of Medical Practice, Toward a Philosophy and Ethic of the Healing Professions* (Oxford: Oxford Univ. Press, 1981).
- ³ E.D. Pellegrino and D.C. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (Oxford: Oxford University Press, 1987).
- ⁴ E.D. Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions," *Journal of Medicine and Philosophy*, Vol. 26, No. 6, 2001, pp. 559-579.
- ⁵ See Bernardo Ramazzini, *Diseases of Workers* (1713), rev., trans. Wilmer Cave Wright (Chicago: University of Chicago Press, 1940); Thomas Percival, *Medical Ethics: A Code of Institutes and*

- Precepts Adapted to the Professional Conduct of Physicians and Surgeons* (1803), ed. S. Russell (Manchester); Johann Peter Frank, *Complete System of Medical Polity* (System einer vollständigen medicinischen Polizey) (Manheim, Schwann, 1777-8) referenced in Fielding H. Garrison, *History of Medicine* (Philadelphia: W.B. Saunders Company, 1929), 321.
- ⁶ Roy Porter, "Diseases of Civilization," in *Companion Encyclopedia of the History of Medicine*, eds. W.F. Bynum and Roy Porter, vol. I, 596-599 (New York and London: Routledge, 1993).
- ⁷ Winch and Taylor.
- ⁸ Aristotle, *Politics* 1330, b6.
- ⁹ *Ibid*: a17.
- ¹⁰ Aquinas, *De Regime Principum* 1, 15.
- ¹¹ *Ibid*: 1,1.
- ¹² E.D. Pellegrino, "Rationing Health Care: Conflicts within the Concept of Justice," in *The Ethics of Managed Care: Professional Integrity and Patient Rights*, eds. William B. Bondeson and James W. Jones (Dordrecht: Kluwer Academic Publishers, 2002).
- ¹³ Especially social contractarians, like Veatch (2000).
- ¹⁴ Emanuel 1999; A. Buchanan, "Managed care: Rationing without justice, but not unjustly," *Journal of Health Politics, Policy, and Law*, Vol. 23, No. 4 (1998), 687-95.
- ¹⁵ (NE1094a1 and Book I)
- ¹⁶ H. Jonas, *The Imperative of Responsibility: In Search of an Ethics for Technological Age* (Chicago: University of Chicago Press, 1984), 52.
- ¹⁷ I. Murdoch, *Metaphysics as a Guide to Morals* (New York: Allen Lane, Penguin Press, 1993).
- ¹⁸ Pellegrino, E.D. and D.C. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (Oxford: Oxford University Press, 1987).
- ¹⁹ Veatch, 2000.
- ²⁰ Another example at this point would be the effort by Chinese society to limit the number of children its citizens could have for the sake of reducing its ever-burgeoning population versus the desire of individual citizens to bear children, often male heirs.
- ²¹ R. Macklin, "Consent, coercion, and conflicts of rights," *Perspectives of Biological Medicine*, Vol. 20, No. 3 (1977), 360-71; United States Advisory Committee on Human Radiation Experiments, *Final Report* (Washington, D.C.: Supt. Of Docs, U.S. G.P.O., 1995).
- ²² L.P. Knowles, "The lingua franca of human rights and the rise of a global bioethic," *Cambridge Quarterly of Healthcare Ethics*, Vol. 10, No. 1 (2001), 253-63.
- ²³ Pellegrino, E.D. and D.C. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (Oxford: Oxford University Press, 1987).
- ²⁴ S. Hauerwas, *Naming the Silences: God, Medicine, and the Problem of Suffering* (Grand Rapids, MI: Wm. B. Eerdmans, 1990).
- ²⁵ D. Novak, "The human person as the image of God," In *Personhood and Health Care*, D.N. Weisstub, D.C. Thomasma, and C. Herve (eds.) (The Netherlands: Kluwer Academic Publishers, 2001); D.N.

- Weisstub and D.C. Thomasma, "Human dignity, vulnerability and personhood" In *Personhood and Health Care*, D.N. Weisstub, D.C. Thomasma, C. Herve (eds.) (The Netherlands: Kluwer Academic Publishers, 2001).
- ²⁶ E.H. Loewy, *Suffering and the Beneficent Community: Beyond Libertarianism* (Albany: State University of New York Press, 1991); *Freedom and Community: The Ethics of Interdependence* (Albany, NY: State University of New York: 1993).
- ²⁷ J. Welie, *In the Face of Suffering: The Philosophical-Anthropological Foundations of Clinical Ethics* (Omaha, NE: Creighton University Press, 1998).
- ²⁸ U. Jensen and G. Mooney, *Changing Values in Medical and Health Care Decision Making* (Chichester/Wiley/New York, NY: A.R. Liss, 1990).
- ²⁹ T.K. Kushner and C. MacKay, "Joseph J. Jacobs on alternative medicine and the National Institutes of Health," *Cambridge Quarterly of Healthcare Ethics*, Vol. 3 (1994), 442-8.
- ³⁰ An example might be the practice of female castration in some African cultures. This practice has been widely criticized by bioethicists and physicians.
- ³¹ E.D. Pellegrino and D.C. Thomasma, "Dubious premises – evil conclusions: Moral reasoning at the Nuremberg Trials," *Cambridge Quarterly of Healthcare Ethics*, Vol. 9, No. 2 (2000), 261-74; also see: M. Gross, "Treading Carefully on the Moral High Ground: Response to 'Dubious Premises – Evil Conclusions: Moral Reasoning at the Nuremberg Trials.'" *Cambridge Quarterly of Healthcare Ethics*, Vol. 10, No. 1 (2001), 99-102.
- ³² R.G. Wilkinson, *Unhealthy Societies: The Affliction of Inequality* (London/New York: Routledge, 1996).
- ³³ D.C. Thomasma and E.D. Pellegrino, "Challenges for a philosophy of medicine of the future: A response to fellow philosophers in the Netherlands," *Theoretical Medicine*, Vol. 8 (1987), 187-204.
- ³⁴ E. Van Leeuwen and G.K. Kimsma, "Philosophy of medical practice: A discussion approach," In *The Influence of Edmund D. Pellegrino's Philosophy of Medicine*, D.C. Thomasma (ed.) (The Netherlands: Kluwer Academic Publishers, 1997), 99-112.
- ³⁵ M. Foucault, *The Birth of the Clinic; An Archeology of Medical Perception* (London: Tavistock Productions, 1976).
- ³⁶ S.J. Reiser, *Medicine and the Reign of Technology* (Cambridge: Cambridge University Press, 1978); *The Machine at the Bedside* (Cambridge: Cambridge University Press, 1984); Jonas 1984. See also: R. Vos and D.L. Willems, "Technology in medicine: Ontology, epistemology, ethics and social philosophy at the crossroads," *Theoretical Medicine and Bioethics*, Vol. 21, No. 1 (2000), 1-7.
- ³⁷ R. McKeon (ed.), *The Basic Works of Aristotle* (New York: Random House, 1941).
- ³⁸ St. Thomas Aquinas, "Preface to the Commentary on Sense and the Sensed Object," Ed and Trans by R. McInerny, *Thomas Aquinas: Selected Writings* (London/New York: Penguin Books, 1998), p. 453.
- ³⁹ Ibid: 15-16.
- ⁴⁰ J. D'Oronzio (ed.), *Cambridge Quarterly of Healthcare Ethics*, Vol. 10, No. 3 (2001); D.C. Thomasma, and G. Diaz Pintos, *Autonomy and International Human Rights* (The Netherlands: Kluwer Academic Publishers, forthcoming).

⁴¹ E.D. Pellegrino, "The internal morality of clinical medicine: A paradigm for the ethics of the helping and healing professions," *Journal of Medicine and Philosophy*, Vol. 26, No. 6 (2001), 559-79.

⁴² See Hippocrates, *On the Art*.

⁴³ Some of the difficulty of the Hastings Center group in arriving at a consensus arose because these distinctions were not made clearly enough. The group tended to expand the definition of medicine so broadly as to absorb or "medicalize" almost all aspects of life. Such an expansion defeats any attempt to define ends. It places ends in conflict with each other and weakens any attempt to establish a hierarchy of goods among the many ends "medicine" may serve. See: I. Nordin, "The limits of medical practice," *Theoretical Medicine and Bioethics*, Vol. 9 (1999), 105-23.

⁴⁴ G.B. Shaw, *The Doctor's Dilemma* (New York: Brentano's, 1913).

⁴⁵ E.D. Pellegrino and A.S. Relman, "Professional medical associations: ethical and practical guidelines," *JAMA*, Vol. 282, No. 10 (1999) 984-6.