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[Book Review of] *For the Patient's Good: The Restoration of Beneficence in Health Care*, by Edmund D. Pellegrino and David C. Thomasma

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part distinguishes the various classes of patients who would be considered by some as candidates for euthanasia, and details the kind of treatment appropriate for each. This chapter also spells out the requirements for good team care of the very debilitated and dying and shows how euthanasia can only compromise proper team care. The final chapter considers the specific measures needed to care for the patients in the threatened categories of people discussed in the first part of the Report.

The Report ends with a succinct conclusion, a useful glossary of terms and a competent index. A brief but useful note on the Arthur case, an influential infanticide case decided in the mid-1980s, is added.

The Report notes that the Linacre Centre is undertaking a new study on brain death. That is a welcome announcement. One hopes that the Centre will also take up a development in the euthanasia controversy which it does not address: namely, the growing practice of and concern about withholding artificially provided food and water from the comatose. Had that issue emerged clearly at the time the Report was written, its judgment that handicapped newborns were the group most at risk for the "benefits" of euthanasia might have been different. For now it appears that the permanently unconscious are at least equally at risk. Such is the dynamism of the movement towards euthanasia. Even so, this book is by no means outdated. Its arguments and analyses are not likely to become obsolete. For they state as well as I have seen stated, the core of the sanctity of life vision.

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For the Patient's Good: The Restoration of Beneficence in Health Care

Edmund D. Pellegrino and David C. Thomasma

Oxford University Press, Oxford and New York, 1988, 256 pp. Hardcover. \$29.95

In this book, Pellegrino and Thomasma continue their project of constructing a medical ethics based on a retrieval of beneficence, a project they began in their earlier work, *A Philosophical Basis of Medical Practice* (1981). In the present volume, the authors leave the plane of a general philosophy of medicine, in order to elaborate an ethics of medical practice that will support ethically and medically sound clinical decisions, under contemporary circumstances. Their model, which they name beneficence-in-trust, is a conscious alternative to the quasi-hieratic paternalism of an earlier Hippocratic era: the contractarian patient-autonomy model which today enjoys widespread hegemony, and the teleology of social utility which now appears aggressively ascendant.

The case this book makes for the option of grounding applied medical ethics in the good is persuasive, for many reasons. It provides a basis for continuity with the best in the Hippocratic tradition. It tends to supply a foundation for concrete ethical norms which comport with time-tested intuitions of what is right and wrong. As well, it dialectically elevates and integrates insights of the competing patient autonomy model, which are of undeniable value, and it is articulated within a meta-ethical framework making feasible its application under conditions of moral pluralism, by allowing for the interaction of differing conceptions of the good on those levels which can be distinguished from the minimum agreement necessary to ground the covenant between doctor and patient. Not least of all, it offers a unified protocol for ethical decision-making under clinical conditions which appears fully informed by the responsible physician's regard for the sanctity of life.

respect for the person, and societal diversity in matters of morality.

In a critical vein, admittedly, some may question whether the concept of the "relational good," which the authors choose as the starting point of their applied ethics, is sufficiently basic to enable their ethics to survive as more than an interim *modus operandi* amid the clashes of contemporary pluralism, since this concept arguably presupposes implicit attitudes and convictions, which such pluralism, once given quarter, may ultimately undermine. Some may ask whether the authors do not give too extensive a role to "substituted judgment" as a principle for solving treatment dilemmas, without adequate constraints against their becoming a subterfuge, at least in the wrong hands, for killing. Some may note, too, that elements of paternalism, as opposed to beneficence, may still color the authors' understanding of the good patient, and some may even grant that the authors' attempt to give concrete expression to their ethics of beneficence-in-trust through a new substitute for the Hippocratic oath does not quite succeed. But, to stress such putative weaknesses would be unjust. On balance, this volume accomplishes much, under very difficult prevailing conditions, and it deserves praise as a welcome addition to the literature on medical ethics.

Pellegrino's and Thomasma's new work is essential reading for any physician or ethicist engaged in clinical decision-making in medicine. This book not only stakes out an important theoretical option in medical ethics clearly, but also it does so with profound practical moral knowledge of the clinical situation and with an enviable synthetic grasp of the contemporary literature of medical ethics. The following review seeks to introduce readers to the contours of Pellegrino's and Thomasma's argument and to acquaint them more closely with the nature of the contribution which this work represents. Where appropriate, the review will note and explain its occasional *caveat*.

The Meaning of Beneficence as a Foundation for Medical Ethics

If ethical approaches can generally be divided into those emphasizing rights and those emphasizing the good, and if the now dominant contractarian model of patient autonomy belongs among those emphasizing rights, then Pellegrino's and Thomasma's model belongs, along with the traditional ethos of medicine, among those emphasizing the good. In fashioning their approach, the authors begin from and require assent, however, only to that conception of the good implicit in the physician-patient transaction: the good of healing. They prescind from any unitary account of the good, a choice which may broaden their model's present appeal, but regrettably may lead to its long run disintegration, for the reason voiced above. Proceeding inductively, the authors conclude that the fact of the patient's illness orients him to the good which he lacks, that is, the good of bodily health, and the act of the physician's profession as physician dedicates her to this same good.

According to the authors, the medical transaction, by its nature, aims primarily at the enhanced biological functioning of the bodily organism. But, they recognize that the goal of health, even so defined, has more particular contextual, existential, and conceptual determinates. Conceptually, the patient's bodily health can be understood only as a dimension of the whole person, the good at stake being the health of the patient's body as he experiences it — as an aspect of himself. The authors call this concept "the lived body." Since bodily health is an aspect of the good for the person who is a free and unique moral agent, the patient will, in any given existential situation, have his own unique weight, moreover, to give the relative benefits and burdens presented by treatment options, and only he will be able to say what best advances the good of his health all things considered — whether he wishes, for instance, to accept a hypertensive medication which may have the side-effect of causing impotence. Finally, the context of the patient's overall prognosis influences the weighing of particular benefits and burdens in deciding how to treat particular systemic problems.

In this approach, the doctor's underlying goal or continuing baseline of concern is to maintain and apply his competency in furthering the biological functioning of the patient's body, and to advocate to the patient that he accept treatment fostering such functioning, within the limits of what the patient considers to advance his health, in a more wholistic

wholistic sense. Some circumstances may justify the doctor in withholding treatment at the patient's request, which might marginally advance the biological good of the patient's body. But, the authors argue that he is never morally justified in cooperating with an intention, even through an act of omission, to end the patient's biological life. This and other norms of medical ethics are grounded in the good of the patient's biological health. They bind the physician morally, by virtue of both the physician's act of profession and the physician-patient covenant. As will be seen, in some cases, they may also bind the physician because health is a precondition to the patient's exercise of moral autonomy.

In this framework, the good at stake, for both doctor and patient, is always "relational". Since the physician is obligated to pursue the patient's health in the particular sense specified by the conceptual, contextual, and existential determinates which were mentioned, acting in the patient's good means not only pursuing the patient's biological welfare, but doing so, at all times, according to the patient's informed existential assessment of the utility of available treatment options. According to the authors, a critical role for the physician is developing and maintaining communication with the patient which can effectively integrate the patient's existential evaluations into the decision-making process.

The authors suggest that such communication will be engendered, where the physician grants primacy to the existential circumstances of the particular patient; commits himself to negotiation with the patient which is truly open-ended in aiming at a present rather than *a priori* ranking of implicated values; seeks to arrive at decisions through consensus with the patient; and finally, strives, with the patient, to preserve as many competing values as the situation permits. The authors further specify that successful physician-patient negotiation presupposes the independent moral autonomy and conscience of both doctor and patient; the physician's fiduciary obligation devolving from his greater knowledge and power; the physician's cultivation of a virtuous character (the authors stress that theirs is essentially a virtue and not a duty-ethic); as well as the physician's commitment to reaching the morally right and good decision, within the limits of the situation's inherent ambiguity.

Because of societal breakdown in shared values, the authors stipulate that the physician and patient are to structure their negotiations within a meta-ethical framework, recognizing that each may have a differing conception of the good. The framework proposed by the authors requires that the parties to the medical transaction recognize, as analytically distinct, each of the following understandings of the good: the biological functioning that forms the primary baseline of the doctor and patient's shared concern; the patient's unique existential assessment of what health requires, given all of the patient's values here and now; the patient's integrity as a moral agent capable of reasoned moral choice about such an assessment; and, ultimately, the patient's conception of his "ultimate concern" or his "good of last resort," according to which he values everything else in his life. As the physician and patient negotiate toward a consensus on appropriate treatment, they necessarily will share a regard for the good of biological health and the good of the patient's reasoned moral choice, since these are values implied in the physician-patient covenant, but they may differ in their existential assessment of the good at stake and in their respective interpretations of the "good of last resort". The authors recognize that the latter kind of disagreement may be the most intractable. In the case of a conflict, the competent decision of the patient prevails, but the authors contend that the doctor, as a free moral agent, ought to withdraw from the case if the treatment decision offends his sense of morality. For example, the writers argue that the religious objector's right to refuse a life-saving transfusion should be respected, but so, too, should the doctor's right to withdraw where his conscience requires it.

In this scheme, the physician obviously must devote considerable energy not just to the pursuit of the patient's biological health, but also to promoting the good of his reasoned moral choice. He must provide the patient with a continuing account of the probabilities and uncertainties relevant to treatment decisions. He must ensure that such information is not overmathematicized, and he must otherwise convey it in a manner favoring meaningful assimilation by the patient. Moreover, the physician must keep in view the intrinsic assault which illness represents on the patient's autonomy, psychologically, socially and perhaps,

cognitively. The doctor has a fiduciary duty to the patient to help him retain true moral autonomy in the face of the assaultive character of disease.

Among his strictly medical goals, the authors suggest that the physician must, in addition to pursuing the patient's total bodily health, seek to preserve the medical conditions necessary for the patient rationally to make moral decisions about the course of treatment. This ancillary goal makes it essential that the doctor informally monitor the patient's competency, and treat causes of incompetence which are relevant to ongoing treatment decisions, even though, at times, this means overriding the patient's express directives. In the view of the authors, the physician may be so justified, where necessary, to stabilize a crisis until probabilities become clear, reverse a defect in mental competence, or correct psychiatric interference in social relations.

While it is clear that Pellegrino and Thomasma have integrated the value of patient autonomy into their approach, in counterdistinction to their "contractarian" rivals, they obviously understand the value of autonomy to be derivative of and subordinate to that of beneficence. They reject the contractarian notion of ethicists like Engelhardt which simply places the physician's competency at the service of the patient's values, whatever these may be. According to the authors, such approaches have entered and dominated much of medical ethics only during, perhaps, the past 20 years, although they have obviously been current in the political culture since Enlightenment times. Conceptually, such approaches make the value of autonomy an absolute prelogical presupposition, and they do so in a way that is neither pluralistic nor philosophically justified. Practically, they lead to the "abandonment" of the patient to a spurious autonomy, since the fact of illness pervasively erodes the patient's meaningful exercise of autonomy. Pellegrino and Thomasma correctly argue that serious damage will ensue to the moral standards of medical practice and to democracy itself, if the contractarian patient autonomy model succeeds in displacing the value of beneficence, which has been bequeathed to medicine as its ethical foundation, by the hippocratic tradition.

The author's presentation of their model shows that they have thought deeply about the physician's role. Such may not be as true with regard to the role of patient. The virtues they espouse for patients include candor, compliance, nonlitigiousness, noninterference in the medical transactions of other patients, and gratitude to their own physicians. While these enumerated characteristics are positive enough in their place, the list is strangely passive. One would have expected to see the authors develop a statement of the intellectual and moral virtues relevant to sustaining psychic and social wholeness in the face of illness, and to making moral decisions about the treatment of illness, or to describe the steps which might promote the will and self-knowledge which are preconditions to healing. Since the authors do none of these things, some readers will conclude that they have not yet succeeded in disentangling beneficence from paternalism.

If one underlying concrete problem absorbs Pellegrino and Thomasma, it is the tendency of burgeoning technological innovations to overwhelm moral control of medical decisions. The problem is particularly acute, as the patient approaches death. The existential value of incremental benefits to the patient's short term biological functioning becomes increasingly difficult to measure, as inevitable death comes nearer. In this context, the authors are rightly concerned about the danger of "therapeutic belligerence," i.e., modes of treatment which subject the patient to treatments with marginal or no benefit to his biological state, but which are of serious cost to his human dignity. They argue that, under circumstances restricted to imminent and inevitable death, it makes sense to permit medical judgments that the "quality of life" of the patient no longer warrants attempting to extend his biological life. However, they are adamant that by "quality of life", they mean the patient's existential experience of life and not the value of the patient's life in the estimation of others.

The authors focus, also, on the irrevocably comatose patient, whose life has been artificial, extended by modern technology beyond the cessation of consciousness. They hold firmly that, in such cases, the physician has a *prima facie* duty indefinitely to continue extending artificial support to the patient's life, even though the patient's bodily good, at that point, cannot meaningfully be conceived as more than basic "comfort". The withdrawal of treatment which will bring bodily death in its wake, is *prima facie* permitted, they say, *only* where the treatment brings with it a degree of bodily *burden* which can be said to contradict the claim that providing it equals giving physical comfort.

Since the authors classify medically delivered nutrition and hydration as a form of treatment, this amounts to a position in the current debate on that topic. In order to understand fully their position in the matter, one must note the critical exception which they

make to the *prima facie* rule just stated. This exception is grounded in the principle of "substituted judgment," and it runs as follows: since a conscious patient always has the right to refuse a particular treatment based on his existential assessment of the burden which it represents, the doctor is said also ordinarily to be bound by *proxies* which tell him what the patient would have decided, in present circumstances, were he not unconscious. Such a proxy may be a written directive, such as a "living will," or it may be a surrogate decisionmaker, such as a family member who claims to know that patient's relevant convictions. Equipped with a proxy request to withhold artificial forms of life support, such as artificial nutrition and hydration, the physician may thus withhold them, even where, in the *prima facie* case, they would be mandatory, as conducive to the patient's bodily comfort.

The authors are careful to draw several lines aimed at preventing this "substituted judgment" exception from eroding respect for the sanctity of life. First, they deny the applicability of the substituted judgment exception to the class of never competent patients, since these patients have never had the opportunity to come to an existential balancing of values which could qualify the judgment in the *prima facie* case. The authors rightly see this restriction as important because, as a group, never-competent patients are particularly vulnerable to utilitarian exclusion from societal benefits. Second, they require the physician to be an advocate for the unconscious patient who rejects the force of proxies which are not demonstrably valid, applicable, free of conflict of interest. Third, they emphasize that the substituted judgment of the surrogate decisionmaker must go exclusively to what existential burdens this patient would have felt from this treatment option. The surrogate decisionmaker may not substitute his own values or those of the "reasonable man".

For all of the strengths of the authors' attempt to deal with the difficult nutrition-hydration debate, their attempt seems to suffer from serious weaknesses. Most critically, it does not clearly specify the criteria for determining when the refusal of treatment by a competent patient is *suicidal* in nature. They would seem to agree that formal cooperation with a conscious "suicidal" refusal (as in the *Bouvia* case) would be wrong and should be against the professional ethics of medicine. By the same token, implementing such a refusal for a postcompetent patient under a "living will", would be equally wrong and should equally be deemed a violation of professional ethics.

When is the refusal of treatment a form of suicide? Some have attempted to make this delineation by requiring that nutrition and hydration always be deemed basic care rather than treatment, with the consequence that rejecting them will be suicidal where death is proximately caused by their removal. The authors reject this criterion. In their own *prima facie* case, in which the patient is assumed to express no wish one way or the other, they make the imminence and inevitability of death from other causes a criterion for the licitness of withholding marginal medical benefits, but they pointedly refrain from applying this criterion in setting objective moral limits to when the physician may implement a "substituted judgment" to remove nutrition and hydration. The authors also fail to pursue a possible argument that where objective proof does not exist of a present and disproportionate physical or psychological burden, beyond the fact *per se* of the artificial nutrition and hydration, the act of withdrawing the treatment should be viewed as suicidal in nature. Neither do they explore the possibility that at least where any higher consciousness remains, however senile or imbecilic, the minimal burdens of medically assisted nutrition and hydration should be viewed as presumptively nonburdensome, so that withdrawal would ordinarily be suicidal. One could be more confident in the authors' extensive reliance on the "substituted judgment" exception if they developed an aspect of these or some other criteria for the sake of delineating the specific difference separating suicide from refusing treatment, to ensure that implementing a substituted judgment is never formal cooperation by the physician, in what amounts to delayed suicide or murder.

The authors, moreover, do not appear to be sufficiently sensitive to the fact that the notion of "substituted judgment" is, in itself, nothing more than a legal fiction. Strictly speaking, it is impossible to enact the judgment of another. The most that is possible, in reality, is for a judgment to be *deemed* representative and to be based on what the other is *deemed* to have wanted. In fact, the judgment always remains that of the surrogate, and is never actually that of the unconscious patient. The surrogate decisionmaker will always necessarily interpret the supposed wishes of a Karen Ann Quinlan against a backdrop of his/her own beliefs about reasonableness. He/she cannot help being influenced by a concern with "gatekeeping" over family, institutional, or societal resources. Furthermore, the patient's written attestation of his "negotiated values", in the form of a living will, is likely, after only minimal institutional experience, to become a standard form expressing what amounts to the "reasonable man"

standard that the authors mean to repudiate. For all of these reasons, there is a distinct danger that the "substituted judgment" exception proposed by Pellegrino and Thomasma may actually serve as a subterfuge which permits the elimination of patients for economic reasons, without requiring society to face what is occurring. Such is ironic, since the authors generally pose convincing arguments against the social utility model of medical ethics which they term "Physician as Gatekeeper".

The real and substantial contribution of this volume lies in its attempt to coordinate a general framework for clinical decisionmaking which balances respect for the good with respect for patient autonomy, within an essentially hippocratic framework giving priority to the good. Especially impressive is the authors' articulation of a protocol for negotiated decision-making between physician and patient under difficult clinical conditions. One hopes that the authors return to the attempt to provide a new Hippocratic oath for the medical act of profession, which adequately embodies their synthesis. The articulation in the present volume requires revision to clarify that, according to the authors' own understanding of medicine, the patient has no categorical power to release the physician from duties which are to be considered nonfeasible.

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