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Father Smith gave the following talk at the Annual Lenten Conference held at St. Vincent's Hospital and Medical Center in Manhattan and attended by the physicians on the medical staff.

I would like to say a word in behalf of virtue — virtue in the practice of your profession. That virtue is "trust." Talk of virtue might strike some as somewhat intangible, but the absence of some "intangibles" can have very tangible effects.

For some, medical ethics is somewhat intangible, yet its absence has very tangible effects. Sometimes, the simplest things are the most difficult to explain. If we say there is no difficulty, that's simplistic; to say it's all too difficult, that's simply a cop-out.

Consider the primary concern of standard medical ethics, a most basic tenet of the Judeo-Christian ethic — the total good of the whole patient, the treatment and care of the *whole patient*: body, mind, soul and spirit! [1]

Surely, it's hard to disagree with that kind of puff. Isn't that precisely the kind of marshmallow statement we have come to expect from "Churchy types" who dress as I do? Nonetheless, I suggest that we really try to think this one through and thoroughly, that we highlight its individual and institutional meaning, no matter what institutions we work for or in or at, but especially so in a religiously affiliated institution such as this.

Again, some may consider it customary, even obligatory, for religious types to take refuge in intangibles such as the whole patient: body, mind, soul and spirit. Intangible? Seemingly so, yet when missing, absent or forgotten, very tangible effects!

In post-Watergate America, there has been a rush to recover morality in all the so-called "learned professions." Here we were, humming along in an uneasy marriage of convenience with the "expertise fallacy." What I mean by the "expertise fallacy" is this: if everyone is just super-trained in some specialty, that will make them "good" at that specialty, "good" at their work, and that's "good"! But is it?

Does anyone still labor under the delusion that science is somehow value free? That the delivery of health care is simply a matter of refined technique, as if technique is somehow exempt from value judgments?

Nothing is exempt from value judgments; everything is subject at least to priority critiques. There is no such thing as a moral vacuum and that is one clear danger. If one pretends to have trained in a moral vacuum, he or she might be tempted to practice or attempt to practice in a moral vacuum when, in fact, all sorts of personal judgments, individual priorities and private biases surround every decision that we ever make. Some very "intangible" purposes have very tangible effects.

Nature, we know, abhors a vacuum. I don't think there is such a thing as a moral vacuum either, and I know for sure that publishing and journalism abhor vacuums, too. Consider the post-Watergate rush for "rediscovered ethics"; all sorts of radical critiques have rushed to judgment and into print. Medicine was certainly not an exception. Probably the next worst thing to no attention is too much attention. Items:

Ivan Illich publishes his *Medical Nemesis* (New York: Pantheon, 1976). As he previously insisted that teachers were the worst enemies of education, here he argues that doctors are the real enemies of good health care. Not quite as extreme as Illich, George Annas publishes *The Rights of Hospital Patients* (New York: Avon Books, 1975). The subtitle may say it all: "The Basic American Civil Liberties Guide to a Hospital Patient's Rights." Recently, some things along the lines of self-help and self-assessment have arrived. [2]

There is also the "advocacy literature," what I would call in medicine the "anti-trust lobby," not out to break up economic cartels such as OPEC, but the "don't-trust-your-doctor" approach: Arthur Freese, *Managing Your Doctor* (New York: Stein & Day, 1975); Arthur Levin, *Talk Back to Your Doctor* (New York: Doubleday, 1975); Stanley Sagov and Archie Brodsky, *The Active Patient's Guide To Better Medical Care* (New York: McKay, 1976).

Then Stephen Jonas published his book, *Medical Mystery* (New York: W. W. Norton, 1978), an unrelenting broadside at U.S. medical education. One reviewer notes that Dr. Jonas seems to have forgotten what only a teaching professor could forget: discomfort is immediate, prevention is indefinite. [3]

At the same time, there is a mountain of published works on medical ethics. Much comes from the Kennedy Center in Washington, D.C. and from the Hastings Center, just north of here. Oddly, more and more of what is published involves less and less of what is practiced. Large bulks of this material are geared for physicians engaged primarily or exclusively in research and that represents 3% or less of the physicians in this country. Please don't misunderstand me; some of

these questions are monumental. Indeed, some of the biochemical medicine will change the very nature of medicine because it is a shift away from doctoring the patient to doctoring the race.

But, the root problem in most of this is not, I think, an information problem, nor a knowledge problem. The root question is an ethical one — not allegedly superior or advanced ethics — but rather basic ethics, most basic to your profession.

Dr. Herbert Ratner reviewed the Hippocratic Oath in a series of characteristically incisive editorials in his publication *Child and Family* a short time back.[4] Quickly and unambiguously, he got down to that first-mentioned intangible, the altruistic commitment to the sick patient as a "whole" person — body, mind, soul and spirit.

That is the element that precisely differentiates the profession of medicine from a union, a trade, or a business. Just as man needs health, and justice and grace, so the medical, legal and ministerial professions have, as their primary obligation, the good of the patient in medicine, the good of the client in law, and the good of the believer in ministry.

Good of Whole Patient

For medicine, it is the good of the WHOLE PATIENT. To assure this dedication, a profession must have at least two things: 1) it must be organized, and 2) it must have a code of ethics — an ethical code that conforms to its healing purpose, a code to which all promise allegiance. To this, men and women vow to act for the benefit of my patients.

A license to practice or a shingle to note availability — these are supposed to guarantee the professional minimums. Clearly, incompetence is both inhumane and immoral. But, it is one's allegiance to an ethical code that converts, or should convert, a professional person into a "professed person" — professing in practice the good of my patients.

The learned professions are supposed to serve basic human needs; needs which transcend slogans and journalese; needs which transcend both very "in" trends and very "far out" trends; needs that surpass the arrogance of what happens to be in vogue this year, this month or this week.

So it is with law. The professional must be learned in law and obligated to the purpose of his profession which is justice. When a lawyer advises perjury, he sabotages all of us. Recall Watergate. Some of the best products of our best law schools, on both sides, turned out to be some of our best liars. That kind of problem hurts because it is so fundamental. It has nothing to do with I.Q., nor with who wrote for the *Law Review*, nor with expertise. It has to do with morality and the failure to keep a professional oath.

So it is with medicine. The professional must be learned in medicine and obligated to the purpose of the profession — the promotion and protection of the life and health of those in his care. When the good of the individual patient is overlooked, perhaps society, the state, or research gains an extra advocate, but that patient has lost his doctor.

No profession is immune to ignorance, human weakness or temptation, and that most definitely includes my own. And that is why the function of a professional code and ethic is to give the professional his or her mark — the target for which you must aim. To miss chronically or to permit the miss to become a habit is to institutionalize self-service and change a dedicated goal into a sophisticated cover-up.

Now, whether we like this or not, one trend seems to be very clear in our society: we have privatized our ethics. As religious institutions have lowered their public profile and even, at times, their religious profile, more and more our society turns to the courts to determine questions of right and wrong.

A drastic decision came from our own New York Court of Appeals on December 27, 1978, ruling that doctors can be held liable for abnormal births.[5] This is not for negligence on their part, but if they do not offer the means to discover some suspected defect, and then the means to abort a defective birth, they can be held liable for the costs of any less than perfect birth.

Thus, law tells medicine how to practice medicine, not for medical reasons but for legal ones. What an invitation to "defensive medicine"!

Medical ethics has suffered the same assault that every other ethic has in our society, that slow grinding reduction, "What's Legal Is Moral!" Most professions promise little more than that, and most of us promise no more to each other. Mostly the promise is: I promise not to do anything illegal!

But that non-promise has an open drain built into it, a drain that won't hold water, much less morals. When my only promise is not to do anything illegal, then with every change of law, we have a change of promise.

It is now legal to kill an unborn; it will soon be legal to release (as they say) mercifully (as they say) the incurable (as they call them); it's legal for teachers to strike; for some clergy to make a nice living off attacking the churches that sponsor them; laetrile is good for you if some court says so; a Lee Marvin non-marriage is as good as a real marriage if some court says so.

Some laws are changing pretty fast. If all we ever promise each other is not to do anything illegal, we may promise nothing at all. We promise only to change with the trends of the times — whatever the direction that change takes: left, right, full speed in reverse. This is no promise at all; it only promises a lowest common denominator morality in which the moral denominator can become uncommonly low.

We already have a traffic court, but almost all ethical traffic is going

in one direction — to court. I don't know that much about law, I do read newspapers. Financial penalties are imposed for assisti at less than perfect births; in California, arbitration contracts are r ac- ing lawsuits for doctors — sign an arbitration agreement before u er- going treatment. [6]

Events Solidify Trend

Several media events of death and dying solidify the same nd: the Quinlan case in New Jersey, the Saikewicz case in Massachu tts.

I don't think the Quinlan case belonged in court, but to c rt it went, not once but twice. I thought the first decision by Judge luir, in Chancery Court, was correct, but the second, New Jersey Su eme Court, was incorrect on many counts. What mystifies me most c all is the effect on the physician-patient relationship about which rdly anyone says anything. [7]

As I understand it, patients seek out the doctor of their choic But the patient does not *dictate* therapy because, presumably, the p tient lacks the trained expertise to do so. The patient concurs in bu does not control the physician's plan. If I do not concur in or even c cline one physician's plan, then I seek another doctor. Eventually, must find a physician in whose decision I do concur.

When Mr. Quinlan did not concur in the doctor's treatm t as offered, he should not have gone to court to get the court to or r the doctor to do it his way; he should have gone for another d ctor. Obviously, patients have the right to concur in therapy, but ot to control medical treatment by way of court order lest the att nding physician be disenfranchised and that troublesom cloak calle "the right to privacy" be ordered by court or committee to fo e the doctor to practice what he does not consider or think is th best treatment.

In Massachusetts, the Saikewicz case has generated all sorts of confusion. In a 41 page opinion (11/28/77), the Massachusetts Supreme Judicial Court — seven justices without dissent — rejected Quinlan and affirmed that all decisions on either life-support systems or continuing life-extending therapy in otherwise dying patients who are incompetent because of mental retardation, incapacity, or under age, must go before a probate court for approval.

I have read many reviews of that decision; most written by lawyers are positive, most written by doctors are negative. But again, there was no real need to go to court on that case, and instead of that court limiting itself just to the case before it, it established a whole class on which courts alone can rule.

A recent article in the *Forum On Medicine*[8] argues that it's not such a bad decision, while quietly suggesting that if all states had so-called "Living Wills" or "Natural Death Acts" we would not have

these kinds of problems. The one thing we don't need is extra legislation on death and dying. Most of the ambiguous proposals presented so far to the different legislatures are no more than clever pieces of social engineering that we do not need at all.

Conscientious and competent physicians have been making conscientious and competent decisions in consultation with nearest of kin in everyday circumstances in almost every hospital in the country about the use or non-use of extraordinary means. That conscientious consultation and decision-making must not change; no extra laws are needed there!

Our society is becoming extremely litigious, even litigation happy, and this is getting dangerous because it fosters the illusion that we can and need to legislate everything. Not so! Those of you who are parents might have entertained the hope that one of your children might have followed you in the medical profession. You might want to think more about that; it may be better to have a lawyer in the family if you are to practice or ever retire in peace.

With his extraordinary prescience and intelligent reserve, the late Pope Pius XII, in an address to a Congress of Catholic Doctors (9/11/56),[9] reached way back to cite the Roman historian Tacitus: "*Corruptissima re publica plurimae leges*" *(The Annals,* Bk. 3, n. 27). A superabundance of laws is proof of a corrupt society; a superabundance of laws is a sure sign that society is falling apart for the simple reason that no one trusts anyone very much any more.

The medical profession, like every profession, rests on the basis of trust. And you cannot legislate trust!

I trust you know what you're doing. I trust you tell me the truth when I ask what's the matter with my injured leg. I trust your concern is for me — your concern as *my* doctor with me as *your* patient. I trust your promise is alive and well — that altruistic commitment to the *whole patient:* body, mind, soul and spirit.

I trust your concern is for my life, health and bodily integrity. If we have to go around and check each other out with a moral Geiger counter to figure out where you stand on euthanasia — say on a scale from 1 to 10, are you liberal or conservative on this? — well then, frankly, I don't trust you, which means you're in trouble, I'm in more trouble, and your profession is in real trouble.

Problem Is a Moral Question

This is not a knowledge problem. It is not an I.Q. problem. The smartest among us are not necessarily the most virtuous. The problem is a moral question which should be beyond question. One of the functions of a professional code of ethics is to make sure that society does not even ask you the wrong kinds of questions.

If you, as a physician, give and keep and mean your professional

oath and ethic, then I trust you and have no real questions; but if n , then I have nothing but questions — questions like "Where do y draw the line this week?"

Some alleged humanitarians want to legislate Death-with-Dignity s they love to call it. Most of the proposals are in the language f "mercy" and "sympathy." But, what makes "mercy killing" o dangerous is that it sounds so compassionate. "Death" can be a *me* , but what most often is meant is a "mercy" to relatives, to attenda s, to society, to third party payers. For whose benefit does any pat nt die? The uses of death are *infinite* once it becomes a legal means or solving human problems. Admittedly, there is much mentic ed sympathy in that movement; however, law can only legalize killin it cannot legislate sympathy.

The physician has a covenant of trust with the patient to preve or cure his disease, to slow its progress, to relieve its symptoms, and his covenant of trust is guaranteed only by that trust.

For 2,500 years we have separated the witch-doctor from the ed- ical doctor, separating the power to cure from the power to k — 2,500 years of an oath based on trust. I trust the physician will up- port and heal people, that he give no man poison, no noxious d ugs, that he first do no harm. That is still the first and foundational c non of all medical ethics: *Primum non nocere!* First, do no harm!

In dramatic or acute cases of heroic treatment, how far shoul you go, or when is enough enough? I want and trust the physici n to continue in that role for which he is trained and at which he is racticed and experienced. Frankly, I have more faith and trust i Dr. Average and Dr. Normal than I do in any board consisting of la nen, professional persons, sociologists, judges or clerics.

No physician is infallible. I no more bank on your infallibility than I do on my own. But my limited experience is this: the greatest fallibility will be found in boards, agencies, committees, regulatory commissions, instruments of the state in which no man's conscience is really held hostage to and for specific decisions.

Committees cannot think, only individuals are endowed with that marvelous capacity. Too often the capacity of each committee member to think varies in inverse proportion to the number of persons on that committee. Decisions are not made in a vacuum. And to understand these kinds of decisions, one must be involved in and confronted with the facts.

No two situations of death and dying are identical because no two situations of fact are identical here: each is unique. Thus, the generalities and universalities of law are especially unsuited for determining uniquely individual situations.

Our common law is often disparaged as being out-of-date, out-of-step or out-of-touch with the rapid pace of advancing technology. So, some suggest that the way to catch up is to pass new laws and more

laws. I would not agree. Most of the presumptions of common law are profoundly pro-life and pro-virtue. They are, most often, the best measure of a good society and I have great respect for them, for all the particular judgments in particular cases made by thoughtful and experienced men and women. [10]

I have much less respect for general statutes drawn up in haste, often to achieve a political result in the midst of some current crusade or divisive debate. Too often, the Congress in Washington and the Legislature in Albany hasten to devise, for expediency's sake, some statutes which are at odds with the reasoned experience and settled behavior of human beings. Legislation is not the best, nor should it be the normal, means of affecting human behavior.

Long ago, a pagan historian who did not share my Faith saw this very problem: "*Corruptissima re publica plurimae leges*" — when the state was most corrupt, laws were most abundant.

The core problem in ethics is not knowledge; if anything, it is wisdom. But in our society, we often mistake computer-sounding knowledge for wisdom. The core problem is commitment to an oath and ethic in profession and in actual practice, to the good of the whole patient, body, mind, soul and spirit.

A dangerous companion of the "expertise fallacy" is the "prestige syndrome." Why the present passion to advance professionally by way of publication, book-writing, degree-gathering, prestige-building? Is much, or any, or most of this at the expense of patient care? Any step up that steps on or over a patient is a step backwards.

Some might still remark, "That's nice, but all rather intangible." Not so! No, it's very tangible when commitment to oath is absent or lacking or confused; the results are painfully tangible.

The hospital I work in, however, is more of a business than a profession. I attend more meetings than I attend patients; it's more of a contest than an art or vocation. Maybe so; but it is precisely there in the contests, the meetings and in your profession that you will live ethical principles or you will not. What we do is of and from what we are. That's character which is virtue.

Principle Needs Dedication, Protection

It is in actual practice that we carry out our profession — the good of the whole patient, body, mind, soul and spirit. That bed-rock principle needs dedication and protection, and always deserves human care as it must be formed and informed by trust. Even when technology can do no more, or frankly can do nothing, it needs and deserves human care and that care and dedication need the institutional and individual allegiance of all of us in oath, in ethic and in practice.

Now I know as you do, that some consider it clever to be cynical, enlightened to be unbelieving, and sensible to be prudently silent. But

the cynical, unbelieving, sensible types have been all too willing to p t professional success ahead of personal standards, and cleverness ah d of character. That just does not serve the whole person. As Prof. P l Ramsey often points out, the good that we can do will only be c n- plemented and completed by the harm we refuse to do.

I began by remarking that I would say a word on the practice of virtue in your profession, essentially that which secures, strengths and really cements the ethics of your profession — *trust*!

No law, no committee, no blue-ribbon panel of experts will do at for you, nor can you delegate it to anyone else. It will be your pro s- sion and your lived practice of ethics which will most secure what ou need most — trust. That is virtue lived. The good you can do wil be completed by any harm you refuse to do on the same basis — trust

REFERENCES

1. *Cf.* "Preamble" of *Ethical & Religious Directives for Catholic Health cil-ities* (Washington, D.C.: United States Catholic Conference, 1975), pp. 1-2.

2. *Cf.* R. Gots and A. Kaufman, M.D., *The People's Hospital Book* (New rk: Crown Publishing, 1978); I. Rosenfeld, M.D., *The Complete Medical Exam* New York: Simon & Schuster, 1978).

3. Review by M. J. Halberstam, M.D., in *New York Times Book Review*, Sunday, Dec. 31, 1978, pp. 11, 18, 19, at p. 11.

4. Ratner, Herbert, M.D., *Child and Family*, Vol. 9, pp. 290-292; Vol. 1 pp. 2-3; Vol. 10, pp. 98-100; Vol. 10, pp. 194-197; Vol. 10, pp. 290-291; Vol. 1 pp. 2-3.

5. *New York Times*, Dec. 28, 1978, pp. A, 1; and B, 6.

6. *New York Times*, Jan. 29, 1979, p. A, 12.

7. Diamond, Eugene, M.D., "Comments and Criticism: The Quinlan Case," *Linacre Quarterly* Vol. 44 (Aug., 1977), pp. 262-265.

8. Glantz, L. and Swazey, J., "Decisions Not To Treat: The Saikewicz Case and Its Aftermath," *Forum on Medicine*, Vol. 2, no. 1 (Jan., 1979), pp. 22-32.

9. Pius XII, Pope, Address to 7th International Congress of Catholic Physicians (Sept. 11, 1956) in *Acta Apostolicae Sedis*, Vol. 48 (1956), pp. 677-687, at p. 683.

10. Agree with and here summarize M. C. Shumiatcher, J.D., in *Canadian Medical Association Journal*, Vol. 117 (Sept. 3, 1977), pp. 520-522.