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THE IDENTITY AND STRUCTURE OF MEDINCE IN EDMUND DANIEL PELLEGRINO'S PHILOSOPHY OF MEDICINE

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Abbreviations

AMA American Medical Associations
BC Before Christ
BCE Before the Common Era
Ca. *Circa, about*
CE Common Era
CF Confer compare
IMM Internal Morality of Medicine
EMM External Morality of Medicine
GS *Gaudiun es Spes*
HIV Human Immune-deficiency Virus
IMM Internal Morality of Medicine
IMM Internal Morality of Medicine
NE Nicomachean Ethics
ST *Summa Theologiae*
WHO World Health Organization

General Introduction

Every community in the history of humanity aspired to understand medicine and its practical use. This has been so and will continue to be so because medicine deals with the universal human experience of illness and disease. Sickness is a universal human experience that cuts across every history, race, age, and gender. Its reality in human life, sometimes, makes it appear as if it is part of our human nature to be sick. This doctoral dissertation undertakes the moderate task of exploring the philosophical basis of medical practice. It is an investigation into the relevance of philosophy in the medical profession. The study begins on the basis that every practical problem is susceptible to philosophical inquiry since philosophy provides solutions and guidance to both theoretical practical or moral issues of life in a manner that is different from those of the particular sciences. Philosophy provides solutions to ethical problems through the application of philosophical methods of inquiry and analyses. We approach this task by recasting how philosophy interacts with particular sciences and shapes professional roles. This work considers philosophy's role in aiding health care professionals to confront the ethical challenges and dilemmas in their struggle to attain the goals of the practice of modern medicine.

The dissertation considers the problem of the necessity for a moral guide and philosophical intervention in medical practice. It calls for a philosophical re-definition of the profession of medicine, its essence, the good that it seeks, and the practical challenges confronting health care providers in the phenomenology of the clinical encounter. We propose a philosophical model of combatting the contemporary problems of medicine by appealing to Edmund Daniel Pellegrino's[1] proposals and approaches to medical practice.

[1] Edmund Daniel Pellegrino was born on June 22, 1920 and died on June 13, 2013. He was an American bioethicist and academic who served as the 11th president of The Catholic University of America (CUA) from 1978 to 1982. For 35 years, Pellegrino was a distinguished professor of medicine and medical ethics and the Director of the Kennedy Institute of Ethics at Georgetown University. Pellegrino was an expert both in clinical bioethics, and in the field of medicine and the humanities, specifically, the teaching of humanities in medical school, which he helped pioneer). He was the second layman to hold the position of President of Catholic University. He was the Chairman of the President's Council on Bioethics, under the 43rd U.S. President, George W. Bush, and was the founder of the Edmund D. Pellegrino Center for Clinical Bioethics (renamed in his honor in 2013) at Georgetown University. See, https://en.wikipedia.org/wiki/Edmund_Pellegrino. Accessed 25 January, 2022.
Pellegrino received solid training in the classics and philosophy in a Jesuit high school and afterward at St. John's University in Brooklyn. For this reason, early in his academic career, he became concerned about the need for contemporary philosophy of medicine to ground the ethical practice of medicine. Thomasma argues that even those who disagree with Pellegrino think that his insistence on a philosophical basis for modem medicine is a particular strength of his contribution to the theory of health care. He argued that contemporary challenges in medicine and technology are in danger of outstripping current health care theories, endangering traditional commitments to the patient's good. For this reason, he inaugurated and was the first editor of the Journal of Medicine and Philosophy. He saw the journal as a primary vehicle for stimulating the thinking in the philosophy of medicine. See, Thomasma, David. "Edmund D. Pellegrino Festschrift," In *The Influence of Edmund D.Pellegrino's Philosophy of Medicine*, edited by David Thomasma (Dordrecht: Springer, 2011), 6.

The object of the study

The object of this study focuses on the philosophical inquiry into the ends and means-related problems in medical practice. The themes of ends and means are essential elements in every moral judgment. They remain the central pillars on which judgments concerning the morality of human action, either as of right or wrong, good or bad, or as moral or immoral, depend. In this inter-disciplinary study, we employ Pellegrino's teleological conception of medicine as a paradigm to facilitate our approach to the structure and identity of medicine. Pellegrino centered his thought on the possibility of a practical moral philosophy that could resolve the issues related to medicine. He stated clearly that his aim was "to search for a moral philosophy of medicine based on the nature of medicine. Without this, medical ethics becomes what social convention, politics, economics, or sheer pragmatics make it. Given its enormous power for good and evil, medical ethics cannot serve the personal and common good without clarity about its ends and purpose."[2]

This dissertation aims at dissecting and analysing Pellegrino's theory of medicine and at showing the relevance of his view and its contribution to the contemporary bioethical debates on issues surrounding the practice of modern medicine. The dissertation focuses on the philosophical foundations of the concept, nature, and essence of medicine by revolving around what Pellegrino calls the central dilemma of modern medicine – What is it? What is it for? What knowledge does it need?[3] This current dilemma[4] of medicine, in turn, becomes the central

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Early in his academic career, he saw the indispensability of modern medical philosophy in strengthening the ethical foundations of medical practice. See, Tadeusz Biesaga, *Spór o podstawy etyki medycznej Teleologizm E. D. Pellegrino a kontraktualizm R. M. Veatcha* (Kraków: Uniwersytet Papieski Jana Pawła II, 2014), 11. Pellegrino is one of the great pioneers in the modem philosophy of medicine because his foresight, creativity, innovation, and scholarship are far ranging and distinctive. Pellegrino brings to the field of academic medicine a truly catholic, universal outlook. His years as an innovative administrator, a dean of new medical schools, an early president of the Society for Health and Human Values, a chancellor of a major health sciences center, president of a medical center, president of a university all contribute to a universal vision of the task and challenges of medicine and health care in our age. See, Thomasma, *Festschrift*, 5.

[2] Edmund Pellegrino, *The Philosophy of Medicine Reborn: A Pellegrino's Reader*, eds. Tristram H. Engelhardt and Fabbrice Jotterand (Indiana: University of Notre Dame Press, 2008), xv.

[3] Edmund Pellegrino, "The Healing Relationship: The Architectonics of Clinical Medicine," in *The Clinical Encounter: The Moral Fabric of the Patient-physician Relationship,* ed. Earl E. Shelp (Dordrecht: Reidel Publishing Company1983), 153.

[4] The terms ethical problems, ethical issues, and ethical dilemmas have profound significance in our discussion on medical ethics. They may appear to mean the same thing but they differ slightly. According to Georgina Hawley, ethical issues are those phenomena that have the potential to become a problem. For example, the phenomenon of abortion is an ethical issue that has the potential of becoming an ethical problem. Following the above definition, ethical problems arise from a moral or ethical issue. Ethical dilemmas are more than just a problem like these, when examined, have two possible ways or options of solving the problem; however, neither of these options appear to be correct. See Georgina Hawley, *Ethics in Clinical Practice An Inter-professional Approach* (England: Pearson Education Limited, 2007), 36. In another sense, Dilemmas are situations in which moral reasons come into conflict, or in which the application of moral values are problems, and one is not clear of the immediate choice or solution of the problems. A dilemma becomes a situation of moral complexity. For

problem of the philosophy and ethics of medicine - defining the end of medicine and the morality of its practice. This dissertation offers a comprehensive vision of Pellegrino's call for a phenomenological and teleological derived philosophy and ethics of medicine. His teleological analysis of medicine provides a tool for discovering the ultimate meaning of medicine and provides a foundation for building a sound and distinctive ethic[5] and morality for professions of medicine as a moral enterprise. Hence, this spells out the two major variables to be analyzed in this work, namely, the philosophical definition of medicine and ethics of its practice, which Pellegrino views as inherent in the philosophy of medicine.

Pellegrino confines his inquiry to clinical medicine as a paradigm for propounding his theory of medicine. His theory of medicine as teleological is expressed and actualized in the phenomenology of the clinical encounter in the physician-patient healing relationship. The clinical meeting in which the sick person in pain seeks help from a professional physician who offers to help is, according to Pellegrino, the core, summit, the mega and melting, and of course, the starting point of the philosophy and ethics of medicine and all medical activities.

His approach is characterized by essential elements such as the notion of disease and health, the nature of the physician-patient relationship in the healing process, and the goals of medicine as the proper focus of his philosophy of medicine. There are reasons why it is worthwhile to undertake such a project. First, Pellegrino's philosophy directly addressed the central problems or dilemmas of modern medicine that arise because of the complex nature of contemporary society. Second, his humanistic approach to medical ethics provides a suitable philosophical foundation for building professional ethics for medicine.

Formulating the Statement of the Problem and Thesis of the Dissertation

This dissertation is motivated by a series of issues concerning the nature and essence of medicine. Interest in understanding the nature and meaning of medicine has for a very long time being a fundamental question in philosophy, theology, and in other scientific disciplines.

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example, a person promised to meet a friend and dine, but he has to help his uncle who is involved in an accident, one has to fix the priority. See Naagarazan R.S. *A Text Book on Professional Ethics and Human Values* (Bangalore: New Age International (P) Ltd., Publishers 2006), 25.

[5] Our use of the terms ethics and ethic are both deliberate and justifiable. They are used by Pellegrino to indicate the difference between philosophical ethics of right and wrong and the ethic of medicine as a set of principles that guide the conduct of behavior in medical practice as a special kind of profession. Generally speaking, as nouns the difference between ethics and ethic is that ethics is (philosophy) the study of principles relating to right and wrong conduct while ethic is a set of principles of right and wrong behavior guiding, or representative of, a specific culture, society, group, or individual.

The discussion goes back to the earliest centuries of Greek philosophy. It is a topic often discussed in both local and international bioethical literature. Marcum notes that the debate over the nature of medicine is an ancient and spirited one, which has not abated even in modern times but has intensified since the beginning of the twentieth century when the fortunes of medicine were tied to those of the natural sciences. The current debate over the nature of medicine is in terms not so much of art or science but rather in terms of its essence and ends.[6] Understanding and discovering the true nature and essence of medicine becomes not only an important task but also an indispensable role of contemporary scholars. Pellegrino remarks: "Unless we are clear about what medicine is, we risk deceiving ourselves, our patients, and our society."[7] We are building on a claim that the problem of contemporary medicine is not only caused by the development of science and technology but also by professional deficiencies and the lack of understanding of the true and traditional meaning of medicine itself.

The complexity of the modern world has led to the increasing witness of the erosion of ethical and professional values. The most fundamental and urgent need in today's pluralistic society where ethical standards are eroding and constantly being challenged is the need for an informed conscience and a coherent moral philosophy peculiar to medicine. As captured above, the central problems or dilemmas of modern medicine arise from the fact that the nature of contemporary society is characterized by pluralism and relativism that makes it so hard to arrive at objective truth and consensus about the nature of reality. Modern medicine has reached a lamentable state of affairs because of so many factors. One problematic situation is that there is in our pluralistic society no agreed-upon philosophical anthropology or metaphysics. Lacking these, we lose the foundation upon which some typical idea of the good for humans could be based. As a result, the *telos* toward which medical practices were thought to dispose of the agent becomes vague. Consequently, differences in moral ends become relativized, subjective, and negotiable in response to the moment's difficulties. As a further consequence, the virtues ordered to those ends of necessity become problematic.[8]

It is viewed that the issues which medical law has had to contend with are very ethical and complex. These issues are moral because they are concerned with the termination of the patient's life in distressing conditions or the so-called doctor-assisted deaths.[9] Scott Smith

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[6] James Marcum A., *Humanizing Modern Medicine: An Introductory Philosophy of Medicine* (Springer Science + Business Media B.V., 2008), 301.
[7] Pellegrino, *The Healing Relationship*, 153.
[8] Pellegrino, *The Philosophy of Medicine Reborn*, 12.
[9] Abubakar Sadiq Ogwuche, *Preface to Compendium of Medical Law Under the Commonweath & United States Legal Systems with treatise on Assisted Conception by Prof. Giwa Osagie* (Lagos: Maiyati Chambers, 2006), iii.

describes our contemporary world as morally confused and lacking moral knowledge, and in most need of moral guidance. He writes: "We live in a time of widespread moral confusion. People are searching, sometimes fervently, for moral guidance."[10] In response to this yearning, ethics consultants have become a new occupation. They offer expertise in dilemmas faced in biomedical and other professional practices, as we see in the high demand for professional ethics in our time.

Regarding the biomedical approach, Smith argues that one reason for the need for moral guidance in the medical profession is that "today we are facing several kinds of decisions that previous generations never had to encounter. For example, biotechnological breakthroughs force upon us create new issues, such as, should cloning of humans be allowed? Or to what extent should we permit fetal tissue research? To what extent and for what purposes should we permit the manipulation of human genetic materials?"[11] These scientific and other professional-related issues raise a host of moral challenges, which previous generations never had to face.

Given our society's pluralistic nature and culture in which there is no generally accepted body of knowledge and overreaching moral norms, it has become challenging to find an external perspective shared by everyone that could function as an objective or neutral point of view in matters of different ethical dimensions. It is undoubtedly because of these contemporary fragmentations of points of view and ideologies that the history of modern philosophy has witnessed several philosophical movements and new issues arising from ethical challenges. No society can thrive in a state of lack of moral lawlessness and fragmentation.

These divergences in ethical theories could sometimes have a negative or positive effect on moral agents' moral judgment and actions. This is so because moral ideas highly influence moral actions. In this sense, the crises of ethical theories are not only the problem of ethical theories but also the application of ethical theories to practical ethical problems, mainly as they are found in various spheres and professions in life. The best-known example of the problem of applying ethical theories to concrete life situations is so pronounced in the field of medical ethics.

The field of medicine faces more professional, ethical dilemmas than any other profession in the world. This is probably because it deals with sensitive issues of life and death. The problems that make the headlines in the media are, typically those of abortion, euthanasia, physician-assisted suicides, surrogate motherhood, stem-cell research, and genetic engineering.

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[10] Scott Smit R., *Virtue Ethics and Moral Knowledge: Philosophy of Language after MacIntyre and Hauerwas* (New York: Routledge, 2017), 1.
[11] Smith, *Virtue Ethics and Moral*, 1.

However, there are many more subtle ethical issues in medicine dealing with autonomy–paternalism, the physician-patient relationship, consent, disclosure, and issues concerning privacy or confidentiality. There has been a growing demand for philosophers to clarify the ethical dimensions of professional roles in medicine.[12]

It is lamented that no idea in modern society has been more debased than the idea of a profession. Today, anyone who undertakes any activity full-time, for pay, or with high skill, anyone who performs some needed service, can call himself or herself professional. The list ranges from the traditional professions to other modern professional roles such as athletics to astrophysics, from carpentry to car salesmanship, from medicine to mortuary science, from pipe fitting to politics. It is so harmful to the extent that whoever is not an amateur, a dilettante, a hobbyist, or an apprentice is accorded the title of professional. Pellegrino summarizes the ethical situation in modern professions in these words: "The professions today are afflicted with a species of moral malaise that may prove fatal to their moral identities and dangerous to our whole society. This malaise is manifest in a growing conviction among the conscientious doctors, lawyers, and ministers that it is no longer possible to practice their professions within traditional ethical constraints."[13]

Making a particular reference to the medical profession, Pellegrino laments further on the moral degeneration in professional life: "We are now a morally heterogeneous society, divided on most fundamental ethical issues, particularly about the meaning of life and death. Without a common conception of human nature, we cannot agree on what constitutes a good life and the virtues that ought to characterize it. As a result, the ethics of the professions, especially the medical profession has turned to the analysis of dilemmas and the process of ethical decision-making. For many, ethics consists primarily of balancing rights, duties, and prima facie principles and the resolution of the conflicts among them. Procedural ethics has replaced normative ethics. This avoids the impasses when patients, clients, and professionals hold fundamentally opposing moral views."[14] Similarly, McCullough thinks that it is not technology that confounds contemporary medical ethics. Instead, the fundamental problem is the presence of a plethora of moral understandings of technology and many views regarding the telos of medicine that previously helped define what was proper to it.[15]

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[12] William F. Lawhead, *The Voyage of Discovery: A Historical Introduction to Philosophy*, Fourth Edition (USA: Cengage Learning, 2007), 586.
[13] Pellegrino, *The philosophy of medicine reborn,* 231.
[14] Pellegrino, *The Philosophy of Medicine Reborn*, 244.
[15]Laurence McCullough, "The Legacy of Modem Anglo-American Medical Ethics: Correcting Some Misperceptions," in *The Clinical Encounter: The Moral Fabric of the Patient-physician Relationship,* ed. Earl E. Shelp (D: Reidel Publishing Company, 1983), 61.

One other problem of modern medicine is that it is "more technical than practical, but the essence of the medical enterprise is still a practical one."[16] This manifests in a situation where the ancient grounding of medicine in care and compassion is challenged by a biomedical model that defines medicine simply as applied biology.[17] Modern medicine tends to completely detach itself from medical practice, the human effort to give meaning to illness and suffering. This tendency ignores the fact that medicine is limited to a practical response, that of caring competently, using the best resources of scientific knowledge. Hence, medicine should not be conceived solely as a technical venture but as "the practice of healing or rather the practice of competent care for the ill which takes place in a healing relationship, not in the technique per se. Medicine *per se* is not the skillful gesture of the surgeon (it could be an act of slaughter as well), but it is that act together with its sense as a moment of a caring relationship. Only within the horizon of the caring relationship does that gesture constitute a medical act."[18]

Medicine should not be seen only as a technical answer to technical problems. It should transcend beyond the level of the rule of efficiency to be connected to a network of meanings with broader perspectives in the moral life, where competent care is a part of the more significant effort to face the limits and promises of the human condition. The moral resources, unlike technical resources, are so designed in such a way that they give sense to illness, suffering, and death, together with the practical answer of caring and the activity of healthcare professions.[19] Russell Maulitz has argued forcefully and shared the feeling that things are changing and that as far as medicine and health care are concerned, the ground is shifting under our feet. He sees the litany in profit hospitals, the science of the biomedical model, diagnosis-related groups, the malpractice crisis, and so on.[20] In response to and within the above atmosphere and context, Pellegrino developed his theory of medicine. Considering the toxic nature of modern medicine and the ethics that guide its practice, there emerges an urgent demand and need to review and promote the need for such kinds of literature that elucidate the

[16] Robert Mordacci, "Medicine as a Practice and the Ethics of Illness," in *Life- Interpretation and the Sense of Illness within the Human Condition: Medicine and Philosophy in Dialogue*, eds., Anna-Theresa Tymieniecka and Evandro Agazzi (Netherlands: Kluwer Academic Publishers, 2001), 127.
[17] Edmund Pellegrino and David Thomasma, *Helping and Healing* (Washington D.C.: Georgetown University Press, 1997), 27.
[18] Mordacci, *Medicine as a Practice and the Ethics of Illness,* 129.
[19] Ibid.
[20] Russell C. Maulitz, "The Physician and Authority a Historical Appraisal," in *The Physician as Captain of the Ship: A Critical Reappraisal,* Nancy M. P. King, Larry R. Churchill, and Alan W. Cross eds., (Dordrecht: D. Reidel Publishing Company, 1988), 1.

modalities for which the challenges of modern medicine can be resolved. This work is in a bit of way an attempt towards such a contribution.

My thesis is that Edmund Pellegrino's theory of medicine as teleological is an adequate response to the problems of modern medicine. I do not claim or defend Pellegrino's teleological theory of medicine theory to be the ideal response to the challenges of modern medicine; neither do I project it as the only response. My claim is that it is adequate because it is rooted in the very nature and end of medicine itself. Being rooted in the essence of medicine provides a solid foundation that cannot easily be destroyed without self-contradictions. My overall aim in this dissertation is to justify that Pellegrino's theory of medicine stands the taste of time because of its uniqueness as being rooted in the essential nature and essence of medicine itself. The sufficiency of Pellegrino's theory flows from the fact that it redefines medicine and relates it to the phenomenon of the physician-patient relationship. He positions medicine from the mere level of scientific definition by giving it philosophical backing as an indispensable guide to its practice. His thought attributes a more specific definition of medicine higher than the biomedical model; this specific definition identifies medicine as *medicine qua medicine.*

An extension of the thesis of this dissertation reflects on the inevitability and indispensability of virtues in medical practice. It holds that virtues are inevitable and indispensable for medical practice. Pellegrino's medical ethics embraces the combination of both principle and non-principle-based models. Both the principle and non-principle approaches form a vital part of Pellegrino's defense of modern medical ethics. Pellegrino endeavors to show the connection that exists between principles and virtues, knowledge and character, techniques and practice, expertise and clinical judgment. In this way, he brings about the integration of both theory and practice. Pellegrino's *teleologism,* therefore, attempts to harmonize the divergent ethical theories into a formidable force that can prevent pluralism and relativism. I acknowledge that Edmund Pellegrino is not the first philosopher to call for a revival and return to the humanistic practice of medicine. This does not deny his unique contributions to the development of the philosophy of medicine.

My choice of Pellegrino was inspired by his unique style of writing and his ideas about the goal-oriented nature of medicine, which reflects and calls for a return to the classical-medieval ethics and his insistent on the possibility of building the morality of medical practice in connection of the classical ethics. My choice of him was inspired by his progress and immense contributions towards developing the philosophy of medicine, which serves as a solid foundation for any medical ethics. The height of Pellegrino's progress is evident in his methodological precision and in his ability to identify the intrinsic telos and the internal

morality of medicine. Worth inspiring is his contribution in the formulation of a virtue-based approach to medical practice as a remedy to the contemporary challenges in medical practice, especially about the physician-doctor healing encounter.

Research Questions

This dissertation will attempt to uncover and unpack the relation between philosophy and medicine based on the views of Pellegrino. The dissertation is systematically structured to answer these questions in an attempt to achieve its goals/objectives.

What are the central claims/theses in Pellegrino?

How does he justify these claims?

What are the sources of his philosophical inspiration?

What paradigm does Pellegrino use in his proposal?

What are Pellegrino's preferred conceptions and methods of philosophy?

What do Pellegrino's claims and arguments presuppose?

Does the influence of Pellegrino's view and proposals respond adequately and proffer solutions to the philosophical problems and medical dilemmas in contemporary society?

The Importance of the Study

The goal of this work is aimed at a deeper understanding of the concept of medicine. It seeks to unveil the transcendental reality of the nature of medicine through Pellegrino's teleological explication of the nature of medicine. There is no doubt that academic philosophy does not seem to produce practical solutions, theories, or accumulated knowledge in the way we would expect other applied disciplines to do. One of its functions is the heavy responsibility of showing people how to live and function rationally by offering a rationale for the diverse moral convictions, which people learn at different levels of life.[21] This study is essential in its own right as a substantive contribution to the philosophy of medicine. It achieves this project by reviewing and analysing Pellegrino's writings on the prominence of philosophy in medicine and his contributions to the philosophy of medicine, medical humanities, and bioethics.

[21] Cf. Martyn Evans, 'introduction' to Advances *in Bioethics: Critical Reflection on Medical Ethics*, ed. Martyn Evans (London: Jai Press Inc., 1998), 14-15.

The findings and conclusion of this study will rebound to the benefits of society, considering that the interaction between philosophy and medicine plays a crucial role in the well-being of man and the stability and development of the society. The reality of the numerous modern medical professional challenges and the expected demand for solutions to the current ethical dilemmas in medicine justifies the need and necessity of a philosophy of medicine. Many people in society today have lost confidence in medical professionals' abilities in delivering the goal of medicine. We hope that those insights from Pellegrino's theory of medicine will provide efficient guides that will improve the standard of medical practice and serve as a guide for the reformulation of the theory of medicine in accordance with its original sources.

The study will critically examine the sources of the contemporary challenges and confusion in medicine that emerge due to contemporary ethics-values, and further, indicate philosophical solutions to resolving the conflict. Pellegrino was not only in search of solutions for the scientific/technological problems of medicine but also the philosophical problems connected to the domain of medicine.

This work offers at different levels practical purposes for health professionals and health care providers in their various capacities. On one level, this research serves as a resource material for equipping healthcare students with the intellectual skills to reflect upon the values, challenges, and expectations of medicine which they hope to practice someday. On another level, it is intended for physicians and other healthcare professionals who cannot practice effectively without falling back to the philosophy of medicine as a crucial subject. This work seeks to help physicians navigate the plurality of models available for medical knowledge and practice with philosophical analysis.

More so, the study is essential to both bioethicists, philosophers, and public health policy-making organizations and agencies in their respective domains. Thus, it is believed that the study will be a resource on which to draw a framework of thinking, especially for potential and professional medical workers, the government, and the public in the current debates on medical matters. The interchange of views between physicians, philosophers, nurses, and psychologists recorded in this work about the subject matter provides a broader approach and knowledge to interdisciplinary medical issues. We hope that this study affords the reader, whether nonprofessional, physician, or philosopher, a helpful perspective on the process of knowing what occurs in medical practice at a more profound and critical level.

The Limited Scope of the Investigation

Our investigation is limited to the theoretical aspects of medical practice. I do not intend to delve into practical bioethical cases of the clinical encounter. This research does not consider data analysis of any suitable or real-life bioethical cases and situations, such as abortion, euthanasia, or other bioethics issues. It is simply a theoretical approach.

The relationship between philosophy and medicine is not of one question or problem but many tangles. More still, the confines of philosophy are universal. Philosophy and medicine as distinct disciplines are both broad in their respective domains. They have different branches through which they study their subject matter.

For philosophy, our primary concern is ethical although anthropological, metaphysical, and sometimes epistemological and logical elements may be employed to prove some points. Our notion of medicine is not from the generic point of view. Our scope of the investigation is limited majorly to clinical medicine and within the confines of Pellegrino's thought. We note quickly that there exists a difference between Western and non-Western medical systems and notions of disease and medicine itself. The notion of an organic disease as a cause of a sickness is the central concept in the western model, unlike in non-western systems, where there is no concept, or only a limited concept of disease as a cause of a sickness, in such non-western contexts, sickness is believed to be caused by an invasion of evil spirits, or witchcraft, or upset ancestors there.[22] Our notion on medicine and the relationship between the medical physician and the patient in this study is in the Western context.

The expectations or hopes that modern patients usually have regarding physicians within the practice of western medicine are different from those of the non-western models of medical practice. Amundsen Darrel and Ferngren Gary argue that first of those expectations are of the fact that physicians are above all products of scientific training and orientation, that is, that they deal with disease and other physical ailments that are both scientifically or empirically and rationally verifiable, not those of magically, mystically, or superstitiously elements. These expectations result from the Greek impact on medical theory and practice. The second form of expectations is chronologically concurrent with the first and a product of Greek medicine. They expect that physicians be guided by specific basic standards of deportment or professional etiquette in dealing with patients. The third category of patients' expectations are as a result of Christian influence, is the expectation, and they are expectations, that physicians

[22] Dorota Szawarska, "Curing and Healing: Two Goals in Medicine," in *Handbook of the philosophy of medicine*, eds. Schramme Thomas and Edwards Steven (Dordrecht : Ebook: Springer, 2017), 90.

are compassionate and motivated, at least in part, by a genuine concern for their patients. While the last form of patients' expectations is the expectations, generally taken for granted as much as the first, and thus a product of the late middle ages.[23]

Research Structure

The dissertation is composed of five chapters which explore the philosophical basis of medicine in the teleological structure of Edmund Daniel Pellegrino, who is said to have been heavily influenced by the classical-medieval (Aristotelian-Thomistic) teleological ethics. It concentrates on Pellegrino's theory of medical morality and argument on the certainty of virtues in medical practice. This research presents Pellegrino's proposals for a renewed approach in the method of medical practice- a humanistic approach to medicine characterized by virtues.

The dissertation begins with an introduction which presents the what, how and why of this investigation. It presents the research questions, the summary of the proposals, the object, the scope, the significance, the sources, the goal of the investigation, and the methods of the study. The initial part of the introduction provides a justification for choosing the research topic as a significant theme in moral philosophy. The statement of the problems pointed out the primary/secondary issues and the ethical dilemmas associated with modern medicine that demand urgent attention and clarification from moral philosophers, ethicists, and bioethicists, as the case may be.

Chapter one articulates Pellegrino's Philosophical basis and interpretations of medical practice. It gives central attention to the philosophical assumptions that Pellegrino adopted to formulate his philosophy and ethics of medicine. It provides a solid background to the philosophy of medicine by outlining the different factors that necessitated the formation of the philosophy. It provides the arguments on the inseparability of philosophy and medicine and the various modes of philosophy's interaction with medicine. The chapter considers the difference between the philosophy of medicine and bioethics and the philosophy of science.

Also explored in this chapter are the critical elements of Pellegrino's concept of medicine as teleological in medicine is said to have an intrinsic telos that determines its identity and morality. The chapter also explores the different modes of interaction between philosophy

[23] Amundsen Darrel and Ferngren Gary, "Evolution of the Patient-physician Relationship: Antiquity through the renaissance," in *The Clinical Encounter: The Moral Fabric of the Patient-physician Relationship,* ed. Earl E. Shelp (D: Reidel Publishing Company, 1983), 43.

and medicine and distinguishes in clear terms what philosophy of medicine is in its scope and content. This chapter also considers the attributes of medicine as a moral enterprise and its internal and intrinsic telos that mark its internal morality as distinct from the external morality.

Chapter two explores the core of Pellegrino's philosophy of medicine—the patient's lived experience of illness. The phenomenology of the clinical encounter is the mega and melting point of all medical activities and as the final pathway through which all medical knowledge, public medical policies, and scientific researches ultimately come to affect the lives of the sick persons who seek healing from persons who profess to heal (physicians). The chapter underscores how Pellegrino limits medical inquiry to the clinical healing relationship between the patient and the physician, which construes the phenomenon of the clinical encounter. He does not deal with 'medicine' generically. By clinical medicine, he meant using medical knowledge for healing and helping sick persons here and now in the individual physician-patient encounter.

This chapter is devoted to a philosophical examination and description of the structure of clinical medicine by providing a brief historical consideration of the evolution of the physician-patient relationship beginning from the primitive to the contemporary period. It outlines Pellegrino's proposals that it is a fact of illness or disease, the act of promise by a physician, who offers to help the patient caught in the predicament to disease and the act of medicine-making the technically right and morally good decision that best serves the needs and the interest of the sick person as grasped by that person and her physician. The chapter concludes by examining the nature of the good sought in medical practice and provides beautiful approaches to its realization. It is argued that to attain the good of medicine requires the integration of principles and virtues and expertise and clinical judgment.

Chapter three explores virtue ethics in contrast to the counterpart ethical theories of utilitarianism and deontologist. It traces the historical background of virtue ethics from the classical, medieval periods to the debates on contemporary resuscitation of virtue as a basis for medical morality. The historical overview covers the classical-medieval period, centring on Aristotle's account of virtues and Thomas Aquinas's virtue ethics. The contemporary resuscitation of virtues as the basis for Professional medical morality centres on Alasdair MacIntyre's *After Virtue* and Pellegrino's virtue account for medical professional roles. Reference is made to other contemporary virtue ethicists such as Elisabeth Anscombe, Philippa Foot, Williams Bernard, Julia Annas, Rosalind Hursthouse, Christine Swanton, Michael Slote, and a gamut of others.

Chapter four focuses on Pellegrino's arguments for a virtue-based (humanistic) morality and its application for medical practice. It explicates particular virtues, including the natural religious virtues that guide the physician in practical clinical decision-making and help him do what is conducive to the ends of medicine. This chapter considers the role of faith and reason in medical morality; it gives special attention to the catholic perspective on medical morality. James Drane's virtue-based account of medical morality is prioritized in this chapter, as the closest account is similar to Pellegrino's.

Chapter five presents the results and findings of the study and seeks to situate the relevance of this research in the context of the contemporary practice and world of clinical medicine. It aims to locate the various aspects in which the knowledge gathered from Pellegrino's theory of medicine could be helpful in the practice of modern medicine. It is a critical reflection on the themes of sickness and healing, virtue, goodness, faith, and reason as poles for relating the relevance of Pellegrino's theory of medicine.

The study concludes by proffering directions for further debates and exploration on medical practice and morality. These proposals for future and further directions in this area of study demonstrate the groundbreaking nature of every form of academic research.

Methodology

The inter-disciplinary coverage of this dissertation called for the adoption of several methods. To meet the goals of this dissertation we will apply a combination of three basic methodologies to cover the diverse topics, literary styles, and literature from which we expect to pull together Pellegrino's views on the object and subject matter under consideration in this study.

We employ the method of textual analysis to enable us not just to extract what has been said but critically and systematically grasp the problem confronted in such text and present it in such a manner that evokes a response. Our analysis of Pellegrino's readers is to trace and ascertain the object of investigation: the identity and essence of medicine and the necessity of virtues for sound medical practice. In analyzing Pellegrino's account on medicine, our curiosity and motivation are to find answers as to what degree does his standpoint of the theory of medicine and virtue ethics add significantly new perspectives to moral theory and contribute positively to the moral debates surrounding many vexing professionals (medical and public health) issues. We will use synthesis as a method to synthesize not only the opinions of Pellegrino but texts and documents of a diverse range to exemplify various constructs related

to the philosophical analysis of medicine. We draw upon the works of many thinkers whose ideas bear a close affinity and build upon those that comprise Pellegrino's philosophy of medicine as a healing relationship.

We also employ a historical-philosophical approach through which we delve into the historical relationship that has existed between philosophy and medicine from the ancient past to the present. Pellegrino wrote many treatises on the philosophical basis of medical practice. In fact, besides being a professional physician, he spent a significant part of his life trying to articulate a philosophy of medicine. His style and method of thinking and writing were heavily influenced by the classical- medieval (Aristotelian-Thomistic) traditions. Hence, his thought pattern was moderate realism. In other words, he was primarily realistic in his approach to the theory of medicine as a practical human activity.

From the professional perspective, this thesis employs an expository descriptive to show the need for medical care providers, while engaged in healing professional roles, in working towards achieving the goal of medicine, which culminates in the healing encounter between the physician and the patient. The entire methodology of this work can be described as a combination of textual analysis, historical-philosophical and expository-descriptive approaches because it portrays a vision of the identity and structure of medicine that brings historical medical and philosophical traditions face to face with the recent experiences of the practice of modern medicine the intellectually engaging and socially transforming proposals of Pellegrino.

Sources of Literature

There are three classes of literature in consideration for this dissertation. The first class of literature is Primary sources. This work is a product of a wide range of available written by Pellegrino, a prolific author. He is the founding editor of the *Journal of Medicine and Philosophy,* and he is said to have published more than 550 articles and authored, co-authored, or edited twenty-four books.[24] His most important works include *The virtues in medical practice 1993; For the Patient's Good: The Restoration of Beneficence in Health Care 1995; The Christian Virtues in Medical Practice 1996; Helping and Healing 1997*; *Biotechnology and the Human Good 2007; The philosophy of medicine reborn: A Pellegrino reader 2008*.

[24] Pellegrino, *The Philosophy of Medicine Reborn*, 441.

The second class of literature is secondary sources. The publishers (Reidel) of the Philosophy and Medicine series, which deals with the philosophical aspects of medicine and health care, have published 127 volumes from 1975 -2019. A good portion of these publications is useful in this work. The most significant secondary texts that would be consulted are commentaries on the works of Pellegrino, and those who wrote on topics related to this dissertation such as David Thomasma, Tadeusz Biesaga, Daniel Sulmasy, and others.

The third class of literature is tertiary sources. These are supplementary sources such as encyclopedias, Journals, Magazines, Bulletins, and Newspapers. There are also numerous materials from conferences and symposia within and outside the University circle that will be sourced and consulted.

Having stated the intentions of this research, discussed the layout and methodology, and briefly reviewed the literature there remains only to acknowledge a personal hope that the words and ideas that follow do some small justice to the works of Edmund Pellegrino, my constant companion over the last three years, and with whom it has been a privilege to engage.

Chapter One: A Survey on the Philosophical Foundations of Medical Practice

Introduction

This chapter is an essential guide and opening into a philosophical survey of medicine's features, foundations, meaning, nature, purpose, and relevance to humanity. The chapter examines the rational characteristics of medicine. It also brings us in touch with the reality of some of the most pressing questions and issues facing the twenty-first-century philosophers' treatment of the issues concerning the meaning, nature, and ends of medicine. More so, it presents a survey on the inevitable relationship and dialogue between philosophy and medicine. It demonstrates the manner in which Pellegrino placed bioethics, medical humanities, and health care policy within an innovative vision of the philosophy of medicine: the internal morality and the telos of medicine.

This thoughtful consideration of the fundamental issues of medicine revolves around the philosophical basis for the medical profession and the need for a moral philosophy of medicine that will aid a sound medical practice amid the rising challenges and dilemmas in the phenomenon of the physician-patient relationship in the clinical encounter. The chapter responds to the question about the nature of medicine as a moral enterprise and the possibility of a suitable moral philosophy for health care professions based on the nature and ends of medicine.

Pellegrino claims that given its enormous power for good and evil, a medical practice cannot serve both the personal and common good unless its ends and purpose are explicitly clarified.[25] The above statement from Pellegrino informs our discussion about the necessity and indispensability of moral philosophy for health care professions. Thus, the central question to be addressed in this regard is whether there exists or whether it is possible to formulate a suitable moral philosophy based on the nature and ends of medicine that can resolve the problems of professional roles among physicians.

Pellegrino's goal-oriented model of medicine is highly influenced by the methodologies of the convergence of classical and medieval philosophy. It is also enriched by some elements of realist phenomenology. It is in line with Pellegrino's proposals that I set out in this chapter to demonstrate the convergence between philosophy and medicine, skills and practice,

[25] Pellegrino, *The Philosophy of Medicine Reborn*, xv.

knowledge and judgement, and to respond to the question about the existence and possibility of a suitable moral philosophy based on in the nature and ends of medicine. I argue in this chapter for the necessity and possibility of a sustainable philosophy of medicine as a basis for medical practice.

1.1 On the Need for a Philosophy of Medicine

From ancient times up to the present, people have pondered about the relation between philosophy and medicine. The genesis of modern philosophy of medicine or ethics of medicine is generally taken to have begun with the teachings of a master physician in ancient Greece, named Hippocrates (ca. 470–ca. 380 BCE). The empirico-rational core of his innovative teachings of medicine was rooted in Greek philosophy, but they also embodied, centrally, a purely speculative doctrine about the nature of human maladies. His instructions were much later extended by Galen[26] (ca. 130–ca. 200 CE), in Rome, half-a-millennium later.[27] These teachings, which had undergone modifications within the course of history, still have much influence on modern debates about medicine. While we acknowledge that there is a very long historical literature on the development of the philosophical theory of medicine, our primary concern in this work is not to specifically explore these historical modifications since the scope of our investigation is limited primarily to Edmund Pellegrino's theory of medicine. Pellegrino's interest in a view of medicine dates to the 1970s. This was a time when the moral precepts of traditional medical ethics[28] first came under severe philosophical scrutiny.

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[26] Claudius Galen (129–199 C.E.) has been described as one of the most influential physicians in the world of medicine. He lived 600 years after Hippocrates, but he became a strong believer in Hippocratic ideals and set about to revive many of the Greek physician's original teachings, including Hippocrates' belief in the importance of "humoural balance." He became a skilled pharmacist, a remarkable anatomist, and a leading scientist of his day. See, Kate Kelly, *History of Medicine Early Civilizations: Prehistoric Times to 500 C.E.* (New York: Facts on File, Inc, 2009), 121.

[27] See Miettinen, O. S. *Medicine as a Scholarly Field: An Introduction* (Switzerland: Springer, 2015), 3.

[28] Ethics or morality plays an important role in human relations and activities. It plays a unique role in professional roles as well. We see this role in how ethics helps physicians in effective medical practice. John Williams explains that the connection between ethics and professional roles is possible because ethics as the study of morality deals with careful and systematic reflection on and analysis of moral decisions and behavior, whether past, present or future. Morality consists of the value dimension of human decision-making and behavior. The language of morality includes nouns such as 'rights', 'responsibilities' and 'virtues' and adjectives such as 'good' and 'bad' (or 'evil'), 'right' and 'wrong', 'just' and 'unjust'. According to these definitions, ethics is primarily a matter of knowing whereas morality is a matter of doing. From this, he explains that since ethics deals with all aspects of human behavior and decision-making, it is a very large and complex field of study with many branches or subdivisions. Medical ethics is closely related, but not identical to, bioethics (biomedical ethics). Whereas medical ethics focuses primarily on issues arising out of the practice of medicine, bioethics is a very broad subject that is concerned with the moral issues raised by developments in the biological sciences more generally. Bioethics also differs from medical ethics insofar as it does not require the acceptance of certain traditional values. See John R. Williams, *The World Medical Association Medical Ethics Manual* (France: The World Medical Association Inc., 2009), 9.

Scrutiny consisted of applying existing systems of ethics, like utilitarianism, *deontologism,* or *prima facie* principles, to the ethical dilemmas then emerging from a combination of scientific progress and changes in social and political mores. It soon became evident that no convincing case could be made for a universal agreement on the ethics of medicine.[29] This period was characterized by a clash of ideas in moral theories and socio-political ideologies concerning the nature and meaning of medicine. Robert Veatch, in a similar way, also describes the period in question here as a period, "When religious and philosophical ethicists brought their fact/value distinction to medicine. Drawing on Hume and more recent philosophical strains, health providers and patients were forced to acknowledge that in medical decision-making, one cannot derive clinical or policy recommendations from medical science."[30]

More so, Pellegrino lamented that the contemporary cultural climate of the Anglo-American society and the industrialized West had called the fundamental means and ends of medicine into question, leading him to propose a renewed reflection on medicine's basic concepts, including health, disease, and illness.[31] Despite the fact that universal agreement on moral issues between physicians[32] and patients was no longer possible in the pluralistic society, Pellegrino persistently proposed that construction of professional ethics, based on a new appreciation of what makes for a proper healing relationship between patient and physician, was both possible and necessary.[33] He set out to restructure the philosophical and moral foundations of medicine. Pellegrino proposes the following as qualities of the philosophy of medicine, which he envisioned to be a suitable tool for the resolution of the challenges and

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[29] Edmund Pellegrino, "Philosophy of Medicine: Should it be Teleologically or Socially Construed?" *Kennedy Institute of Ethics Journal* 11, no. 2 (2001): 169.

[30] Robert Veatch M., "How Philosophy of Medicine Has Changed Medical Ethics," *Journal of Medicine and Philosophy* 31, no. 6 (2006): 593.

[31] Joel Michael Reynolds, *Philos Ethics Humanit Med*. 2018; 13: 8. Published online 2018 Jul 4. doi: 10.1186/s13010-018-0061-4

[32]In most writings of Pellegrino, he uses the words physician, doctor, health care provider, health professional interchangeable to mean the same thing in the phenomenology of the clinical encounter of the patient-physician relationship. We too shall use these terms interchangeable in this dissertation in the same sense as Pellegrino does. These terms all refer to the professional or the physician who offers to help the vulnerable patient in need of healing. I am using them conscious of the fact these terms are etymologically further from their current meaning. For example, etymologically, "a doctor is one who teaches; a physician, one concerned with questions of nature; a surgeon, one who deals manually; a therapist, one who heals, cures, or cares. However, in common usage, a doctor may be a physician or a surgeon or both. Physician may be used interchangeably with doctor but surgeon may not be. Therapist, in common parlance, is not a substitute for any of the other three, but denotes one dealing, on a less sophisticated level than they, with the physical (and sometimes psychological) needs of patients." Darrel Amundsen and Gary Ferngren, "Evolution of the Patient-physician Relationship: Antiquity through the renaissance," in The *Clinical Encounter,* edited by Earl E. Shelp (Dordrecht: Reidel Publishing Company, 1983), 3.

[33] Edmund Pellegrino, "Toward a Reconstruction of Medical Morality," American *Journal of Bioethics* 6 (2006): 67. This article was originally published in The Journal of Medical Humanities 8, no.1 (1987). Reprinted with permission from Springer Science and Business Media. My citation are directly taken from the 2006 edition.

dilemmas of modern medical practice. He wrote: "Given the moral heterogeneity of the modern societies and the cosmopolitan character of scientific medicine, any sound philosophy of medicine will need to be 'internal' to medicine itself. It cannot be derived solely from any external philosophical system as in the past. Such a moral philosophy will be based on four things: the phenomena of human illness, the special nature of medical knowledge, the moral nature of clinical decisions, and the claim of medicine to be a profession."[34] Understanding and discovering the true nature and essence of medicine becomes not only an important task but also an indispensable role of contemporary scholars. Pellegrino remarks that without a moral philosophy that provides a distinctively clear vision of medicine, we run a great risk. He writes: "Unless we are clear about what medicine is, we risk deceiving ourselves, our patients and our society".[35] The above citation captures in every sense, the significance of the entire theory of medicine anticipated in Pellegrino's vision.

Pellegrino envisioned a moral philosophy specific to medicine; a philosophy that would be before medical ethics. It should provide a philosophical foundation for defining what constitutes good medicine, the good physician, and the moral obligations that derive from these definitions. A moral philosophy of medicine that would itself be grounded in the nature of health, illness, suffering, and healing; the logic and epistemology of medical knowledge; and, especially, in the nature of the physician –patient relationship.[36]

In line with Pellegrino, Nafsika Athanassoulis argues for the necessity of philosophy as a guiding principle in medical practice. He describes medical ethics as a sub-discipline of moral philosophy and avers that it is impossible to reflect on it in anything else than a philosophical manner.[37] Philosophy, therefore, becomes an indispensable tool for reflection into medical issues. Philosophers are expected to expand their sphere of influence by teaching disciplines, engaging in interdisciplinary work, and bringing their research into a more professional and public domain. The best way to enter into this process, as Athanassoulis suggests, is by "engaging philosophically with a wider public through the issues raised in medical ethics."[38] Interestingly, our efforts in this philosophical study are attempts to contribute towards this very mandate.

Long before now, Pellegrino is said to have virtually, from the start of his academic career, envisioned a philosophy of medicine as providing a humanistic approach to medicine

[34] Pellegrino, *The Philosophy of Medicine Reborn*, 433-4.
[35]Pellegrino, *The Healing Relationship*, 153.
[36] Pellegrino, *The Philosophy of Medicine Reborn,* 434.
[37] Nafsika Athanassoulis, *Philosophical Reflections on Medical Ethics* (UK: Palgrave Macmillan, 2005),1.
[38] Athanassoulis, *Philosophical Reflections*, 2.

in an increasingly fractured and technologically advanced society.[39] Pellegrino holds firmly that there must be a philosophy of medicine from which medical ethics emanates. Commenting on Pellegrino's theory of medicine, Daniel Sulmasy wrote: "His most foundational idea is that the ethics of medicine is inseparable from the philosophy of medicine. As he put it, one must know what medicine is before one can reasonably begin to think about how health care professionals ought to act, or make normative prescriptions about medical care."[40] This concern is clearly expressed in Pellegrino's words, "one of my major concerns, in recent years, has been what I perceive as the need to rebuild a basis for medical ethics and medical morality."[41] It is sometimes asked whether medical morality or ethics[42] is a distinct species of morality, or does it constitute simply a special arena for moral judgements and ideas that are familiar to us across daily life?[43]

Similarly, Thomasma describes the function of the philosophy of medicine as contributing to medical ethics by providing it with value statements, interpreting general principles, and applying moral theory to a specific problem in medicine.[44] These are apparent indications that underline the enthusiasm and urgency with which Pellegrino set out to accomplish his project of re-constructing a distinct moral philosophy for practicing medicine.

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[39]David Thomasma, "Establishing the Moral Basis of Medicine: Edmund D. Pellegrino's Philosophy of Medicine," *The Journal of Medicine and Philosophy* 15, (1990):246.

[40]Sulmasy Daniel P. "Edmund Pellegrino's Philosophy and Ethics of Medicine: An Overview" Kennedy *Institute of Ethics Journal* 24, no. 2 (2014): 105.

[41] Pellegrino, *Toward a Reconstruction*, 67.

[42] It is good that we clarify the sense in which medical ethics issued in this work. The terms medical ethics and ethics in medicine are used interchangeably to refer or to express the same reality. However, there exists from the technical point view, a thin distinction between the two expressions. It is therefore important to know that the distinction between medical ethics and ethics of medicine is useful for delineating the role of medical ethics in the clinical setting. Thomasma puts this distinction in a clear way: "Ethics of medicine can be used to describe the more abstract discussion of a range of clinically posed problems as might appear, for example, in a general examination· of issues in abortion or euthanasia. Such discussion is complex and would necessarily involve the lengthy examination of issues, which would forestall any urgent or immediate decisions about patient care. In the clinical setting, such discussion is out of place because of the clinical imperative, making some decision about patient care. On the other hand, medical ethics can be used to describe a more analytic, case-oriented approach to a specific moral issue. Instead of a general discussion of the major issues involved in euthanasia, then, a specific case is discussed. The patient care objectives are interlaced in the medical ethics discussion, and some action by the staff is recommended. Instead of an exploration and clarification of principles, the goal of medical ethics as a clinical discipline is to contribute to a patient care decision in a specific clinical setting (the intensive care unit, for example)." David, Thomasma C., "Medical Ethics: A Clinical Base," *The Linacre Quarterly* 49: no.3, Article 11 (1982): 268 Available at: http://epublications.marquette.edu/lnq/vol49/iss3/11

[43] Martyn Evans, introduction to *Advances in Bioethics: Critical Reflection on Medical Ethics,* ed. Martyn Evans (London: Jai Press Inc., 1998), 9. Evans responds to the question on whether health care ethics is a distinct species of ethics, somehow completely unrelated to moral ideas of judgements elsewhere in life, by saying that it is not. See Martyn Evans, "Learning to See" in Medical Ethics Education, in *Advances in Bioethics: Critical Reflection on Medical Ethics,* edited by Martyn Evans (London: Jai Press Inc., 1998),100.

[44] David Thomasma C., "Clinical Ethics as Medical Hermeneutics," in *Medical Ethics*, ed. R.S.Downie (England: Dartmouth Publishing Company Limited, 1996), 120.

Furthermore, the starting point of any debate in health care or medicine must find its roots in the philosophy of medicine. Pellegrino attaches much importance to the philosophy of medicine and refers to it as a starting place for moral reflection on medical issues, a philosophy from which bioethical and biomedical debates find their bearing. He argues that the practice, the ethics, and the social role of medicine depends on the philosophy of medicine to which we commit ourselves.[45] His work encompasses the critical explorations of the healing relationship, medicine as a profession, the patient's good, the role of autonomy, the problem of commercializing health care as a commodity, and the importance of virtue-based normative ethics for health care.[46] In these themes, we see the comprehensive vision of the scope of Pellegrino's thought.

From the start to the end, Pellegrino has held that it is only a philosophy of medicine that is essentially based on the nature and ends of medicine that can help fuse disparate themes in modern society, such as the control over our technology, the nature of human responsibility, personhood, and the duties we have to one another.[47] Pellegrino argued that just as in other professional and social roles, the virtues of medicine are derived from the nature of medicine as a human activity. On the necessity and the indispensability of sound professional ethics in medical practice, he radically argues: "professional ethics, its groundings, the source of its moral authority, and the way they are justified are of concern for all of us. Therefore, the philosophy of the profession that grounds the ethics is better than an idle academic exercise."[48] His overarching view was that once one understands what medicine is as a human practice, and understands its purposes, then, and only then, can one derive a set of moral expectations for practitioners and establish norms for the relationship between medicine and society.[49]

In collaboration with David Thomasma,[50] Pellegrino began his philosophical reflection on medicine by beautifully stating that in the relationship among the disciplines in the medical

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[45] Edmund Pellegrino, "What the Philosophy Is" *Theoretical Medicine and Bioethics* 19 (1998):331.
[46] Tristram H. Engelhardt Fabbrice Jotterand, introuction to *The Philosophy of Medicine Reborn: A Pellegrino Reader,* Tristram H. Engelhardt Fabbrice Jotterand (Indiana: University of Notre Dame Press, 2008), xv.
[47]David Thomasma, "Edmund D. Pellegrino Festschrift," in *The Influence of Edmund D. Pellegrino's Philosophy of Medicine* ed. David Thomasma (Dordrecht: Springer, 2011), 5.
[48] Pellegrino, *The philosophy of Medicine Reborn,* 9.
[49] Sulmasy*, Edmund Pellegrino's Philosophy*, 106.
[50] It is sometimes difficult to separate Pellegrino's thought from that of David Thomasma especially when it comes to some issues on the philosophical foundations of medicine, although at some points in his writings and presentations Pellegrino exonerates Thomasma from any anticipated blame of some stands taken. He however, mostly proudly refers to Thomasma as close friend, coauthor, collaborator and a colleague with him he worked and from whom he benefited immensely for a quarter of a century. He acknowledges that sometimes he finds difficulty in separating his ideas from Thomasma's because of their close collaboration. They had together developed themes on philosophy of medicine in their different series. In 1983, they developed their most fundamental statement of the philosophical basis of medical practice, which they grounded in a philosophy of the body and mind phenomenologically considered. See Pellegrino, *The philosophy of Medicine Reborn,* 153.

field, moral philosophy remains the guiding discipline.[51] In medicine and its practice, Pellegrino sees the existence of some concepts and terms that demand a philosophical definition of medicine rather than defining it as a knowledge base.[52] It was an attempt to change the mentality of viewing medicine simply from the mere biomedical point of view merely as an empirical science to a mentality that views it as a reflective, theoretical discipline that integrates medicine with medical humanities. Concepts such as health and disease cannot be interpreted without the aid of sound philosophical reasoning. More importantly, the act of the medical profession itself demands more than just technical competence. For a physician to go beyond technique to contemplate the human object of his ministrations, he must turn to the humanities for those meanings which medical science alone cannot give.[53] This implies that good medical care needs more than just a scientific orientation. Pellegrino avers: "Medicine, or more properly healing, is a practical enterprise requiring a fusion of technical competence and moral judgment."[54]

Pellegrino held firmly that there should be a philosophy of medicine from which medical ethics emanates. "His most foundational idea is that the ethics of medicine is inseparable from the philosophy of medicine. In his words, one must know "what medicine is" before one can reasonably begin to think about how health care professionals ought to act or make normative prescriptions about medical care."[55] A significant and exciting confession made by Pellegrino regarding his journey in search for a philosophy for medicine states: "My inquiry into the ends and nature of medicine has inevitably taken me into the terrain of philosophy. I am not a professional philosopher of course, but a philosophically inquisitive physician."[56] The reason for this confession lies in the fact that Pellegrino was not a professional philosopher but a "medical truant,"[57] one whose interest and curiosity led him to philosophize medicine.

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[51] Pellegrino, *The philosophy of Medicine Reborn,* 154.
[52] Ibid, 132.
[53] Pellegrino, *The philosophy of Medicine Reborn*, xiv.
[54] Edmund Pellegrino and David Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), 86.
[55]Sulmasy, *Edmund Pellegrino's Philosophy*, 107.
[56] Pellegrino, *The Philosophy of Medicine Reborn*, xv.
[57] A 'medical truant' as described by Pellegrino is any physician who goes behind technique to contemplate the human object of his ministrations by turning to the humanities for those meanings which medical science alone cannot give. This compulsion makes them "medical truants" or trespassers beyond the bounds of medicine. Pellegrino describes this medical truancy as beneficial and advantageous to physicians in the sense that it is complementary and it gives physicians the great pleasure of seeing ordinary the ordinary phenomena of medicine in new and more profound ways. See Pellegrino, *The Philosophy of Medicine Reborn*, xv-xvi.

Motivated and prompted by his enthusiasm and philosophical curiosity, Pellegrino intended a philosophy of medicine, which will serve as an ethical enterprise that is aimed at the good of the patients not their harm, and which must discern what is right and good, what ought to be done as well as what can be done. A philosophy of medicine that would concentrate on the ethics 'internal' to medicine- to those ethical issues arising in the kind of activity medicine is one based in a healing relationship as well as competence in knowledge and skill appropriate to a healing relationship.[58] As a clinician and a philosopher, Pellegrino devoted his entire professional life to medical issues and the reflection on the philosophy of medicine and medical ethics. Pellegrino dedicated the last decades of his life to bioethics and the philosophical foundation of medicine, achieving spectacular successes in this field. On numerous occasions, he received awards.[59]

Stating his flaming desire to reconstruct a fuller, more universal, and at the same time an integrated theory of medicine, Pellegrino also outlines three major factors which inspired philosophers and physicians to speak seriously of the possibility of the philosophy of medicine as a field of inquiry, either to affirm or deny it. The first interest, according to Pellegrino, "is the mutuality of interest in the subject matter of medicine to which I have already referred. In every era, some physicians wanted to understand the phenomena they observed and the nature of the art they were practicing. In every era, philosophers were fascinated by the need for a deeper understanding of the phenomena that medicine could not afford. To achieve these ends, the critical trans-medical perspective of philosophy has always seemed essential."[60]

The following factors focus on some of the limitations of bioethics in resolving medical dilemmas. Pellegrino writes:

> A second reason for the current interest in the philosophy of medicine is the tremendous emphasis in the last twenty-five years on medical ethics and bioethics. As successive theories of medical ethics have surfaced, it has become apparent that there is a need for a grounding for ethics in something beyond principles, virtues, casuistry, care, hermeneutics, etc. The first step in this grounding would have to be articulating a theory and philosophy of medicine. Such a theory is necessary to put the competing ethical theories into some proper relationship to each other and resolve some of the contradictions between and among them. In short, we need to move from medical ethics or bioethics to a more comprehensive moral philosophy of medicine and the health professions.[61]

[58] Ibid, 41.
[59].Joanna Żołnierz, Jarosław Sak, "The basics of Edmund D. Pellegrino's medical ethics," *Journal of Education, Health and Sport*, 9 (2018):904.
[60] Pellegrino, *What the philosophy of Medicine Is*, 316.
[61] Ibid, 317.

The bottom line of this argument boils down to Pellegrino's position that medical ethics must be inherent in a philosophy of medicine, which serves as a basis for harmony in medical practice.

The last factor is existential seeking for a philosophy of medicine that addresses the vicissitudes of human experience. Pellegrino's words:

> A third factor fostering interest in a philosophy of medicine is the turn to Existential, Hermeneutic, Phenomenological, and Post-Modern approaches to ethics and philosophy. These philosophical perspectives are more open to lived experiences of patient and physician and to the particularities of moral choice, suffering, dying, finitude and compassion. These are phenomena of great interest to philosophers who seek to comprehend them in more concrete ways than is congenial in the analytical mode still dominant in contemporary Anglo–American philosophy. These are also the same phenomena physicians and patients confront experientially every day. Critical reflections on these lived experiences lead naturally to the fundamental and comprehensive grasp that could qualify as a philosophy of medicine. To be sure, a post-modern philosophy of medicine would reject ideologies, emancipatory narratives, and absolutism in favor of a diversity of language and concept. But it still would be a philosophy of medicine.[62]

Similarly, one of the reasons advanced by Tristram and Jotterand for the special receptivity in America in the latter half of the twentieth century to acknowledging a connection between the humanities and medicine is that through a complex set of social developments, American society was secularized and the profession of medicine transformed from a guild to trade, just as medicine became effective, expensive, and productive of significant cultural and significant moral questions.[63] These and many other reasons paved the way for the emergence of a field of philosophy of medicine.

1.2 The Interaction between Philosophy and Medicine

Pellegrino admits that the history of philosophical reflections about medicine is long, complex, and challenging. He admits his inability to possibly do justice to its historical development or to the many versions in which it has appeared in the past and the present. Still, he draws upon some particular themes to illustrate some of the distinctions and definitions.[64] Throughout antiquity, the relation between philosophy and medicine was very close. It is commonly agreed among some western philosophers that from ancient Greece with Hippocrates to the modern era, philosophy has been at the basis of medicine. Moreover, as far as medicine is concerned, it is generally agreed, and indeed obvious, those ancient medical

[62] Pellegrino, *What the philosophy of Medicine Is,* 317
[63] Engehardt Tristram and Fabrice Jotterand, "An Introduction to Edmund D. Pellegrino's Project," in The *Philosophy of Medicine Reborn,* 5.
[64] Cf. Pellegrino, *What the Philosophy of Medicine Is*, 316.

authors, from the Hippocratic writers onwards, heavily relied on philosophers, not just for their views on physiology, but also for their conception of their art and their moral precepts for the doctor. Nevertheless, often they also formed straightforward philosophical ideas of their own. There is a whole tradition of philosophical thought in ancient medicine, particularly concerning the nature of medical knowledge, which is independent of the study of the philosophers and was substantial enough to at times even influence the views of the philosophers.[65]

It is established that the ancient Greeks gave medicine its rational identity by liberating it from its primitive, superstitious, religious and magical traits. According to James Longrigg: "One of the most impressive contributions of the ancient Greeks to Western culture was their invention of rational medicine. The Greeks first developed sound systems of medicine for the most part free from magical and religious elements and based upon natural causes."[66] The significance of this revolutionary innovation of raising medicine to a rational status resulted in a radically new conception of diseases whose causes and symptoms were now accounted for in purely natural terms and not in terms of some mythical, superstitious, magical or religious beliefs and practices.

Pellegrino recalls that philosophers and physicians were not easily distinguishable in ancient Greece. He underlines that Hippocrates grossly overstated the case with his grandiose dictum: '*Iatros philosophus Iso Theos*' (The physician who is a philosopher is like a god).[67] Pellegrino interprets Hippocrates as saying that good medical care needs more than just its scientific orientation.[68] This expresses the strong connection and dialogue between medicine and humanities.

Thus, it is within this humanistic affiliation context of medicine that Pellegrino describes medicine as the most humanistic of all sciences and insists that any physician who goes beyond the technique to contemplate the human object of his ministration must turn to the humanities for those meanings, which the medical science alone cannot give.[69] He admits that it was this compulsion that made many physicians become 'medical truants' trespassers beyond the bounds of medicine.[70]

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[65] Michael Frede, "Philsophy and Medicine in Antiquity," in *Human Nature and Natural Knowledge,* eds. A. Donagan, A. N. Perovich, Jr., and M. V. Wedin (Netherlands: D. Reidel Publishing Company, 1986), 211.
[66] James Longrigg, *Greek Rational Medicine Philosophy and Medicine from Alcmaeon to the Alexandrians* (New York: Routledge, 1993), 1.
[67] Pellegrino, *The Philosophy of Medicine Reborn*, xiii-xiv.
[68] Ibid. xiv.
[69] Ibid.
[70] By "medical truant" Pellegrino refers to the modern term used for a philosophizing non philosopher. A physician who trespass the perimeters of clinical experts which he acclaims himself to be one. See Pellegrino, *The Philosophy of Medicine Reborn,* xiii.

Philosophical reflections about medical matters have a lengthy background. At the beginning of his philosophical reflection on the philosophy of medicine as a field of inquiry, Pellegrino acknowledged that though the area is relatively nascent, philosophical reflections about medical matters are as old as medicine and philosophy. Pellegrino asserts: "In every era, critical thinkers, both in medicine and philosophy, have sought levels of understanding about medicine and its practice not attainable within the purview of the methodology of medicine itself".[71] On this intimate relationship between philosophy and medicine, Tosam Jerome writes: "Beginning with the ancient Greeks, philosophy provided medicine with the methodological and analytical tools to examine issues related to disease and health. In this interactive process, medicine has also provided philosophy with material for philosophical contemplation. Although separate disciplines, each borrows the conceptual resources of the other for resolving problems."[72] This long-standing relationship remains the fertile ground on which Pellegrino based his teleological philosophy of medicine. The interaction between philosophy and medicine in some way provides a forum for philosophy to reflect on medicine.

Philosophy and medicine as distinct disciplines have different outstanding goals, but they both strive in a complementary way to ensure man's welfare in other dimensions. On the goal-oriented centered relationship between philosophy and medicine. Pellegrino writes:

> Any topic examined as part of the philosophy of medicine should start with the realities, phenomena, and data of medicine itself. Such a study would derive from what medicine is as a phenomenon of the real world. In its turn, the philosophy of medicine would help to define what medicine is ontologically and morally. This is a narrower view than the more expansive definitions of philosophy of medicine. Still, it is more suited to the depth and levels of understanding and the reach for ultimacy that characterize philosophical reflection when it is directed to medicine as medicine.[73]

Given the projects of medicine and philosophy, the dialogue between them is inevitable.[74] It shows that medical the profession needs the help of professional philosophers just the same way as it needs the cooperation of basic scientists. Philosophy elevates medicine from the physical to the ontological level of understanding the concepts of disease and healing. The application of profound philosophical thought on medicine and its practices reveals a depth that necessitates exploration before simply following the aims of curing all. Intellectual rigor matched with modern medicine can engage patients and help them make independent, informed decisions and assist physicians in thinking more clearly, analytically, and empathetically.[75]

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[71].E. Pellegrino, *The philosophy of Medicine Reborn*, 23.
[72] Jerome Tosam, "The Role of Philosophy in modern Medicine," *Open Journal of Philosophy* 4, no.1 (2014): 77. http://dx.doi.org/10.4236/ojpp.2014.41011 p
[73] Pellegrino, *The Philosophy of Medicine Reborn*, 39.
[74]Ibid, 42.
[75] Richard Fenton, "What is the Place for Philosophy within the Field of Medicine? A Review of Contemporary Issues in Medical Ethics," *Philos Ethics Humanit Med* 13 no. 16 (2018), https://doi.org/10.1186/s13010-018-0070-3

Both medicine and philosophy meet squarely and fundamentally to understand human condition and nature in its existential modalities and remedy human ills. For Anna-Theresa Tymieniecka and Agazi Evandro, the encounter between philosophy and medicine is "particularly intimate and significant –cooperative and complementary-when it comes to medicine's interpretations of human illness, its symptoms, its causes, its prognosis, and its treatment, and when it comes to philosophy's discovery and pursuit of the rays of human life concerns, man's existential entanglements with other beings, our circumstantial sphere of interdependence, and the moral and spiritual valuation of life and its strivings."[76]

1.3 Four Modes of Philosophical Reflection on Medicine

Pellegrino uniquely propounds that philosophy and medicine interact at four different basic levels. For this season, philosophical reflections on medicine become multi-dimensional. Any attempt to analyze the relationship between philosophy and medicine without considering or perfectly harmonizing the various modes of their interaction may result in ambiguity and contradictions. Thus, Pellegrino claims that to arrive at a distinct and clear understanding of the philosophy of medicine, we must draw a careful distinction between these various modes of interaction between philosophy and medicine.

In pursuing this distinction, Pellegrino proposes, categorizes, compares, contrasts, and distinguishes four models for conducting a philosophical inquiry into medicine. Through his analysis of the different perspectives of interaction between philosophy and medicine, he can arrive at a distinct definition of the philosophy of medicine as distinct from other forms of associations between philosophy and medicine. This project of distinguishing philosophy of medicine from other of philosophy's relation with medicine is unique to Pellegrino's thought. We now proceed to examine the four dimensions of the dialogue between philosophy and medicine as advanced by Pellegrino.

[76] Ana-Theresa Tymieniecka and Agazi Evandro, *Life- Interpretation and the Sense of Illness within the Human Condition: Medicine and Philosophy in Dialogue* (Dordrecht: Kluwer Academic Publishers, 2001), ix.

1.3.1 Philosophy and Medicine

The first mode of philosophical reflection on medicine is an inter-disciplinary approach to the relationship between philosophy and medicine. According to Pellegrino, this model takes the form of a mutual dialogue through which the ancient Greeks enjoyed a long history of mutually beneficial but undiluted interaction. In this mode of philosophizing, philosophy and medicine each retain their identity and enters as a distinct discipline into independent and autonomous dialogue with the other. For example, it can be an effort at identification or compare and contrast the way each field studies the phenomena peculiar to medicine. It can define similarities and differences in subject matter, method, or mutual influences of one on the other.[77] Pellegrino explains this category by citing examples with the Hippocratic writings, which were devoted to establishing the independence of the method of medicine from that of philosophy. According to Pellegrino, the Hippocratic authors' affirm the importance of observation of individual cases and reasoning based on empirical evidence. They repudiate speculation and mainly speculation as practiced by certain philosophers and philosopher-physicians.[78]

Pellegrino provides peculiar instances of the dialogues between philosophy and medicine by referring to the philosophies of Socrates and Plato. They frequently used the medicine as an example of a *techné* practiced within ethical constraints. Plato, at one point, went so far as to liken the physician who was also a philosopher to a god. Galen, who practiced both medicine and philosophy, took this identity relationship seriously in his work. In the Symposium, Plato chides the physician, Eryximachus, for his *technicism*, for his attempt to explain all human existence through his art. Elsewhere, he has Nicias say that physicians should not presume to go beyond knowledge of the nature of health and disease.[79] Pellegrino uses these instances to show how distinct philosophy and medicine dialogued without each losing its identity and how medicine operated without extending its reach into philosophical problems.

On the mutual benefits of this interaction between philosophy and medicine, Pellegrino also presents how in the Hellenic Period, physicians and physician-philosophers drew heavily on the teachings of the major philosophical schools. Pellegrino also appeals to Lester King, who provides a detailed account of how seventeenth and eighteenth-century intelligent systems drew upon medicine theories, especially for their metaphysical and logical content.[80]

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[77] Pellegrino, *What the Philosophy of Medicine Is,* 321.
[78] Ibid.
[79] Ibid.
[80] Ibid, 321-322.

After a lengthy historical review of this kind of relationship between philosophy and medicine, Pellegrino concludes by indicating the shift like their dialogue to the ethical basis for mutual understandings of philosophy and medicine. These ethical aspects play a significant role in Pellegrino's philosophy of medicine, as we shall see subsequently in his medical ethics. He wrote:

> Philosophical reflection on medicine has shifted again, this time to medicine as an ethical enterprise. In the 1960s, philosophers were attracted by the need for a more rigorous and sophisticated analysis of the dilemmas of medical progress than medicine itself afforded. Physicians and philosophers drew on principles and concepts developed in the great ethical traditions – the classical, medieval, Kantian, and Utilitarian. Most recently, as philosophers explored the practical issues, they also uncovered the need for a more substantial grounding for medical ethics than ethical analysis, problems, dilemmas or cases could provide. As a result, inquiry was directed to alternative theories to those based on principles. Ethical theories based on casuistry, philosophies of care, experience, or virtue became prominent. In Europe, more attention was paid than in America, to hermeneutics, phenomenology, narrative, and interpersonal relational theories as they were exemplified in medical ethics and practice.[81]

1.3.2 Philosophy in Medicine

What does Pellegrino mean by Philosophy in medicine? While the first mode that we have just considered above is broader and interdisciplinary, the second category of the relationship between philosophy and medicine refers to the application of specific or recognized branches of philosophy like logic, metaphysics, axiology, ethics, and aesthetics to medical matters. This second mode of philosophical reflection on medicine is limited to and focuses on the philosophical study of the scientific foundations of medicine.[82] The primary goal of this mode of conducting philosophical examination on medicine is said to be devoted to philosophical research of the scientific foundations of medicine. Pellegrino affirms that this is the sense in which most recently reviewed articles and books now interpret the philosophy of medicine. In addition, on this view, theories of medical knowledge or ethics, for example, drawn from existing theories of epistemology or moral philosophy, are applied to medical problems, concepts, or experiences.[83] Medical diagnosis, for example, is examined for its logic, and images of health and disease are analyzed for their ontological or epistemological status.

The most fruitful example of the power of philosophy in medicine given by Pellegrino is the principle-based system of Beauchamp and Childress, whose claims are now being questioned for their lack of foundation on universal fundamental moral philosophy. They have

[81] Pellegrino, *What the Philosophy Medicine Is*, 323.
[82] Pellegrino, *The Philosophy of Medicine Reborn,* 33.
[83] Pellegrino, *What the Philosophy of Medicine Is*, 323.

skillfully and wisely taken four principles of 'the common morality' as prima facie guides to the resolution of practical medical ethical dilemmas.[84] With his belief that principles are essential to any viable ethics of medicine, Pellegrino tried to ground them in a philosophy of medicine, one derived from the clinical phenomena of medicine, itself. In doing so, he hopes to show that there is no essential conflict between philosophy in medicine and philosophy of medicine.[85] In Pellegrino's view, therefore, there is no conflict between the philosophy of medicine and philosophy in medicine.

1.3.3 Medical Philosophy

Pellegrino describes this category as the vaguest and most loosely defined of the current terms. He defines medical philosophy in two ways. The first sense of the definition of medical philosophy refers to any informal reflection on the practice of medicine by physicians on clinical medicine based on their reflections on their own clinical experiences. This might include styles of exercise such as: therapeutic enthusiasm, nihilism, or minimalism; diagnostic enthusiasm which leaves no test unused; diagnostic artistry, which pursues an elegant form of clinical epluchage, selecting just the correct number and kind of tests; then some want to be a friend the patient; those who, on the contrary, feel a certain 'distance' is more conducive to the healing relationship; those who favor formal or informal modes of address or dress, etc. These matters are rarely subjected to legal analysis but are argued as conducive to good or inadequate care of patients.[86] The second aspect of his definition of medical philosophy is based on the clinical wisdom of reflective clinicians that has always been a source of inspiration and practical knowledge for conscientious clinicians. On this second aspect, Pellegrino thinks of the works of William Osler and Francis Peabody, or of Richard Cabot and Lewis Thomas. Their works are not philosophical in any formal sense, but in the more informal, traditional sense of the search for wisdom – in their cases, as that wisdom emerges from reflective and meditative cogitation on years of learning by experience. They are examples of practical wisdom, the kind of reflective understanding beyond empiricism of how to practice a craft with perception contained in the Greek notion of *techné.*[87]

[84] Ibid.
[85] Ibid, 324.
[86] Pellegrino, *The Philosophy of Medicine Reborn,* 34.
[87] Ibid.

1.3.4 Philosophy of Medicine

This model constitutes the most essential and significant aspect of Pellegrino's categorization of the modes of philosophical reflection on medicine. It is the climax of Pellegrino's concept of philosophical reflection on medicine, which he qualifies as a philosophy of medicine. We shall give much attention to this category because it constitutes the foundation of the variables of this dissertation. According to Pellegrino: "The philosophy of medicine consists in a critical reflection on the matter of medicine – on the content, method, concepts, and presuppositions peculiar to medicine as medicine. To this end, the philosophy of medicine, of necessity, must transcend the methods of medicine, that is, the methods of science, clinical observation, and clinical judgment. Its purposes are different than the purposes of medicine *per se.* Philosophy of medicine makes the specific method and matter of medicine the subject of study by philosophy. Philosophy of medicine seeks philosophical knowledge of medicine itself. It seeks to understand what medicine is and what sets it apart from other disciplines, and from philosophy, itself."[88] Pellegrino argues that philosophy and ethics of medicine are not balkanized provinces forcibly detached from the body of philosophy. They remain in dialogue and dialectics with current and accepted theories like principlism, caring, and deontological or virtue theories.[89]

In the same light, Pellegrino argues that the philosophy of medicine possesses the same relationship as the philosophy of other disciplines. He writes: "Philosophy of medicine has the same relationship with philosophy as the philosophies of history, art, law; literature, etc. have to those disciplines. In each case, critical reflection seeks something beyond the content of those disciplines, something beyond the methods of inquiry peculiar to each as a discipline. The philosophy of any discipline is a search for ultimacy, for a grasp of the reality of the things studied beyond what is discernible by the discipline studied."[90] For Pellegrino, the philosophy of medicine is to be distinguished from other relationships between philosophy and medicine. For him, its focus is medicine as a distinctive discipline.

On the one hand, he says that determining such nature of medicine is itself a task of philosophy of medicine; on the other hand, he repeatedly claims that the distinctive feature of medicine is its practical nature, more specifically in the clinical encounter.[91] Philosophy of

[88] Pellegrino, *What the Philosophy of Medicine Is*, 326.
[89] Pellegrino, *The Philosophy* of Medicine Reborn, 53.
[90] Pellegrino, *What the Philosophy of Medicine Is*,, 328
[91]Thomas Schramme, "What is Philosophy of Medicine and Bioethics?" in *Handbook of the Philosophy of Medicine* eds. Schramme Thomas and Edwards Steven (Science+Business Media Dordrecht ebook: Springer, 2017),10.

medicine makes the specific method and matter of medicine the subject of study by the process of philosophy. Philosophy of medicine seeks philosophical knowledge of medicine itself. It aims to understand what medicine is and what sets it apart from other disciplines and from philosophy itself.[92]

The debate over the nature and meaning of medicine, as we have noted earlier, is an ancient and spirited one, which has not been resolved even in modern times but has intensified since the beginning of the twentieth century when the fortunes of medicine were tied to those of the natural sciences. The current debate over the nature of medicine is in terms not so much of art or science but rather in terms of evidence-based or patient-centered medicine. For Pellegrino, a definition of medicine is very instrumental to understanding what constitutes the philosophy of medicine. He argues strongly that it is impossible to define clearly, what constitutes the philosophy of medicine without a definition of medicine, itself. [93] It is absurd to talk about a philosophy of medicine without referring to medicine itself. Pellegrino underlines that any topic examined as part of the philosophy of medicine should start with the realities, phenomena, and data of medicine itself. Such a study will come from what medicine is as a phenomenon of the real world. In its turn, the philosophy of medicine will help to define what medicine is ontologically and morally.[94]

The key to Pellegrino's understanding of the philosophy of medicine is that he believes in a distinctive nature of medicine, *medicine qua-medicine,* which determines its agenda. For Pellegrino, this unique nature of medicine is its practical focus with the related telos of health. He exalts the definition of medicine to more than just being a branch of science, that is, sciences basic to medicine like anatomy, physiology, biochemistry, and defines medicine as a science that embraces activities beyond those inherent in the pursuit of scientific knowledge, a definition that Pellegrino justifies factually and phenomenological in one sense, and by philosophy of medicine in another.[95] In his philosophy of medicine, Pellegrino tries to go beyond the standard definition of medicine that limits medicine to a bio-medical model, which identifies medicine simply as a body of valuable knowledge in the treatment of illness.[96]

Pellegrino sees several limitations in this standard definition of medicine. He traces the first limitation to the fact that such a view: "is flagrantly reductionistic, limiting medicine to biology, chemistry, and physics. Therefore, it suffers from the logical and epistemological

[92] Schramme, *What is Philosophy of Medicine*, 10.
[93] Pellegrino, *What the Philosophy Is*, 326.
[94] Ibid, 328.
[95]Pellegrino, What the Philosophy, 326.
[96] Pellegrino, *The Philosophy of Medicine Reborn*, 127.

deficiencies of all reductionism and commits the error of circuitous reasoning- what we need for the proof is in itself in need of proof by the settlement of the question we are asking. We cannot prove medicine is only biology unless we know first what medicine is- and that is the question."[97] Another limitation of the biomedical definition is "its one-dimensionality, its abnegation of the complexity of illness and therefore, the complexity of healing those who are ill. Since disease and illness have different dimensions, it is hard to see how biology qua biology can be seen satisfactory as an explanatory principle, to say nothing of a therapeutic one."[98]

In his search for the core of the philosophy of medicine: the internal morality and the telos of medicine, Pellegrino holds to a more specific definition of medicine higher than the biomedical model, in his specific definition, he identifies medicine as *medicine qua medicine*. Through this specificity, he grounds his philosophy of medicine in a theory of the healing relationship, namely, the physician-patient relationship.[99] The essence of medicine, according to Pellegrino, is clinical practice and not medical science. This is not a denial of modem medical science, but rather as a reminder that the results of the research and theories of medical science must be put into practice in the clinical encounter between doctor or some other health-care professional and patient and thus, as parts of modem medical practice, are situated in the framework of a meeting between persons or more.[100] The above description of medicine establishes Pellegrino's philosophy of medicine as the product of a direct, explicit engagement with that fundamental question about the nature and ends of discipline as well as a process.[101] Medicine, that is, clinical reasoning, is a *techne* in the classical sense: craftsmanship of healing that involves knowing what to do, how to do it, and why one does it.[102]

Similarly, Beverly Whelton observes that in the phenomenology of the clinical encounter, Pellegrino exposes two activities of doctoring. "The first involves technical, medical content and the objective, empirical methods of science. The second aspect of doctoring is moral. It is a decision and action that is good for this particular patient that is good for the

[97] Ibid, 128.
[98] Ibid.
[99] Ibid, 26.
[100] Fredrik Svenaeus, *The Hermenetics of Medicine and the Phenomenology of Health: Steps towards a Philosophy of Medical Practice, (*Dordrecht: Springer Science+Business Media, 2000), 53.
[101] Daniel F. Davis, "Phronesis, 'Clinical Reasoning, and Pellegrino's Philosophy of Medicine," in *The Influence of Edmund D. Pellegrino's Philosophy of Medicine,* edited by David Thomasma (Dordrecht: Springer, 2011), 175.
[102] Davis, *Phronesis,* 175.

individual both medically, and as a human being." [103] In all this, the compatibility or the complementarity of biomedical medicine and clinical medicine remains inseparable.

In this specific context of understanding medicine as medicine, Pellegrino establishes the subject matter and the central aim of the philosophy of medicine. Its subject matter becomes the problems of clinical and public health medicine that it examines with its perspective, one different from science and even from clinical[104] or public health medicine themselves. Philosophy of medicine seeks to understand the nature and phenomena of the clinical encounter, that is, the interaction between persons needing the help of a specific kind relative to health and other persons who offer to help and are designated by society to help. Philosophy of medicine is concerned with the phenomena peculiar to the human encounter with health, illness, disease, death, and the desire for prevention and healing.[105]

More so, "like a chemical theory of solutions, philosophy of medicine begins in the particularities, in phenomena determined by the kind of activity medicine is, and the phenomena it must consider in pursuit of its healing purposes for individuals and societies. The practice, the ethics, and the social roles of medicine depend on the philosophy of medicine to which we commit ourselves. So, too, do answers to such issues as the ends of medicine and how and by whom they are determined; the dependence or independence of medical ethics vis-à-vis politics, law, or economics; the place of bioethics; the resolution of cross-cultural conflicts in world society, these are the contributions a philosophy of medicine can make to those who use medicine."[106] It becomes clear in Pellegrino's view that there is a subject matter unique to medicine for a philosophy of medicine to address. Philosophy of medicine in this context should not be vague but specific and centered on a unique subject matter that is particular but yet encompassing.

In establishing an argument over the existence of a legitimate field of inquiry called the philosophy of medicine, Pellegrino was preoccupied with questions about whether it can be distinguished from the philosophy of science. He sought to distinguish it from the emerging

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[103] Berverly J.B. Whelton, "Human Life as a Foundation for Ethical HealthCare Decisions: A Synthesis of the Work of E. D. Pellegrino and W. A. Wallace,*" The Linacre Quarterly 69, no. 4, Article 2. Available at:http://epublications.marquette.edu/lnq/vol69/iss4/2*

[104] Pellegrino focuses and lays more emphasis on one of the two aspects of clinical medicine. Clinical practice, which is the activities of diagnosing, treating and preventing disease, as well as promoting health, is one kind. Clinical research is another. Clinical research investigates aspects of diagnoses, treatment and prevention of disease, as well as promotion of health, aspects such as the efficacy of a treatment or improvement of diagnosis. See Paul R. Thompson and Ross E.G. Upshur, *Philosophy of Medicine: An Introduction* (New York: Routledge, 2018), 2.

[105] Pellegrino, *What the Philosophy Is,* 327.

[106] Pellegrino, *What the Philosophy of Medicine Is*, 331.

field of bioethics.[107] In a specific way, Pellegrino defines the philosophy of medicine as a critical reflection on medical issues; he argues, "Philosophical perspectives in medicine are more open to lived experiences of patient and physician and to the particularities of moral choice, suffering, dying, finitude and compassion. Today, the existential, hermeneutics and phenomenological approaches to ethics enable the philosopher to comprehend these medical phenomena in more concrete ways than is congenial in the analytical mode still dominant in contemporary Anglo-American philosophy."[108]

Among the many related issues of a dispute regarding the nature and scope of a philosophy of medicine as a field of inquiry was in particular, the question of how it is derived and by what method of philosophical inquiry it is best pursued. While Stempsey praises Pellegrino for shedding valuable light on the various modes of interaction between philosophy and medicine, he also criticizes Pellegrino for limiting the scope of the philosophy of medicine too much by basing his philosophy of medicine primarily on the foundation of the individual doctor-patient relationship.[109]

In contrast to Pellegrino, Stempsey holds that Medicine encompasses an array of clinical and research activities that ultimately aim at helping the suffering patient. These activities, however, need not necessarily arise from the concrete foundation. Any philosophical reflection, which seeks to analyze the logic of diagnosis, to describe the phenomenology of suffering, or to seek the wisdom required to be a good physician, deserves to be counted as a philosophy of medicine.[110]

One of the central challenges insinuated by Pellegrino at the emergence of the philosophy of medicine as a legitimate field of inquiry was its relation to bioethics and the philosophy of science. He observes: "Only recently, however, has a debate arisen about whether or not there is, or can be, a legitimate field of inquiry called the philosophy of medicine. If there is such a field, in what does it consist? Can it be distinguished from the philosophy of science? What is its relationship to the emerging field of bioethics? Does any practical consequence follow from these distinctions?"[111] Pellegrino was preoccupied with the above-implied challenges that accompanied the emergence of the field of the philosophy of medicine.

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[107] Pellegrino, *The Philosophy of Medicine Reborn,* 23-24
[108] Ibid, 26.
[109] William E. Stempsey, "Philosophy of medicine is what philosophers of medicine Do," *Perspectives in Biology and Medicine* 51, no. 3 (2008):383, DOI: 10.1353/pbm.0.0021
[110] Stempsey, *Philosophy of medicine,* 383.
[111] Pellegrino, *The Philosophy of Medicine Reborn,* 23-24.

Philosophy of medicine is a subject that has been around since the beginning of medicine but has only relatively recently, roughly in the last 40 years, been professionally developed into a discipline in its own right. It has gained a more robust status in relation to medical ethics or bioethics, which focuses on moral issues in medicine, whereas the philosophy of medicine has a broader and less applied remit, addressing metaphysical, epistemological, and other philosophical issues in medicine. There are now dedicated societies and academic centers dealing with different topics in the philosophy of medicine.[112]

Regarding the existence of a philosophy of medicine, Pellegrino affirms: "We both believe, contra Caplan that, there is a legitimate field of philosophical inquiry properly termed: Philosophy of medicine." Indeed, we also agree that the criteria demanded legitimacy by Caplan in 1992 have been fulfilled. Finally, we agree that bioethics today needs a philosophy of medicine, and many of bioethics' most fundamental questions are unresolvable without such a philosophy.[113]

The methods employed by Pellegrino as appropriate for his project are the convergence of classical and medieval philosophy, enriched by some elements of a realist phenomenology.[114] His approach was founded upon a strong sense of realism about the disease and human beings. David Thomasma identifies three methods adopted by Pellegrino in his philosophy of medicine: analytical, realistic, and practical. Thomas explains:

> It is analytical since it starts with the experiences of the clinical setting by emphasizing the doctor-patient relationship and employs modes of analysis closely paralleling clinical reasoning. It is realistic in tone; references are to the realists like Aristotle and Dewey. The phenomenologists are used for their descriptive methods and insights without accepting the ontology accompanying these methods. It is also realistic because it employs the Aristotelian analysis method in a search through a dialectic of other views for the constitutive elements of a discipline of philosophy of medicine. It is practical because, from the start, the philosophy of medicine must make a difference in human conduct and medical education.[115]

Pellegrino combines these three methods in his philosophy of medicine because the clinical encounter, which is the research subject being investigated by the philosophy of medicine, consists of multiple facets. There are various dimensions to this central act of medicine that cannot be adequately examined by just one philosophical method. For these reasons, the investigator must be willing to use whatever philosophical approach or combination of procedures that fit the unique aspect of the problem at hand.[116]

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[112]Thomas Schramme and Steven Edwards, Handbook *of the philosophy of medicine*, (Dordrecht ebook: Springer, 2017), v.
[113] Pellegrino, *The Philosophy of Medicine Reborn,* 49.
[114]Ibid, xv.
[115] Thomasma, *Establishing*, 247.
[116] Robert Lyman Potter, "The Current Trends in the Philosophy of Medicine," *Zygon* 26, no. 2 (1991),268.

1.4 The Question about the Existence of a Philosophy of Medicine

Pellegrino deals with the question about the existence of a philosophy of medicine by categorically stating that "there is a defensible and legitimate field of philosophical inquiry that can be termed properly the philosophy of medicine, that it can be distinguished from other forms of philosophical reflection about medicine, and that the distinctions are of more than heuristic value". [117] In agreement with Wildes, Pellegrino declares: "We both believe, contra Caplan that, there is a legitimate field of philosophical enquiry properly termed: Philosophy of medicine."[118] Furthermore: "Indeed we also agree that the criteria demanded legitimacy by Caplan in 1992 have been fulfilled.[119] Finally, we agree that bioethics today needs a philosophy of medicine as many of bioethics' most fundamental questions are unresolvable without such a philosophy."[120] In the above declaration, Pellegrino responded to the challenging question on the requirements needed for recognizing philosophy of medicine as a legitimate field of inquiry.

The question of the strong relationship between philosophy and medicine resulted in controversy over what the field should be tagged or the name ascribed to it. Should that relationship be philosophy and medicine or philosophy in medicine or philosophy of medicine or medical philosophy? This dilemma of the specificity of the field remained a central agenda of discussion on this subject matter. In a roundtable discussion held at the first trans-disciplinary symposium on philosophy and medicine in 1974,[121] Jerome Shaffer, who in his doubt of the validity of the relationship or interface between medicine and philosophy, expressed his misgivings saying: "I wish to raise some doubts about the validity and value of the Philosophy of Medicine. I am inclined to think that there are medical problems and there are philosophical problems, with no overlap or borderline area between them, no field which

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[117] Pellegrino, *The Philosophy of Medicine Reborn,* 24.
[118] Ibid, 49.
[119] One of the strongest attacks on the existence of the philosophy of medicine came from Caplan who after having studied for decades, a great deal of literature and witnessed teachings and professional activities carried out explicitly in the name of the philosophy of medicine. He vigorously argued against its existence by highlighting that for it to be recognized as a field, it must meet the demands of being defined as a field. Caplan demanded that it must meet the criteria that qualify or confer the status of a field, sub-specialty or topical area on a particular area of inquiry. Caplan advanced the following three provisions that need to be fulfilled before a philosophy of medicine can be conferred the status of a field. Caplan argues that for philosophy of medicine to be qualified a field, its subject must be integrated into cognate areas of inquiry. It requires a canon. That is, a set of core readings, articles, books and case studies, which are taught to those wishing to enter the field, and cited by those who see themselves as working collegially in the field. Finally, to be a field an inquiry, philosophy of medicine ought to have certain problems, puzzles and intellectual challenges that define its boundaries. See Arthur L. Caplan, "Does Philosophy of Medicine Exist?" *Theoretical Medicine,* 13 (1992): 67-77.
[120] Pellegrino, *The Philosophy of Medicine Reborn*, 49.
[121] The first trans-disciplinary symposium on philosophy and medicine was held at Galveston, May 9-11, 1974 but its proceedings were published in 1975.

could be called medico-philosophy or philosophy-medicine on the analogy with bio-chemistry or astrophysics."[122]

In response to Shaffer's doubt about the validity and value of the philosophy of medicine, Edmund Pellegrino rebuked Shaffer by saying that to deny a relationship or interface between philosophy and medicine, Shaffer has of course, "philosophized about medicine - what it is, and how it relates to the other sciences, as well as making assumptions about the nature of man. He has, in fact, exhibited some elements of a philosophy of medicine - even in the process of denying its possibility. But even his *via negativa* is useful and essential to the question of a philosophy of medicine - for it illustrates one of how we may regard medicine ontologically."[123]

1.5 Bioethics versus Philosophy of Medicine

Discussions and debates surrounding bioethics and the medical humanities, especially about their emergence in the latter part of the twentieth century, cannot be understood without referring to the works of Pellegrino, who in a positive and influential way shaped the character of these fields. Pellegrino was preoccupied with the question of the identities, methodologies, foundations, and justification of the areas of bioethics and philosophy of medicine.

Hence, he attempts a fast distinction: "Philosophy of medicine is a subject that has been around since the beginning of medicine but has only fairly recently, roughly in the last 40 years, been professionally developed into a discipline in its own right. It has gained a stronger status concerning medical ethics or bioethics, which focuses on moral issues in medicine. In contrast, the philosophy of medicine has a broader scope, addressing metaphysical, epistemological, and other philosophical issues in medicine. There are now dedicated societies and academic centers dealing with different topics in philosophy of medicine."[124]

Pellegrino defines bioethics as: "The systematic study of the moral issues arising in the application of the biological knowledge to human affairs from agriculture and ecology to medicine and public policy. Implied in this definition are the search for the moral truth and

[122] Jerome Shaffer, 'Round Table', in *Philosophy and Medicine: Evaluation and Explanation in the Biomedical Sciences,* eds., Tristram H.Engelhardt and Stuart F. Spicker (Holland: Dordrecht-Reidel Publishing Company, 1975), 218.
[123] Edmund Pellegrino, 'Round Table,' in *Philosophy and Medicine: Evaluation and Explanation in the Biomedical Sciences,* eds., Tristram H.Engelhardt and Stuart F. Spicker (Holland: Dordrecht-Reidel Publishing Company, 1975), 231.
[124] Schramme and Edwards, *Hand Book of Philosophy of Medicine*, v.

generalized normative guidelines that have for so long characterized the ethical enterprise."[125] Bioethics is criticized on this perspective as being a mere application of moral theories and principles.[126] The term 'bioethics' was coined in the early 1970s by biologists who brought to the public's attention two pressing issues: the need to maintain the planet's ecology, on which all life depends, and the implications of advances in the life sciences and toward manipulating human nature.[127] At its inception, the central issues in bioethics were researched with human subjects, genetics, organ transplantation, death and dying reproduction, and other related matters. Nevertheless, today it has a wide range of theoretical approaches in normative ethics, including utilitarianism, deontology, pragmatism, virtue ethics and feminist ethics.[128] In this, we see that bioethics is connected to the philosophy of medicine regarding the normative issues that it confronts.

As regards the relationship between medical ethics and bioethics, Pellegrino states: "Medical ethics and bioethics, the ancient and the modern, need each other."[129] He agrees that bioethics connotes a broad field of inquiry but contends that, within that field, philosophy has a special place. Philosophical ethics certainly must be in dialogue with all the other pertinent disciplines, but it cannot and should not be subsumed or replaced by them.[130] The influence of Pellegrino's presence, his presentations, and his scholarship framed a broader appreciation of bioethics. In addition to relocating bioethics in a broader context, Pellegrino helped layout its roots in foundational issues within the philosophy of medicine. He achieved this through his role as the founding editor of the Journal of Medicine and Philosophy, a journal he directed to placing bioethics within the reflections of philosophy of medicine.[131]

Similarly, Caplan opines that the philosophy of medicine is not to be equated or confused with the field of bioethics. For him, medical ethics, bioethics, health policy, and medical aesthetics are all examples of philosophy and medicine, which he defines as "the study of the epistemological, metaphysical and methodological dimensions of medicine; therapeutic and experimental; diagnostic, therapeutic, and palliative."[132] In this case, philosophy of

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[125] Pellegrino, *The Philosophy of Medicine Reborn* , 376.
[126] Henk Ten Have, "Images of Man in Philosophy of Medicine," in *Advances in Bioethics: Critical Reflection on Medical Ethics,* vol.4, ed. Martyn Evan (London: Jai Press Inc., 1998), 175.
[127] Bonnie Steinbock, *The Oxford Handbook of Bioethics*, (New York: Oxford University press, 2007),3.
[128] Steinbock, *The oxford Handbook of Bioethics*, 4.
[129] Edmund Pellegrino, "Medical Ethics in an Era of Bioethics," *Theor Med Bioeth (*Springer Science Business Media B.V. , 2012), 33:21–24, DOI 10.1007/s11017-012-9209-1
[130] Edmund Pellegrino, "Bioethics as an Interdisciplinary Enterprise: Where Does Ethics Fit in the Mosaic of Disciplines?" in Ronald A.Carson and Chester R. Burns (Eds.)*Philosophy of Medicine and Bioethics, A twenty-year Retrospective and critical appraisal* (New York: Kluwer Academic Publishers,2002),3 .
[131] Tristram and Jotterand, *An Introduction*, 4.
[132] Arthur L. Caplan, "Does Philosophy of Medicine Exist?", *Theoretical Medicine,* 13 (1992): 69.

medicine should provide an essential foundation for bioethics; it should provide insights into some key problems in the philosophy of science, such as the nature of explanation and theory of evolution, and ought to shape the goals as well as the methods used in both experimentation and research in medicine and health sciences.[133]

George Khushf considers as a core problem within the philosophy of medicine, namely, the concepts of health and disease, to argue that the resolution we give to these problems conditions the understanding we will have of the scope and task of bioethics and the philosophy of medicine, as well as the relation between these two disciplines. Concepts of health and disease would appear to be central to medicine, and they have indeed been a primary focus of the philosophy of medicine.[134]

More on the relationship between philosophy of medicine and bioethics, Schramme remarks:

> Although ethics is a part of philosophy, it is sometimes equated with moral philosophy – and although bioethics is obviously closely related to medicine, bioethics is arguably not a part philosophy of medicine. Philosophy of medicine is distinctive in focusing on conceptual, methodological, axiological, epistemological, metaphysical, and other philosophical issues regarding medicine from a theoretical point of view, i.e., in order to analyze, understand, or explain aspects of the theory and practice of medicine. Bioethics, in contrast, discusses normative problems in medicine from a practical point of view, i.e., in order to provide guidance as to how people should act. Philosophy of medicine and bioethics are here delineated by distinguishing between a theoretical and a practical perspective or stance, not by their scope. Both might focus on theoretical and practical issues in medicine, for instance, they might address medical research aimed at gaining knowledge about the functioning of organisms (an issue regarding the theory of medicine), or they might be concerned with the clinical encounter between patient and doctor (a problem regarding the practice of medicine), but they do this with different aims. Put briefly and somewhat crudely, philosophy of medicine aims at analysis, whereas bioethics aims at guidance.[135]

Bioethics is considered an autonomous discipline; its aim is to solve complex dilemmas in health care.[136] Schrame argues further by noting that for someone to say that philosophy of medicine and bioethics are different fields of study does not mean there is no connection between them. For instance, to discuss the ethics of organ transplantation, one needs a clear understanding of the concept of death. To analyze this concept is a task for the philosophy of medicine. To distinguish between bioethics and philosophy of medicine also does not imply

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[133] Caplan*, Does Philosophy*, 67.

[134] George Khushf, "Why Bioethics Needs the Philosophy of Medicine: Some Implications of Reflection on Concepts of health and disease," in *The Influence of Edmund D. Pellegrino's Philosophy of Medicine,* ed. David Thomasma (Dordrecht: Springer Science+Business Media Dordrecht, 1997), 145.

[135] Schramme, *What is Philosophy of Medicine*, 4.

[136] Henk Ten Have, "From Synthesis and System to Morals and Procedure: The Development of Philosophy of Medicine," in *Philosophy of Medicine and Bioethics, A twenty-year Retropestive and critical appraisal* eds*.,* Ronald A.Carson and Chester R. Burns (New York: Kluwer Academic Publishers, 2002), 105.

that there are no issues regarding value or morality in the philosophy of medicine.[137] As already stated, the philosophy of medicine analyzes concepts such as health, disease, or care, and it tries to identify the values and norms underlying medicine. In addition, it deals with epistemological questions, for instance, regarding the status of clinical judgment and the methods of gaining medical knowledge. It implies that to be a bioethicist; one needs some acquaintance with the philosophy of medicine. To do the philosophy of medicine properly, one needs some knowledge of the ethical problems in medicine.

Pellegrino explicitly excludes biomedical ethics from the philosophy of medicine. He also describes as an essential part of the philosophy of medicine a practical component, the clinical encounter. This functional element is crucial, according to Pellegrino, because of its unique feature, in contrast to, say, biology. In contrast to natural sciences, medicine here aims, namely, the health or healing of living beings. The personal relationship between doctor and patient in pursuing this aim turns the medicine into a value-laden and moral activity. Hence, medicine cannot be reduced to other sciences, for instance, to a mix of biology and psychology.[138]

There are equally some related misunderstandings regarding the relationship between philosophy of medicine and philosophy of science. Some scholars tend to regard these phases of philosophy as overlapping. In distinguishing philosophy of medicine from the philosophy of science, Pellegrino discards philosophy of science's definition of medicine as merely a branch of science by defining medicine like that which embraces activities beyond those inherent in the pursuit of scientific knowledge. In this way, philosophy of medicine becomes a separate and separable entity from the philosophy of science.[139]

Thus, the difference between philosophy and sciences is that philosophy studies reality in its most profound and most radical aspect and seeks its ultimate causes, while particular sciences study specific aspects of reality and seek more immediate and proximate causes. This applies to both the natural sciences like biology, physics, and chemistry and psychology. These sciences limit themselves to their level of research, but philosophy studies all reality in general and tries to discover the ultimate explanation of its very being.[140] It is within this sort of distinction that Pellegrino elevates the definition of medicine. Pellegrino does not elevate medicine above science but elevates medicine's purpose within a philosophical context as

[137] Schramme, *What is Philosophy of medicine*, 4.
[138] Ibid, 8.
[139] Cf., Pellegrino, *What The Philosophy of Medicine Is*, 236.
[140] Maurice M. Makumba, *Introduction to Philosophy*, (Nairobi: St Paul Communications, 2005), 35.

seeking the ultimate meaning and understanding of medicine, which he captures in his phenomenology of the clinical encounter.

In this elevation, medicine is understood in a higher dimension than it is in the philosophy of science. Pellegrino specifies that this elevation of medicine is only possible within the confines of the theory of the healing relationship between the physician and the sick person:

> Medicine qua medicine comes into existence in the clinical encounter or in public health when the knowledge of the sciences basic to medicine is employed for a specific end, i.e., for the cure, containment, amelioration, or prevention of human illness in individuals or in human societies. Not just the ends and purposes of the sciences, therefore, shape medicine qua medicine. Medicine uses scientific knowledge for its own specific ends, which are healing, helping, curing, and preventing illness and disease and promoting health, i.e., the optimum well-functioning of the whole human organism or human society. Pursuing those ends with individual patients and families is the enterprise of clinical medicine; pursuing them with communities and societies is the enterprise of public health or social medicine. Philosophy of medicine as medicine, then, has as its subject matter the problems of clinical and public health medicine that it examines with its own perspective – one different from the perspective of science and even from clinical or public health medicine, themselves. Philosophy of medicine seeks to understand the nature and phenomena of the clinical encounter, i.e., the interaction between persons needing help of a specific kind relative to health and other persons who offer to help and are designated by society to help.[141]

Medicine is both a science and an art; it has theoretical as well as practical aspects. It is different from many other sciences in its interpersonal aspects, the encounter between patient and clinical personnel. Hence, there are accordingly philosophical aspects of medicine that are not usually found in other areas of philosophy of science.[142] The key to Pellegrino's understanding of the philosophy of medicine is that he believes in a distinctive nature of medicine, 'medicine-qua-medicine,' that determines its agenda. For Pellegrino, this unique nature of medicine is its practical focus with the related *telos* of health.[143]

Reiss Julian and Rachel Ankeny argue that philosophy of medicine serves as a foundation to both bioethics and philosophy of science, which occupies a special place in the philosophy of medicine. They substantiate this claim by outlining that bioethics analyzes fundamental components such as concepts of disease that frequently arise in medicine. Philosophy of medicine also makes significant contributions to the general philosophy of science, particularly to understandings of explanation, causation, and experimentation and debates over applications of scientific knowledge. Finally, the philosophy of medicine contributes immensely to discussions on methods and goals within both research and practice

[141] Pellegrino, *What the Philosophy of Medicine Is*, 327.
[142] Schramme*, What is Philosophy of Medicine*, 5.
[143] Ibid, 9.

in the medical and health sciences.[144] The relationship between these areas of academic activities does not contradict each other. Instead, they contribute to a better understanding of the related issues that rotate within them.

1.6 Medicine as Teleological

Pellegrino has been described as a prominent philosopher of medicine who argued the case for intrinsic goals of medicine.[145] One most distinctive features in Pellegrino's philosophy and ethics of medicine is its teleological structure. A structure that provides a rich presentation of Pellegrino's thought and its development. His concept of medicine as teleological remains the pillar or the nucleus that gives meaning to his philosophy. It serves as a foundation from which derives every one of his arguments on the nature of medicine.

Hence, the key to Pellegrino's understanding of the philosophy of medicine is that he believes in a distinctive nature of medicine as an end or goal-oriented. Through the teleological model of his view of medicine, Pellegrino presents an alternative approach to the biomedical model by defining medicine in terms of the ends, purposes and the terminus towards which medicine is directed as a humanity. His teleological theory of medicine is grounded in the nature and ends of medicine as a special kind of human activity. Moreover, the future becomes the determining principle that defines what kind of knowledge medicine needs.[146] Convinced that there exists a telos that defines the art of medicine, Pellegrino builds philosophy of medicine as a healing relationship, oriented to the end of a right and good healing action for the individual patient.[147] In this teleological terrain, the telos of medicine which Pellegrino identifies as the healing or the good of the patient is the essence of medicine and the goal to which all medical activities are directed. For him, "defining medicine by its end is more philosophically sound than defining it as a knowledge base."[148]

As a philosopher-clinician, Pellegrino declares that his primary aim was "to search for a moral philosophy of medicine based in the nature of medicine. Without this, medical ethics becomes what social convention, politics, economics, or sheer pragmatics make it. Given its

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[144] Reiss, Julian and Rachel A. Ankeny, "Philosophy of Medicine," *The Stanford Encyclopedia of Philosophy* (Summer 2016 Edition), Edward N. Zalta (ed.), URL = <https://plato.stanford.edu/archives/sum2016/entries/medicine/>.
[145] Schramme, *The Goals of Medicine*, 122.
[146] Pellegrino, *The Philosophy of Medicine Reborn*, 130.
[147] Davis Daniel F., "Phronesis, Clinical Reasoning, and Pellegrino's Philosophy of Medicine," In David *The Influence of Edmund D. Pellegrino's Philosophy of Medicine*, ed. David Thomasma (Dordrecht: Springer Science+Business Media, 1997), 195.
[148] Pellegrino, *The Philosophy of Medicine Reborn,* 132.

enormous power for good and evil, medical ethics cannot serve the personal and common good without clarity about its ends and purpose".[149] Referring to his work with David Thomasma, Pellegrino writes, "our philosophy of medicine, and hence the ethics we derive from it, is teleologically structured. It is derived *a posteriori* from the universal realities of the clinical encounter, i.e., healing, helping, caring, and health."[150]

To resolve the contemporary confusion about the nature and ends of medicine, Pellegrino proposes, "a teleological-based ethic of medicine is the only one tenable basis for an ethic of the healing profession as a whole in an era of widespread moral and social pluralism like ours. It is also the only basis for moral authority. The authority derives from an understanding of the ends and purposes for which health professions are established."[151] In Pellegrino's view, the primary cause of the contemporary crisis in the medical profession is the erosion of the teleological ethic that has occurred through the history of philosophy. The only plausible remedy is its re-engagement.

Advocating for the teleological basis of medicine as a yielding catalyst for trashing the modern confusion on the nature of medicine, Pellegrino argues strongly for a return to the Aristotelian and Thomistic teleological ethics as the perfect solution for the modern crisis in understanding the meaning of medicine. He opines: "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. If the end of medicine is to be redefined, the ancient concept of ends must first be retrieved from exile by modern and contemporary philosophy."[152] Pellegrino believes that if the ends of medicine could be discerned, then the good of medical relationships would be known. The virtues of the practitioner could be grounded in this good, and the other obligations of professional ethics could be defined.[153] It is this reason that calls for a serious re-engagement of contemporary philosophy with the Aristotlean-Thomistic synthesis, especially in ethics and moral philosophy. It is evident and vivid that classical and medieval teleological ethics served as a theoretical framework for Pellegrino's end-oriented structure of philosophy and ethics of medicine.

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[149] Ibid, xv.
[150] Edmund Pellegrino, "Praxis As a Keystone for the Philosophy and Professional Ethics of Medicine: the Need for an Arch Support: Commentary on Toulmin and Wartofsky," in *Philosophy of Medicine and Bioethics, A twenty-year Retropestive and critical appraisal* eds., Ronald A.Carson and Chester R. Burns (New York: Kluwer Academic Publishers,2002),76.
[151] Pellegrino, *The Philosophy of Medicine Reborn, 53.*
[152] Pellegrino, "The 'Telos' of Medicine and the Good of the Patient," in *Clinical Bioethics A Search for the Foundation , International Library of Ethics, Law, and the New Medicine* edited by Corrado Viafora , (Netherlands: Springer, 2005), 23.
[153] Pellegrino, *The Philosophy of Medicine Reborn*, 171.

He repeatedly admits that his vision of medicine as teleological is rooted in classical and medieval traditions. He explains: "Our approach here is teleological in the Aristotelian and Thomistic sense, relating virtues of medicine as a practice to the ends of medicine."[154] Pellegrino illuminates not only those conditions, problems, and the imperatives of the process and discipline of the philosophy medicine that are profoundly resonant with the themes of the classical tradition but with Aristotle's description of the epistemology, ontology, and teleology of the moral situation, the situation demanding the exercise of *phronesis* by the agent who wishes to achieve the humanly possible good in that situation.[155] We shall talk more about *phronesis* as an indispensable virtue in medical practice.

The term teleological can be understood based on the different senses of its usage. In a classical-medieval sense as distinct from utilitarian and deontological sense, Pellegrino clarifies his use of the term saying: "It is necessary to clarify my use of the term 'teleological ethics.' By this, I do not mean any form of consequentialism or its major expression in utilitarianism. Nor do I mean a simplistic biological teleologism. Rather, I refer to an ethic based in the notion of the good as the end of moral acts wherein 'good' is defined in terms of the nature of the activity in question, that for which the activity exists. Such an ethic is the antithesis of an ethic of social construction in which the good is defined externally to the activity in question by what we wish or intend the activity to achieve."[156]

Aristotle and Aquinas 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. In its ultimate sense, that end 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 fulfillment of the spiritual nature of humans.[157] Both Aristotle and Aquinas anchored the integrity in the ends of human life and the good. Thus, they linked metaphysics with ethics. The virtues became habitual dispositions to act in such a fashion that the end of human life, the good, that to which it tended by its very nature, could be attained. Both Aristotle and Aquinas used medicine as an example of 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 end of medicine as health, that toward which the activity of medicine tended, that which made it what it was and which distinguished it from other human activities.[158]

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[154] Pellegrino and Thomasma, *The Virtues,* xii.
[155] Davis, *Phronesis,* 196.
[156] Pellegrino, *The Telos of Medicine,* 23.
[157] Ibid, 23-24.
[158] Ibid, 24.

Aristotle is commonly considered the inventor of teleology, although the exact term 'teleology' originated in the eighteenth century. If teleology means the use of ends and goals in natural science, then Aristotle should be regarded as a critical innovator of teleological explanation. Teleological notions were widespread among his predecessors, but Aristotle rejected their conception of extrinsic causes such as mind or god as the primary causes for natural things. Aristotle's radical alternative was to assert nature itself as an internal principle of change and an end. His teleological explanations focus on the internal and intrinsic ends of natural substances—those ends that benefit the natural thing itself.[159] Aristotle's ethics is teleological; for Aristotle, the concept of human nature is goal-oriented. The basic idea is that human nature is not just, whatever people happen, on average, to be. It is not automatic but characterized by an end or a goal (*Telos*). It is the built-in goal.[160]

The central point in the Aristotelian teleology as established is that every rational activity aims at some end or good. In other words, there is always a reason for all our actions. Ethics and politics are concerned with what we should do. If we do something (as distinct from having something happen to us or from a piece of purely reflex behavior), we do it for a reason.[161] His masterpiece, *Nichomechean Ethics*[162], opens its first chapter in describing the object of life, the nature of the highest good for man. According to him:

> Every art and every investigation, and similarly every action and pursuit, is considered to aim at some good. Hence, the good has been rightly defined as 'that which all things aim'. Clearly, however, there is some difference between the ends at which they aim: some activities and others result distinct from the activities. Where there are ends distinct from the actions, the results are by nature superior to the activities. Since there are many actions, arts and sciences, it follows that their ends are many too- the end of medical science is health; of military science, victory, of economic science, wealth. In the case of all skills of this kind that come under a single faculty-as a sill in making bridles or any other of a horse's trappings comes under the horsemanship, while this and every different kind of military science, so in the same way other skills are subordinate to yet others- in all these ends of the directive arts are to be preferred in every case to those of the subordinate ones, because it is for the sake of the former that the latter are pursued also.[163]

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[159] Monte Ransome Johnson, *Aristotle on Teleology* (New York: Oxford, 2005), 8.
[160] Robbert B. Kruschwitz and Robbert C. Robberts, *The Virtues, Contemporary Essays on Moral character,* (California: Wadsworth Publishing Company, 1987),10.
[161] Gerard J. Hughes, *The Routledge Guidebook to Aristotle's Nicomachean Ethics* (New York: Routledge, 2013), 12.
[162] Aristotle explains teleology in connection to rational activities as against mechaniscism. In this book, Aristotle concentrates on the end or goal of human life; he argues that human life aims at *eudaimonia*, which means flourishing or well-being. It is taken as a given, already established in his physics, that all living things strive towards some end; humans are no exception to this law of nature. For Aristotle, nature is purposive and the ultimate purpose is the good of the natural substances themselves. For example, the person who walks for health; that is the end and this end is better for the person than the contrary of health. Opposed to this type of explanation is the way we view rain. We do not claim that rain falls for a better or because it is better; rather the rainfalls because it must i.e. it is necessary. The matter demands that rains falls. Upon being heated, water evaporates and rises. As it rises, it cools, turns to water and falls. This is not purposive behavior; rather, it is a clear example of mechanical necessity. It is a coincidence that the corn grows after the rainfall; this is not a goal or end of the rain falling. See John A. Vella, *Aristotle*, *A guide for the Perplexed* (London: Contiuum, 2008), 81.
[163] Aristotle, *Nicomachean Ethics*, 1094a 1-15.

Distinctively teleological in his approach, Aristotle underlines that various bodies of knowledge or practical sciences are structured toward identifiable good, goal or ends as our reasons for individual actions are as well. Humans are the origin of choice and intentional and deliberate action. This follows from the fact that choice involves reasoning, intention, and desire, and only humans use the rational faculty to modify their desires with thought. Humans are the only animals capable of deliberation. That is to say, only humans are capable of rationally modifying their yearnings, of deliberating about the best means to achieve their desires, and hence of intentionally pursuing their ends. In some cases, the ends of human actions are so important and so common that humans have established techniques (skills, crafts, arts) and lines of inquiry that aim at those ends.[164]

Teleological ethics, that is, ethics as encountered in Aristotle's *Nichomachean Ethic,* because of its teleological structure, provides a natural basis for developing an ethical theory of professional roles in which character traits that count as virtues in everyday life are determined by their connections with *eudaimonia,* the overarching goal of a good human life. Virtues in the context of professional roles can be derived through a similar teleological structure.[165] It is from Aristotle's ethical writings that virtue ethicists acquired various positions, interests, distinctions, and concepts, which were all quite alien to modern analytical philosophy until virtue ethics, became established. After 25 centuries, Aristotle's influence on our society's moral thinking remains profound, and his beautiful ideas continue to be significant to contemporary debates in philosophical ethics.

Like Pellegrino, Macintyre, in his best-known work, *After Virtue*, sees an erosion of the elements of Aristotle's teleological ethics. Macintyre lamented that the contemporary moral decay and disorder, the collapse of tradition, culture, and the Western virtues arose due to the disengagement in Aristotelian teleological ethics. He wrote: "Some large degree in the practice-of morality today is in a state of grave disorder. A society in which the belief in Aristotelian teleology was discredited".[166]

Amidst the divisions and fragmentations of contemporary moral theory, MacIntyre proposes a return to Aristotelian teleological virtue ethics as the way forward. According to him: "the Aristotelian tradition can be restated in a way that restores intelligibility and

[164] Johnson, *Aristotle on Teleology*, 212-213.
[165] Justin Oakley and Dean Cocking*, Virtue Ethics and Professional Roles* (New York: Cambridge University Press, 2003), 205.
[166] Alasdair MacIntyre, *After virtue*: *A study in Moral Theory,* Third edition, (Notre Dame: University of Notre Dame Press 2007), 264.

rationality to our moral and social attitudes and commitments."[167] Macintyre strongly believes that the Aristotelian teleological ethics, which constitutes virtue ethics –the study of moral character- is a critical key for moral formation and building a just and morally sound society. He defined virtue as: "an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such goods"[168] The goal of a discipline or a profession in this context is the icon for determining the morality of that profession.

1.7 Ends and Goals of medical practice

The question about the nature of the goals that define professional practice seems a crucial one, in particular for medical training, since the ethics of medicine depends on the values that are considered the proper ones for it as a practice. Those values depend on the goals defining the medical practice.[169] Pellegrino's discussion on the purposes of medicine relies on his teleological conception of medicine. One way to determine the goals of medicine is by interpreting it as a practice, which is structured by aiming in a specific direction. This is a traditional idea that goes back at least to ancient philosophy. In a teleological approach, the telos, or the end of practice, determines the good for which it is practiced.[170] The teleological theory of medicine serves as a fertile ground on which Pellegrino identifies and discusses the specific medical practice goals. By building on the Aristotelian Thomistic essentialism,[171] Pellegrino has argued the case for the intrinsic purposes of medicine. He proposes a teleological account of this argument, as we have seen above. He claims: "We must assert the obvious: medicine exists because humans become sick. It is an activity conceived to attain the overall end of coping with disordered health's individual and social experience. Its end is to heal, help,

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[167] Ibid, 259.
[168] Ibid, 161.
[169] Roberto Mordacci, "Medicine As a Practice" in *Clinical Bioethics: A Search for the Foundations* ed. Corrado Viafora *(*Netherlands: springer, 2005), 109.
[170] Schramme, *The Goals of Medicine,* 124.
[171] The uniqueness of Pellegrino's concept of medicine is its inherent derivation of its meaning from the nature of medicine itself that he expressed in his essentialist definition of the goals and ends of medicine. "The essentialist approach to the goals and ends of medicine is grounded in the nature of medicine, in what set it apart from other activities as an enterprise of special kind, and defines it as something in the real world independent of the construction the society might put upon that reality. This approach is based in a real definition, a grasp of some extra mental reality from which we abstract that which makes a thing what it is and separates it from all other characteristics it possesses: its so-called accidents or that which is not crucial to what a thing is". See Pellegrino, *The philosophy of Medicine Reborn,* 135.

care, and cure, to prevent illness, and cultivate health."[172] His conception that medicine has an essence finds its justification in the essentialist approach to the theory of medicine. For Pellegrino, "the ends of medicine are as old as medicine itself. They define medicine. They are its essence."[173] It becomes evident from Pellegrino's argument that healing is the essence of medicine and, indeed in the same vein, its genuine identity.

The good of the patient, which Pellegrino identifies, is reflected in the aims of medicine, which formed "the core Hippocratic objective."[174] According to him: "Briefly, the ends of medicine are ultimately the restoration or improvement of health and, more proximately, to heal, that is, to cure illness and disease or, when this is not possible, to care for and help the patient to live with residual pain, discomfort, or disability."[175] Furthermore, he underlines that these aims are not automatic, though they are intrinsic to the nature of medicine. It takes a process of commitment to achieve these goals. This process of responsibility in the clinical judgement, which is characterized by deliberations that result in clinical decision making concerning the choice of medicine and care to be administered to the patient. Pellegrino explains further "there are many decisions along the way to these ends, but in each decision there is a fusion of technical and moral elements. If it were merely a matter of technical correctness, of medical good alone, the major moral principle would be competence. But the subjects of medical decisions are humans, and humans in particular states of vulnerability, anxiety, pain, and dependent upon the physician's knowledge, skill, trustworthiness, and responsible management of the power that professional status confers. Moreover, the physician offers to help and, thus, promises to the vulnerable patient to help attain the ends for which the patient seeks medical help."[176]

Against the social construction of medicine, the end of medicine, or telos, as Pellegrino highlights, cannot be a fruit of very social structure,[177] meeting the economic, social, and state interests or the interests of institutions and researchers involved in the patient's treatment.[178]

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[172] Edmund Pellegrino, "The Goals and Ends of Medicine: How are they to be Defined?" in *The Goals of Medicine: the Forgotten Issues Health Care Reform* ed. Hanson MJ, Callahan (Washington, DC: Georgetown University Press, 1999), 62.
[173] Pellegrino, *The Philosophy of Medicine Reborn*, 140.
[174] Raanan Gillon, "What is Medical Ethics' business?" in *Advances in Bioethics: Critical Reflection on Medical Ethics,* ed. Martyn Evans London: Jai Press Inc., 1998),33.
[175] Pellegrino, *The Philosophy of Medicine Reborn*, 200.
[176] Pellegrino and Thomasma, *The virtues*, 53.
[177] The term "social construction" is used in Hastings Center Goals of Medicine project report to apply to a process of definition of the goals of medicine, arrived by social dialogue, consensus formation, political process, or negotiation. Pellegrino uses this sense in comparison with essentialist approach to the ends of medicine. See Pellegrino, *The Philosophy of Medicine Reborn*, 137.
[178] Daiane Martins Rocha, "The philosophy of Edmund Pellegrino and Bioethical Dilemmas Related Assisted Suicide" *Revista bioética* 21, no.1 (2013): 73.

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. Nevertheless, in clinical medicine, the good of the patient is the end, *primus inter pares*.[179]

In contrast to the teleological or essentialist definition of the ends of medicine, the social construction of the medicine becomes what a particular society wishes it to be. This is a popular approach in an era of moral and epistemological pluralism and democratic institutions as well.[180] Pellegrino says that unlike the essentialist approach to the definition of the ends and goals of medicine, "social construction allows for no permanent theory of medicine and therefore allows no permanent or stable ethics of the profession. This can become the victim of a socially aberrant society, as was the case under German National Socialism, Maoist China, Stalinist Russia, or Imperial Japan. In each case, medicine was redefined as an instrument of social and political purpose, and the physician was made a social functionary. Medical ethics itself became the ethic of social purpose."[181] This social constructionist approach has become so much the trademark of the modern definition of the goals of medicine.

However, concerning the essentialist view, the ends of medicine are defined "internally out of the nature of medicine itself. They grow out of the phenomenology of medicine, that is, that which is more fundamental than medicine itself- the universal human experience of illness. The universality of this experience, its existence beyond time, place, history or culture- and the need of the sick person for care, cure, help and healing that- gives medicine its essential character. These ends make medicine what it is."[182] Pellegrino constructs a universal basis for which medicine can be defined, understood, and practiced in the essentialist dimension of the telos of medicine. As presented in Pellegrino's thought, the ends of medicine by their very nature tend to appear as possessing some eternal attributes. He describes them as beyond culture confines, universal, beyond time, history, and so on.

The distinctive difference in terms of the mentioned goals of medicine between a teleological and a consensual approach depends heavily on methodological differences. A consensual system allows for the purposes of medicine to change historically and socially, whereas a teleological approach aims at a universal and nonrelative determination of the proper goals of medicine.[183] Pellegrino does not deny the fact, the fact that the consensual model

[179] Pellegrino, *The Telos of Medicine,* 23.
[180] Pellegrino, *The Philosophy of Medicine Reborn*, 167.
[181] Ibid.
[182]Ibid, 140.
[183] Schramme, *The Goals of Medicine*, 122-123.

contributes in shaping the realization of the ends of medicine but he rejects authenticity as the foundation to determining the ends of medicine.

As an essentialist, Pellegrino warns that on no account should physicians determine the ends of medicine. Their task is only to realize these ends in a specific clinical encounter and with a particular patient. They are charged with ascertaining, together with the patient, the content and the end of healing. The process of proving indicates that medical practice is not all about technical knowledge. Medicine is not defined solely as knowledge-based but as knowledge, based and directed to a specific end- knowledge required by an architectonic principle- healing or helping a sick person become whole again.[184] Just as physicians do not have any epistemological sovereignty to define the ends of medicine, so do economists, politicians, policymakers, or ordinary people who do not know how to do so. Our sole responsibility is to determine how to use medical knowledge and skill to bring the goals and purposes of medicine we assign to medicine into conformity with its intrinsic ends.[185] Pellegrino argues, "economics, politics, cultural and social values are important, but they are not sovereign. They are subject to restraint, criticism, and even refusal when they seriously impair the ends of medicine."[186] Pellegrino's position is that medicine has an intrinsic end, which is realized in the relationship between the patient and the health care professional as the core of what medicine is, and ever shall be. He makes a point that is novel in the philosophy of medicine and seems hard to deny.[187]

One of the notable features that Pellegrino advances about the essentialists' definition of medicine is that it depends on honest and not on the nominal purpose of medicine, one which describes something in the real world, not just a language game or simply the way we use the word medicine. Another one is that the ends of medicine are built into the reality of medicine as a special kind of human activity. Finally, the limits of medicine are built into its ends. When those ends are no longer achievable- when treatment is not practical or beneficial or when a cure cannot be achieved-care and helping become primary ends.[188]

Many philosophers of medicine identify health as the goal of medicine. Like Pellegrino, Agazzi and Tymienieka categorically state: "In all cultures, medicine has been conceived as a

[184] Pellegrino, *The Philosophy of Medicine Reborn,* 142.
[185] Ibid, 144.
[186]Ibid.
[187] Daniel Sulmasy, "Engaging Pellegrino's Philosophy of Medicine: Can one of the Founders of the Field Still Help us Today?" *Theoretical Medicine and Bioethics* 40, (2019):168, https://doi.org/10.1007/s11017-019-09488-7
[188] Pellegrino, *The Philosophy of Medicine Reborn*, 140.

struggle against illness, and has been characterized by the ways of interpreting illness."[189] Ira Bedzow outlines two general professional goals of medicine by stating that the purpose of medicine is:

> To improve a patient's physical condition and to improve their quality of life. These two primary goals will sometimes be in conflict, such as in cases relating to end-of-life care, yet they are often complementary. For example, improving a patient's health will often lead to a higher quality of life. Conversely, tending to the psychological and social aspects of a person's life will positively affect his or her health. Even though these primary goals speak about "a patient" in general, one should not think of patients as simply opportunities to fulfill one's professional goals. Your patients are not simply a means for you to practice your clinical skills and to improve your professional abilities; caring for particular patients is the goal in itself. The personal relationship between physician and patient is what creates the goals of medicine and is what gives them value.[190]

In a more profound and philosophical perspective, Sloane avers that it is too myopic for one to assume that medicine is the only thing that improves health and prolongs human life. Instead, he argues:

> It is true that modern medicine has made extraordinary advances in understanding and treating diseases, and most of us have benefited from them (indeed, many of us are still alive because of them): germ theory and antibiotics; asepsis, pain management and anesthesia and surgery; epidemiology and public health; the list goes on. However, at a population level, medicine is neither an efficient improver of health, nor is it primarily responsible for the dramatic improvements in health and longevity seen in the 'developing' world. Decent public policy and infrastructure, stable and safe social and political and economic systems, a reasonable level of education and basic social services, including public health and health education, are much more effective in improving population health, as is evident historically.[191]

My alignment with Sloane's argument is that medicine is not the sole source for improving health and prolonging human life. This claim can further be substantiated with instances of the differences in the life span gap between developed continents like Europe and America with the underdeveloped continents like Africa, Asia, and some parts of the world where the social structure is backward and poor. People who live in developed worlds can enjoy more excellent healthy living and live longer than those in the underdeveloped countries live. A good and healthy environment facilitates, ensures, and improves healthy living and prolongs human life, while a ferocious environment breeds diseases and shortens human life. Today, many of Africa's tropical diseases and health threatening cases can be attributed to a lack of decent public policy and infrastructure, stable and safe social, political, and economic systems, a reasonable level of education, and essential social services, including public health and health education.

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[189]Ana-Theresa Tymieniecka and Evandro Agazzi, *Life- Interpretation and the Sense of Illness within the Human Condition: Medicine and Philosophy in Dialogue* (Dordrecht: Kluwer Academic Publishers, 2001), xiii.
[190]Ira Bedzow, *Giving Voice to moral values as a professional physician: An introduction to Medical Ethics* (New York: Routledge, 2019), 37.
[191]Andrew Sloane, *Vulnerability and Care Christian Reflections on the Philosophy of Medicine* (New York: Bloomsbury T&T Clark, 2016), 7.

Identifying health as the end of medicine serves as a road map for physicians. The attainment of health becomes the physician's only business. His role should be limited to only the use of technology and knowledge that advance therapeutic purposes.[192] We do not attribute ends to things and activities. They are not good because we desire them. We desire them because they are good. We can put medical knowledge to the goals and purposes we contrive. Nevertheless, whether these goals are morally good or bad, the use of medical knowledge depends upon whether they fulfill the ends for which medicine exists and which define it *qua medicine.*

A specific identification of health as the good of the patient serves as a catalyst against every form of clinical abuse and misappropriation of medical services. To this end, Pellegrino admonishes: "The physician's knowledge, therefore, is not private property. Nor is it intended primarily for personal gain, prestige, or power. Rather, the professional holds medical knowledge in trust for the good of the sick."[193] Furthermore, these ends guide in the formation and education of physicians and health care providers. The ends become the basis for medical education and formation: "By accepting the privilege of medical education, physicians enter into a covenant to use their medical knowledge for the benefit of society. Moreover, this covenant is acknowledged publicly when the physician takes an oath. The oath, not the degree, symbolizes the graduate's formal entry into the profession. The oath is a public promise, a 'profession' that the new physician understands the gravity of their calling, promises to be competent, and promises to use that competence in the interests of the sick."[194]

The goal-oriented perspective of medicine refutes the views of those contemporary physicians who argue that medicine is a commercial enterprise and health care, a commodity, subject to the caprices of the marketplace. The goal of medicine is not commercial but a moral enterprise because it deals with the life of a human being, the patient's health. Relying strongly on his theory of the patient's good as the end of medicine, Pellegrino affirms: "Health and medical care are not, cannot be, and should not be commodities; the ethical consequences of commodification are ethically unsustainable and deleterious to patients, physicians, and society; commodification does not fulfill economic promises, and health is a universal human need and a common good that should provide in some measures to its citizens."[195] It implies that health and health care cannot be gauged on economic scales; health cannot be priced on monetary grounds.

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[192] Pellegrino, *The Philosophy of Medicine Reborn*, 131.
[193] Pellegrino and Thomasma, *The Virtues*, 36.
[194] Ibid.
[195] Ibid, 102.

Health care is not a commodity because it is not something that we possess and can sell, trade, or give away at our free will. The commodification issue as addressed in Pellegrino centers on health care and not on health facilities, medications, instruments, dressings, and other disposable items used or necessary in health care. These items are, in one sense, commodities since they can be owned, consumed, bought, traded, and donated.[196] These materials are used only as a means to an end of healing and helping the sick person. Ethical questions do not arise directly from these materials but on the nature and manner in which physicians use them in healing activities, particularly in ethical encounters. Therefore, by health care, Pellegrino refers to "the provision of assistance to persons in need of care, cure, education, prevention, or help related to trauma, illness, disease, disability or dysfunction by other persons knowledgeable and skillful in assisting."[197] The personal relationship between the health professional and the sick person in need of help is what Pellegrino repeatedly advanced as the central feature of health care. The point is made that the totality of health care itself is not a commodity even though commodities may be used in the process of providing it. Health facilities and sometimes a piece of medical knowledge can be said to be a piece of a thing that can be exchanged for money, but health or health care itself is not a commodity.

Taking into account the unique nature of the concepts of illness and healing, Pellegrino amplifies his position that health care cannot be a commodity. He writes: "Health care is not a product which the patient consumes and which the doctor produces out of materials of one kind or another. The sick person 'consumes' medication and supplies, and expends money for them, but he does not consume health 'care' as he would a bag of beans or a six-pack of beer. Health or amelioration of diseases may the end of medicine, but health itself is not a weighable commodity."[198] The intimate relationship between the health professional and the patient in the court of healing goes beyond the relationship in other commercial transactions. Health care transactions build on a higher value than in the commercial transactions of commodities and goods.

To respond to the question as to whether health or medical care could be termed as commodity, Pellegrino gives several practical examples to prove the point that health care is not and should never be a commercial commodity. Pellegrino writes: "In a commodity transaction, like buying bread, the persons who buy and who sell have no personal interests in each other beyond the transaction. They are focused on the object or product, on the commodity

[196] Pellegrino, *The Philosophy of Medicine Reborn*, 105.
[197] Ibid, 106.
[198] Ibid, 107.

to be traded. This relationship does not extend beyond the sale or the consumption of that commodity.[199] The medical relationship, in contrast, is intensely personal. Confidence and trust are crucial as is a continuing relationship, at least in general medicine if not in the superspecialities."[200] Consultations in the clinical setting are means of establishing this particular relationship in the healing process. They nourish and assist the communication built in this healing relationship characterized by confidence and trust. These consultations between the patient and the physician create an atmosphere of confidence in which the physician promises to help the sick person who, in his vulnerability, declares his need for help. The health care relationship takes into consideration certain elements that are ignored in commercial activities. In medical care, healthcare providers deal with an entirely different entity from the one in commercial relationships. For instance, in health care, the values and dignity of the human person must come to the forefront of every clinical decision. Human beings who receive health care are incomparable with a commodity that focuses on business relationships. Pellegrino argues that since beneficence, acting for the good of the patient, is the central principle of medical ethics and that is based on the internal morality of medicine, which is intrinsic to the traditional concept of a true profession, medicine therefore is set apart from a business, craft or other occupation.[201]

Commodity and profit-making remain the driving forces of most commercial activities and transactions. I usually watch with amazement in Nigerian markets, especially in the Northern part of the country, how Muslims and Christians who live in hostility due to their religious differences act so friendly when it comes commercial transactions. However, as soon as the transaction is over, the hatred continues. The intimate and personal nature of health differentiates it from every kind of commercial transaction. Medicine, "the science concerned with health and illness of man,"[202] cannot be said to be a commercial enterprise. Like Pellegrino, Thomasma argues strongly that at its root, medicine is a devotion to sick persons by the community. Thus, "health care is more than a commodity; it is a commitment to one another in the community."[203]

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[199] Pellegrino prioritizes medicine as a moral enterprise by portraying it as an exceptional. This priority does not imply that only medical actions are moral. All human actions and interactions are moral by their very nature.
[200] Pellegrino, *The Philosophy of Medicine Reborn*, 107-8.
[201] Cf. Ibid, 363.
[202] Stanisław Kamiński, *The Polish Christian Philosophy in the 20th Century,* edited by Kazimierz Marek Wolsza, (Krakow: Ignatianum University Press, 2020), 195.
[203]David Thomasma, "Virtue Theory in Philosophy of Medicine" in *Handbook of Bioethics,* ed. George. Khushf ((Netherlands: Kluwer Academic Publishers, 2004), 91.

The modern tendency to see health care as a commodity is so factored by the commodification of medicine that the ends of medical practice and activities are viewed solely in terms of commercial and monetary gains, profits, and benefits. Like Pellegrino, Roberto Mordacci believes that there is an internal good to be pursued as a goal distinctive of a particular practice because to describe what kind of practice medicine is, it is necessary to identify at least one distinctive internal good, by which all the activities performed under the general label of medical practice are recognizable in a coherent manner. To do this, he distinguishes between the internal and external ends or goals of medicine. In contrast to health as an inner good or end of medical practice, he states: "External goods are those goods which can be achieved or realized in the course of a particular practice, but are not peculiar to it: for example, medical practice usually brings money, power, and prestige to physicians, but these are external goods, not goods that are peculiar and distinctive of medical practice."[204] It follows that in as much as there are commercial ends or external goals as he classifies them gains that emerge in the process of medical activities, they are not unique internal goals of medicine and do not in any way qualify health care as a commodity. Health or the patient's good is the essential goal or telos that objectively defines medical practice.

In the end, Pellegrino categorically and summarily affirms:

> Health and medical care do not fit the conceptual mode of commodities. They center too much on universal human needs, which are much more fundamental to human flourishing than any commodity *per se.* They depend on highly intimate personal inter-relationships to be effective. They are not objects fashioned and owned by health professionals, nor do patients like other commodities consume them. Stewardship is a better metaphor than proprietorship for medical knowledge and skill.[205]

1.8 Medicine as a Moral Enterprise

Pellegrino is remembered as one of the famous advocates of medical practice as a moral enterprise for virtuous practitioners with the patients' good being at the center of health care. He considered medicine as a skill, art, and perhaps most importantly, a moral enterprise.[206] Pellegrino asserts: "medicine is a moral enterprise, and has been so regarded since Hippocratic times: that is to say, it has been conducted in accordance with a definite set of beliefs about

[204] Roberto Mordacci, "Medicine As a Practice" in *Clinical Bioethics: A Search for the Foundations* ed. Corrado Viafora *(Netherlands*: springer, 2005), 108.
[205] Pellegrino, *The Philosophy of Medicine Reborn,* 110
[206] Lucho.Engelbert Bain, "Revisiting the Need for Virtue in Medical Practice: A Reflection upon the Teaching of Edmund Pellegrino," *Philos Ethics Humanit Med* 13, no. 4 (2018). https://doi.org/10.1186/s13010-018-0057-

what is right and wrong in medical behavior."[207] For him "medicine is at heart a moral enterprise. All its efforts converge ultimately on decisions and actions which are presumed to be good for some person in need of help and healing."[208] Pellegrino repeatedly affirms that the moral nature of medicine depends on his argument that "medicine is a praxis; an activity with its own internal goal, that goal-the good of the patient-is a moral one."[209]

Hence, Pellegrino's proposition that medicine is a moral enterprise is substantiated by the following simple syllogism: "Medicine is an ethical enterprise since it is aimed at the good of the patient, not their harm and, therefore, it must discern what is right and good, what ought to be done as well as what can be done. Medical ethics is also an ethical enterprise since its end is the good of the patient, that is, what ought to be done as well as what can be done."[210] The moral scale for measuring or judging what is good and right in medical ethics finds its roots in this view. To consider a physician's action as either right or wrong, good or bad depends on the idea that the profession is moral and the good that is sought in it is the good or the wellbeing of the patient. Any action, therefore, or clinical decision-making that attains this stipulated goal justifies the rightness of such an action, and its lack, is termed as wrong or evil.

Medicine as an ethical undertaking dates back in its foundational basis to an ancient moral legacy or dictum of *synderesis*, "Do good and avoid evil."[211] This principle of *synderesis,* according to Pellegrino implicitly or explicitly, is the indispensable transcendental ground for any system of ethics of moral philosophy. This is because the good is the end or *telos* of moral science, which gives it its distinctive identity among human activities.[212] Every professional ethics adopts this ancient *syndresis* to suit its purpose and serve as the first principle for its ethics. About 2400 years ago, an un-authored old Greek document was simply entitled the Oath. It appeared to be designed for the swearing-in of a person at the beginning of a medical apprenticeship. In this document, the apprentice vows to repay his teachers and be a good physician in the manner described by the Oath.[213] In this oath, the physician professes: "I will

[207] Edmund Pellegrino, "Toward a Reconstruction of Medical Morality" American *Journal of Bioethics* 6 (2006): 67. This article was originally published in The Journal of Medical Humanities, 8(1), 1987. Reprinted with permission from Springer Science and Business Media. My citation are directly taken from the 2006 edition.
[208] Edmund Pellegrino, "Ethics and the Moral Center of the Medical Enterprise" Bulletin *of the New York Academic of Medicine* 54, no. 7 (1978), 626.
[209] Pellegrino, *The Philosophy of Medicine Reborn*, 361.
[210] Pellegrino, *What the Philosophy of Medicine Is*, 41.
[211] Pellegrino, *The Telos of Medicine*, 21.
[212] Ibid.
[213] Cf., Steven H. Miles, *The Hippocratic Oath and the Ethics of Medicine* (New York: Oxford University Press, 2004),3.

abstain from all intentional wrong-doing and harm."[214] Despite the fact that this document is traditionally attributed to the Greek doctor Hippocrates, most modern scholars do not regard it as having been written by Hippocrates himself.[215]

Notwithstanding, the Hippocratic Oath which served as the first principle of medical ethics meant a lot to Greek physicians as it is still of much relevance to medical ethics today. The Hippocratic Oath expresses the heart of the profession to which physicians are called to commit themselves. It contained the summary of all principles and rules that were organized to address physicians in society in the clinical encounter. Adopting this ethical framework into professional medicine, Pellegrino argues that all the moral precepts of the oath, the other deontological books of the Corpus, and the entire subsequent history of medical ethics are elaborations of this first principle.[216] The dictum *principium primum*, commonly regarded as the first principle of ethics, was adopted by Pellegrino for medical practice as a moral enterprise that enjoins upon doctors the primary duty of acting to benefit the patient in a word, always to act for the patient's good. Therefore, the patient's good is the end of medicine, that to which medicine, by its nature, tends and that, which gives it its definition.[217]

For this reason, Pellegrino submitted that ethics as a formal discipline should be recognized to be as integral to the practice of responsible medicine as the primary clinical sciences.[218] He built the idea of a moral community into the medical profession[219] by identifying medicine as an ethical undertaking. The patient-physician relationship is moral, and a proper understanding of it is crucial for robust morality in medical practice. Any reconstruction of medical morality depends upon a patient-physician relationship that has healing as its goal and not some other purpose such as commercialism or paternalism.[220]

In his attempt to counter and resolve the central dilemmas in modern medical professional ethics, Pellegrino draws on the idea of the medical profession as a moral community that will use its moral power to stand against the forces eroding professional integrity, and to encourage and support those physicians within the community who have the will and the courage to adhere to traditional standards of ethical behavior.[221] Pellegrino argues

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[214] Wikipedia, *Hippocratic Oath*, https://en.wikipedia.org/wiki/Hippocratic_Oath Accessed 25/05/2021 by 11:00pm
[215] Ibid.
[216] Pellegrino, *The Telos*, 21.
[217] Ibid.
[218] Pellegrino, *Ethics*, 627.
[219] Pellegrino and Thomasma, *The Virtues,* 32.
[220] James Marcum, *The Virtuous Physician: The Role of Virtue in Medicine,* (Texas: Springer Science+Business Media B.V. 2012), 278.
[221] Pellegrino and Thomasma, *The virtues*, 32.

that "medicine is at heart a moral community and always will be; that those who practice it are *de facto* members of a moral community, bound together by knowledge and ethical precepts. As a result, physicians have collective, as well as individual, moral obligations to protect the welfare of sick persons in a world that increasingly treats medicine as a commodity, a political bauble, an investment opportunity, or a bureaucrat's power play."[222]

This character of medicine as a moral enterprise lies in the nature of medicine as a specific human activity oriented toward healing and restoration to health. He maintains that arriving at such ends involves many decisions, and in each decision, there is a fusion of technical and moral elements.[223] It is not just a matter of technical competence but involves moral competence. In conformity with the above narrative, Pellegrino presents a unique picture of medical act as no longer just a technique, a technical accomplishment, but also a moral enterprise. This specific nature of medicine is a special kind of human activity that equally differentiates it from other human activities. The process of restoring health to a dysfunctional body requires both technical and moral competencies by the physician who provides health care to a sick person. This special physician-patient relationship serves as a moral fabric in the clinical encounter. In the same vein, David Thomasma argues that medicine is a moral endeavor because medical decisions are ethical; that is, they involve moral values.[224]

In addition, Fuchs argues that medicine is a moral enterprise because "it deals with human problems. The ethics of medicine derives from medicine as a human activity. Its moral nature is prior to, or at least not dependent on faith. Medical ethics thus must accord with human understanding, and in this sense, it has a certain autonomy."[225] Fr. Sokolowski essentially follows this line of thought. He begins with the phenomenology of medicine as a special kind of human activity.[226] He focuses on the art of medicine and the way it functions in the physician-patient relationship. What is at stake is the person of the patient. The patient and the physicians as rational beings play a part in effecting the end of medicine, which is the patient's good. In this relationship, the physician is the embodiment of the medical art whose end is the patient's good.[227]

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[222] Ibid.
[223] Ibid, 53.
[224] David Thomasma, "Medical Ethics: A Clinical Base," *The Linacre Quarterly* 49, no. 3 (1982): 269 Article 11. Available at: http://epublications.marquette.edu/lnq/vol49/iss3/11
[225] Fuchs J, "Catholic Medical Moral Theology," in *Catholic Perspectives on Medical Morals, edited by Edmund* Pellegrin et al. (Dordtrecht: Kluwer, 1989), 83-92.
[226]Sokolowski R, "The Art and Science of Medicine' Theology" in *Catholic Perspectives on Medical Morals* eds., Edmund Pellegrino et al. (Dordtrecht: Kluwer, 1989), 263.
[227] Pellegrino, *The Philosophy of Medicine Reborn*, 351-2.

The emphasis on the technical requirement in the practice of medicine does not remove the fundamental need for moral competence itself. Both are, of course, essential and necessary elements for efficient medical practice. On this view, Pellegrino notes: "Obviously the first moral requirement for any ethics of medicine must be competence because without it the physician's promise to help is a lie. Competence is the indispensable requirement for technically right decisions and the first requirement for a good decision as well. The moral center of medicine, however, occurs at the moment when, having weighed all the things that can be done, the physician recommends what ought to be done - what is in the best interests of the patient. It is here that value decisions must be made."[228] Technical[229] and moral competence are indispensable to medical practice, though they serve from different perspectives but aim at the patient's good. In solid terms, Pellegrino echoes: "Every clinical decision involves technical and value choices."[230]

Pellegrino amalgamates the technical and moral competencies into an integral basis for a holistic understanding of medicine. He insists that the practice of medicine does not consist primarily in the application of science, nor in a philosophical account of central concepts such as disease or the social and political understanding of what it means to be ill. Primarily, the medical practice exists in the very humane actions of one human being towards another to provide comfort, relief, and, hopefully, a cure. As such, medical practice differs from scientific or technological practices. This therapeutic relationship characterizes it as an essential part of the humanities.[231]

Why medicine cannot escape being a moral enterprise as found within Pellegrino's thesis is that the obligations specific to physicians arise from the unique features of the personal relationship between the person who is ill and the person that the sick person goes to asking for help. This resulting relationship has certain features that give it a unique character that generates special mutual moral duties.[232] By these moral duties that emerge from the special relationship between the physician and the patient, Pellegrino does not in any way intend to

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[228] Pellegrino, *The Healing Relationship*, 167-168.

[229] The good of the patient is understood in different terms. The technical competence fall within the biomedical or techno-medical good which encompasses the effects of medical interventions on the natural history of disease being treated. It is the good that can be achieved by the application of expert medical knowledge-cure, containment of disease, prevention and amelioration of symptoms or prolongation of life. It is directly related to the physician's technical competence; it is the first step in fulfilment of the moral obligation of his or her promise to help. See Pellegrino, *The Philosophy of Medicine Reborn*, 167.

[230] Ibid. 98.

[231] Evert Van Leeuwen and Gerrit k. Kimsma, "Philosophy of Medical Practice: A Discursive Approach," in *The Influence of Edmund D. Pellegrino's Philosophy of Medicine* ed. David Thomasma (Dordrecht: Springer Science+Business Media , 1997), 99.

[232] Pellegrino, *The Philosophy of Medicine Reborn*, 150.

isolate medical morality from the general ethics or that the principles, rules, and duties of medical ethics as a discipline are self-justifying. However, that the determination for which principles, obligations, and virtues are most pertinent is linked to the nature of the human relationship that is central to the clinical encounter.[233]

Following the demand for both technical and moral competencies in medical practice, Pellegrino argues the most crucial dilemmas of medical ethics today are not those arising from medicine's scientific progress. They are dilemmas of professional ethics, those that go to the heart of what it is to be a physician. In these matters, medicine faces an unenviable choice.[234] It is the modes of this relationship (that is, what is essential in it - morally essential and relevant for its definition) are the characteristic traits of responsibility, mutual trust, decision orientation, and the curative intention (what the authors call the 'aetiology' of medicine).[235]

Ethical responsibilities are integrated into the scientific curriculum as part of the mastery of scientific fields because scientists must take decisions that may sometimes be of a moral kind. We know that it is always in making a decision that we are confronted with issues of values and responsibility. Therefore, it suffices to say that there must always be a moral value attached to every decision that involves moral agents. These moral values arise because of the fact that trust is an essential requirement in all human relations and dealings. The nature of science as a profession, like medicine, is structured in such a way that apart from learning or knowledge in and for such domains, it also requires judgment in situational cases of moral nature.

Professions are not just technical, so they cannot be described as always being in a standby mode. This is so because social values and expectations define these professions. As we have seen earlier, Pellegrino believed there are social expectations and possibly cultural expectations towards medical work. Still, uniquely he held that medicine is defined not solely by social values but by a peculiar value intrinsic to its nature, qua medicine. Within this context, Pellegrino holds firmly that the need to make decisions and make choices imposes moral obligations on medical personnel. It must reconcile two opposing orders—one based on the priority of its covenant with patients and the other based on the ethos of self-interest.[236] He outlines some moments of challenges to this tension between self-interest and altruism: whether to disclose one's HIV positive status, conflicts about requests or public policy for

[233] Ibid.
[234] Pellegrino and Thomasma, *The virutes,* 31.
[235] Roberto Mordacci, "Medicine As a Practice" in *Clinical Bioethics : A Search for the Foundations* ed. Corrado Viafora, (Netherlands: springer, 2005), 102.
[236] Pellegrino and Thomasma, *The virutes*, 31.

physician-assisted suicide, integrity in scientific research, the medical-industrial complex, physicians' incentives as gatekeepers to keep costs down, and many others. Although occasioned by technology, each of these dilemmas arises from changing roles of the profession in response to public and private expectations.[237]

1.9 Internal Morality versus External Morality of Medicine

The dominant conception of medical ethics proceeds from a substantial distinction between two sets of values, norms, and rules that define medical morality. This "reflects both unprecedented technological advance and the overtaking of traditional values by secularism and pluralism- a largely external form of morality- to be contrasted with the internal morality of medical practice."[238] On this contrast between the internal and the external morality of medicine (IMM and EMM), Roberto Modarci notes:

> The different emphases in European literature seem to have a common denominator: they focus on the dialectic connection between the internal and external morality of medicine without reducing one set of norms and values to another. It is heuristically assumed that on the one hand, there are specific values, standards, and rules intrinsic to the actual practice of medical care (the internal morality); on the other hand, values, norms, and regulations prevailing in social, cultural, and religious traditions that function as external determinants of medicine (the external morality).[239]

The literature on the internal and external norms of medical morality exists as a respond to the basic question of medical ethics, whether the standards governing medical practice should be understood as the application of principles and rules of 'the common morality' to medicine or whether some of these norms are 'internal' or 'proper' to medicine. A similar notion is found in the metaphysical point of view on the structure of being. Concepts of the internal and external (accidental and substantial) modes of being are used to discern the fundamental identity of things and persons. The emphasis is on the internal mode of being, which comes through cognitive analysis that deepens our understanding of the world rather than the mere external or accidental understanding of reality.[240] They are connected perspectives of grasping the meaning of reality in totality.

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[237] Ibid.
[238] Henk Ten Have, *Images of Man in Philosophy of Medicine*, 192.
[239] Henk Ten Have, "A Helping and Caring Profession: Medicine as a Normative Practice" in *Clinical Bioethics : A Search for the Foundations,* edited by Corrado Viafora (Netherlands: springer, 2005), 86.
[240]Cf., Andrzei Maryniarczyk, *Discovery of the Internal Structure of Being*, Translated from Polish to English by Hugh McDonald, (Lublin: Poskie Towarzystwo Tomasza Z Akwinu, 2018), 16.

Pellegrino also uses this conception of the IMM and EMM in his phenomenology of the clinical encounter. In his attempt to respond to the challenges that caused unprecedented changes in medical practice by scientific and social change, Pellegrino revisits the traditional medical ethic in a way more congenial to contemporary mores. He does this by distinguishing the goals and purposes of medicine which are essentially in the nature of medicine as a kind of human activity which determines its ends and its ethics internal against the continuing evolution of the goals of medicine and purposes by process of the social and historical construction of dialogue.[241]

From the above distinction, Pellegrino proceeds to argue that the internal source of morality should be used as a standard for the ethics of medicine and the other healing and helping professions. The ethics of these professions has its source in the nature of these professions, in what is distinctive about them, and the good at which they aim. For instance, healing and helping professions, that is, those which purport to meet particular fundamental needs of humans like health, justice, knowledge, and spiritual consolation.[242] He believed as we have repeatedly stated, that medicine had a definable *telos*, healing the sick, and that medicine therefore had an internal morality based on the reality of the human experiences of illness and death and on the goals of medicine as an enterprise established in response to these predicaments.

A sharp distinction between the internal good and external good of medicine as presented by Pellegrino states that internal goods are different from the external. Internal goods are not to be equated with any form of consequentialism or its most famous expression in utilitarianism. Nor are they equivalent to the simplistic biological teleology so disfavored and ridiculed by contemporary science. Nor are ends to be confused with goals, purposes, or values. These latter are defined externally by social, economic, or political convention. They are not what make clinical medicine the kind of activity it is or aims at. Goals and purposes are thus external to medicine. Instead, an end-oriented internal morality of medicine is an ethic based in the notion of the good as the end, which characterizes moral acts. The good is defined in terms of the aim of the activity for which that activity exists.[243] Internal goods are those realized when trying to achieve the standard of excellence definitive of that practice. External goods are those, which do not contribute directly to the attainment of the aims characteristic of

[241]Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions," *Journal of Medicine and Philosophy* 26, no. 6 (2001):560.
[242] Pellegrino, *The Internal Morality*, 561.
[243] Ibid, 564.

a practice.[244] In medicine as a practice, excellence in healing is, then, a good internal to medical activity while making money is a good external to it.[245]

The case for IMM and EMM is teleologically constructed, taking 'teleology' in its Aristotelian Thomist sense and not in its modern consequentialist or socially built sense. It is also essentialist and realist.[246] Pellegrino's approach is closely related to Kass' conception of the internal morality of medicine. As we saw earlier on the section on aims and goals of medicine, Kass was distinctly Aristotelian and end-oriented. Kass defined the end of medicine as health, that is, the well working of the human organism as a whole; "an activity of the human body following a specific excellence."[247] On this teleological concept of the aims and ends of medicine, Kass built the morality of medicine.

Pellegrino views these social values as external to clinical medicine: "Medicine exists because being ill and healed are universal human experiences, not because society has created medicine as a practice. Rather than a social construct, the nature of medicine, its internal goods and virtues, are defined by the ends of medicine itself, and therefore, ontologically internal from the outset."[248] In his approach, Pellegrino focuses on the clinical encounter as the central moral defining phenomenon of a clinical philosophy of medicine. The phenomena, which characterize this real-world relationship, form the basis for the ethical obligations the physician assumes when he or she offers to heal, help, care for, or comfort a sick person. These compromise the good of the patient as the end of medicine. This morality is internal since it is derived from the nature of medicine itself and not from the application of pre-existing moral systems to medicine.[249]

Pellegrino confines his inquiry to clinical medicine and not medicine generically by defining the IMM he holds as essential and appropriate to the physician-patient relationship ethics. By clinical medicine, he refers to the use of medical knowledge for healing and helping sick persons here and now in the individual physician-patient encounter. This clinical, face-to-face encounter for Pellegrino is the starting point for a philosophy of medicine and is the root of its internal morality.[250] The EMM lies in social medicine, which has its end in the community's health or the whole body politic. These ends of social medicine are defined externally by social, economic, or political convention. They are not what make clinical

[244] Ibid, 562.
[245] Ibid.
[246] Ibid, 560.
[247] Kass, *Regarding the End*, 40.
[248] Pellegrino, *The Internal Morality*, 563.
[249] Ibid.
[250] Ibid.

medicine the kind of activity it is or aims at. Goals and purposes are thus external to medicine.[251]

The good pursued in the internal and external morality, in actual and social construction respectively, also differ. In the end-oriented IMM, the ethic based on the notion of the good as the end which characterizes moral acts. The good is defined in terms of the aim of the activity for which that activity exists. This is an ethic consistent with the notion of the good contained in the quotation from Aristotle and Plato. Such an ethic is the antithesis of an ethic based in a social construction of the goals and purposes of medicine. This latter is an external morality with perilous implications for the patient's good.[252] In this distinction, we discover that that the values and norms that comprise the internal and external morality of medicine are based on different sources, namely intrinsic and extrinsic authorities respectively. Concerning the authenticity of these forms of medical morality, Pellegrino argues: "An internal morality of medicine is not a morality defined or authenticated by physicians or the profession of medicine. The moral authority of an internal morality of medicine is independent of whether or not physicians accept or reject it. Adoption of the precepts of an internal morality in a professional code or oath is not a warrant for its moral authority. That authority arises from an objective order of morality that transcends the self-defined goals of a profession."[253]

The temptation is to misunderstand Pellegrino's internal ethics of medicine as an ethic that is wholly detached from general ethics. Pellegrino corrects this tendency by stating: "An internal morality of medicine or any other profession is not a morality divorced from all ethical theories. It is not a self-justifying body of norms. Rather, it is consistent with virtue- or principle-based ethics. It is not closed to insights from other ethical methodologies like casuistry or a caring system of ethics. The generic notions of the right and the good, truth, and logical consistency still function within an internal morality in the judgment about the way the good end of medicine is defined and actualized."[254] Medicine is not an isolated practice but a part of the pervasive search for the good that constitutes human agency. Therefore, it receives its sense in a rigorous debate with all other practices human life is made. Furthermore: "An internal interpretation of the moral sense of medicine does not entail a separated, special morality disconnected from the rest of moral life."[255]

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[251] Ibid.
[252] Ibid, 564.
[253] Ibid, 564-5.
[254] Ibid, 565.
[255] *Robert Mordacci, Medicine as a Practice*, 118.

According to Pellegrino, "medical moral philosophy ought, to begin with, the nature of medicine itself, as a human activity, which on grounds of natural reason alone, imposes certain obligations on the physician and other health professionals." [256] In Pellegrino's words: "The internal morality of medicine consists, then, of the principles, duties, obligations, and moral character that arise from a consideration of the special nature of the medical relationship expressed in two triads—the three ends of medicine and the three phenomena of the medical relationship. These triads provide the conceptual basis for the duties that devolve on both physician and patient in their joint pursuit of the ends specific to medicine."[257] In this way, the ethics of personal responsibility, integrity, virtue, and character become a solid moral point of reference in medical ethics.

In his realist and phenomenological approach to clinical medicine, Pellegrino opens the clinical scope to its relation with existential sources that build morality. He identifies an internal morality is open to insights from literature, history, or the social and physical sciences. In addition, he admits that these disciplines are valuable sources for detailed existential accounts of the moral life. Moreover, that they facilitate the realist assessment of the telos of medicine. An internal morality draws on all these disciplines to the extent that they enhance our grasp of the existential phenomena of the clinical phenomena of being ill, being healed, and professing to cure. However, internal morality looks beyond cultural and historical contexts to what is familiar to the human predicament of being ill and being healed.[258] From these analyses, Pellegrino offers an explication of the internal morality as essentially grounded on the phenomena of medicine, with particular reference to the nature of the clinical encounter between physician and patient.

Similar to Pellegrino's account, Brody and Miller's conception of the of metaphor internal and external morality focuses on clinical medicine. They share with Pellegrino the idea that the morality proper to medicine derives at least in part from reflection on the nature of medicine as a professional practice. This involves a careful study of the goals or ends of medicine.[259] They agree with Pellegrino's Thomist essentialist internal concept of the morality of medicine in which he views the goals and ends of medicine as similar to Platonic forms, historically unchanging. Physicians of any era may answer questions about the IMM by appealing to these forms' essential and eternal nature. They seem attracted to this essentialist conception in large part because he sees it as the only alternative to the asocial constructionist concept.

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[256] Pellegrino, *The Philosophy of Medicine Reborn*, 350.
[257] Pellegrino and Thomasma, *The virtues*, 193-4
[258] Pellegrino, *The Internal Morality*, 565.
[259] Franklin G. Miller and Howard Brody, "The Internal Morality of Medicine: An Evolutionary Perspective" *Journal of Medicine and Philosophy* 26, no. 6 (2001): 584.

In contrast to the essentialist view, they hold that medicine and its morality could be reinvented more or less at whim whenever external social forces push it in new directions.[260] Despite their agreement with Pellegrino, they find themselves unable to accept Pellegrino's conception, both because of their distrust of Platonic forms and because of their concerns that this conception is inherently conservative and predisposed to view any possible alteration in their sense of the IMM as morally suspect on a priori grounds. They, therefore, propose a conception, which differs from both the essentialist and the social constructionist views advocated by Pellegrino.

Miller and Brody agree and in part disagree with Pellegrino's essential theory of the IMM. Unlike Pellegrino, they propose an evolutionary view of the IMM, which arises from dialectic between the essentialist and social constructionist views.[261] They argue that the dichotomy, which Pellegrino assumes, between essentialist and social constructionist, is false. They prefer to think of the goals and ends of medicine as forming a tradition in evolution. This view implies that the goals of medicine are not timeless and unchanging, but of necessity, they evolve along with human history and culture. The changes in the purposes of medicine are meant to make the practice of medicine more congruent with current social conditions. These evolutionary changes in the IMM will permit new goals of medicine, or internal duties of physicians may be seen as properly within the scope of medicine; and traditional goals or duties may become subject to new interpretations.[262] The point here is that Miller and Brody tend to see the essentialist approach as too rigid and opposed to even changes and interpretations that may result in medicine's advancement and progress.

To this end, Miller and Brody define their approach:

> Our conception of the IMM constitutes an approach to ethical thinking about a range of problems in medical morality but not an all-encompassing, iron-clad theory from which correct bioethical guidance can be deduced. We see the contribution of analysis and application of the IMM in bioethics as promoting an interpretive and responsive process of accommodating and balancing values and norms proper to medicine with the common morality external to medicine in light of changing conditions of social life. As in the case of any evolving tradition, the debate over medical morality calls for continuity and adaptation.[263]

[260] Miller and Brody*, The internal Morality*, 584-5.
[261] Ibid, 585.
[262] Ibid, 586-7.
[263] Ibid, 589.

1.10 Chapter Summary

This chapter has presented a philosophical analysis of the conception of medicine as distinct from the biomedical notion. It described medicine as value-laden in nature, as end-oriented towards an intrinsic goal, and as a moral enterprise because it deals with rational decisions and choices in the clinical encounter that involves the relationship between the physician and the patient. The teleological nature of medicine in which the nature of medicine essentially and intrinsically determines an internal morality of medicine provides a basis for sound medical ethics and morality. The teleological basis of medicine serves as a useful method for trashing the modern confusion on the nature of medicine. It is strictly defined in terms of the Aristotelian and Thomistic teleological ethics. In contrast to social constructionist, definition of medicine, which promotes relativism. Teleological, or essentialist definition of the ends of medicine becomes a guiding principle.

Critical reflection and consideration of the dialogue between philosophy and medicine provides inter-disciplinary insights that bioethics can be clearly understood if analyzed in harmony with medical humanities and within the context of philosophy of medicine. The philosophy of medicine explicated herein is phenomenologically and teleologically derived in approach in which Pellegrino's doctrine teaches that the essence and the genuine identity of medicine are inherent in the nature of medicine itself. In this distinctive nature of medicine, *medicine-qua-medicine,* medicine is treated as a special kind or human art or activity.

Chapter Two: The phenomenology of the Clinical Encounter and the Patient-physician Relationship

Introduction

Chapter two presents Pellegrino's doctrine of the personalistic character of the clinical encounter in which the physician and the patient come face to face with each other in medical practice. This chapter presents the idea of the basic structure of the physician-patient relationship and its constitutive elements. The physician-patient relationship is often presented controversially because of the divergent and sometimes opposing views that accompany it. This chapter deals with the most fundamental issue in today's medical ethics as confronted in Pellegrino: the relationship between the ill persons and those who profess to heal them. It examines Pellegrino's attempt to define the patient's good in concrete terms as related to the phenomenology of the clinical encounter. This reflection on the meaning of good which is sought in the clinical encounter, concerns all of the parties involved in the clinical decision making: the physicians and other health and non-health caregivers, for example, the nurses, the family, the minister, and the social worker. This section also reviews Pellegrino's response to the problems and complexities of the physician-patient relationship, introduced by the capabilities of medicine and the pluralism of values in a democratic society, which are accentuated by the depersonalization inherent in the growing institutionalization, and bureaucratization of the medical encounter.

I intend for this chapter to be the heart of this dissertation and undoubtedly the most essential, critical, and crucial stage in Pellegrino's philosophical theory of the medical practice. The Physician-patient clinical relationship constitutes the climax of Pellegrino's thought as it brings to limelight and to concrete applications of the ideas and values of medicine in a healing relationship. My aim in this chapter is to present and analyze the nature of the phenomenon of the clinical encounter as a special kind of human activity that occurs as a reaction to the reality of the existence of pain, suffering, illness, and disease in human life. More so, to demonstrate how these phenomena guarantee the presence of medicine as a healing enterprise. Other issues on how to achieve a perfect clinical practice are also considered in this section.

2.1 The Phenomenology of the Clinical Encounter

Pellegrino confined his medical inquiry to the clinical healing relationship between the patient and the physician, which combines to form the phenomenon of the clinical encounter. He does not deal with 'medicine' generically. By clinical medicine, he meant using medical knowledge for healing and helping sick persons here and now in the individual physician-patient encounter. Pellegrino's theory of medicine is unique and outstanding for his emphasis on a clinically based approach to medicine. He held this approach so tenaciously as the best tool and remedy to the enormous challenges that confront the modern practice of medicine. David Thomasma underlines that in contradistinction to Hare, Morgenbesser, and Callahan, who ascribed to a non-clinical view of medical ethics by describing it as a branch of philosophical ethics applied to medicine, and Marquis and McKee's question on the validity of clinical medical ethics for different reasons; Siegler, Pellegrino, and Jonsen subscribe and argue for the appropriateness of clinically-based medical ethics as suitable for practical reasons and the complexity of modern medicine.[264] Thomasma, in agreement with Pellegrino, states that a clinically based medicine ultimately benefits both the level and structure of moral decisions in medicine and therefore improves the quality of health care.[265]

For Pellegrino, the clinical encounter, the face-to-face encounter, is the starting point for a philosophy of medicine, and it is the root of its internal morality.[266] The clinical in this instance is the ethical foundation of medicine and at the same time the core element of health care. Drane argues for the indispensability of the doctor-patient relationship in medicine. According to him, almost all the ethical standards of medicine and their corresponding virtues are rooted in the complexities of the physician-patient relationship.[267] One can arguably demonstrate that the themes such as the phenomenon of the clinical encounter, the physician-patient relationship, and the theory of medical good form the fundamental pillars of Pellegrino's thought. The entirety of Pellegrino's view of medicine revolves around these indispensable and essential elements. They represent the bars or pillars upon which Pellegrino's theory of medicine is best expressed and understood as they serve the function of being the terminus of not just the clinical activities but of all medical activities. It is the argued that: "The physician-patient relationship is a foundation of clinical care."[268]

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[264] Thomasma, *Medical Ethics*, 266.
[265] Ibid, 270.
[266] Pellegrino, *The Philosophy of Medicine Reborn*, 66.
[267] Drane, *Becoming a Good Doctor*, 65.
[268]Tyler Johnson. "The Importance of Physician-Patient Relationships Communication and Trust in Health Care"https://dukepersonalizedhealth.org/2019/03/the-importance-of-physician-patient-relationships-communication-and-trust-in-health-care/ Accessed 26 January, 2022.

Pellegrino describes the clinical encounter as comprising of the three phenomena which serve as the starting point of the definition of medicine what makes medicine what it is and as the omega point upon which the actions of individual doctors, as well as the whole health care system converge, that moment when some human being in distress seeks help from a physician within the context of a system of care.[269] Similarly, Thomasma describes the clinical setting as "the heart of medicine."[270] Robert Sokolowski refers to the clinical encounter as a medical activity and describes it as the identity and actuality of medicine as science and art and as the climax of medicine.[271] The clinical level of medicine engages both physician and patient in medical activity, and this activity has some of the features of a conversation or dialogue and reasoning.

Pellegrino explores the phenomenology of the clinical encounter on a thesis that "the exploration of the existential, experiential, and phenomenological aspect of being ill, professing to heal seemed to be the most likely starting point of for a philosophy of medicine and the first step to the ethics of medicine."[272] Similarly, John William describes the physician-patient relationship of the clinical encounter as the cornerstone of medical practice and, therefore, of medical ethics.[273]

A phenomenological approach[274] to the clinical encounter for Pellegrino is an inescapable tool for understanding medicine and its practice because the origin of the clinical relationship "is care, and medicine represents a specific and highly sophisticated determination of that form, in which medical care is the competent and scientifically based practice of caring for the ill."[275] Pellegrino proposes the physician-patient relation as unique to medicine and the basis to which sound medical morality and sound philosophy of medicine should be construed.[276] What is unique about the medical encounter is the interaction between someone who is ill, on the one hand, and someone who professes to heal, on the other. Like Pellegrino,

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[269] Pellegrino, *The Philosophy of Medicine Reborn*, 150-151.
[270] Thomasma*, Medical Ethics*, 266.
[271] Robert Sokolowski, "The Art and Science of Medicine" in *Catholic Perspectives on Medical Morals: Foundational Issues,* eds. Edmund Pellegrino, John Langan John and Collins Harvey (Dordrecht: Kluwer Academic Publishers, 1989), 263.
[272] Pellegrino, *The Philosophy of Medicine Reborn*, 150.
[273] John Williams R.., *The World Medical Association Medical Ethics Manual* (France: The World Medical Association Inc., 2009), 34.
[274] The sense of the phenomenology used in Pellegrino's theory is not in the sense of the in-depth description of experience, but in the sense of the philosophical school of thought originating in Germany with the work of Edmund Husserl. In this sense, our daily phenomenological description can tell us how it feels to be in a certain way, to have a certain disease or to be in a particular situation of illness; or to meet a specific moral problem. This phenomenological dimension helps us to dig deeper and to discover what is constitutive of the experience of illness. See Søren Holm, "What Does Phenomenology Offer to Medical Ethics?" in *Medical Ethics Education Advances in Bioethics: Critical Reflection on Medical Ethics*, ed. Martyn Evans (London: Jai Press Inc., 1998), 230.
[275] Mordacci*, Medicine as a Practice and the Ethics of Illness*, 119.
[276] Pellegrino, *Toward a Reconstruction of Medical Morality*, 69.

some scholars opine that this healing bond or professional bond that exists between the healer and patient is not only a means of delivering treatment, but also it is or can be an aspect of healing itself.[277] A phenomenological approach to the philosophy of medicine seems to be the most effective method and the closest to personal reality.

In this doctrine of the clinical encounter, Pellegrino captures his philosophy of medicine in terms that underscore the unique nature and ends of medical practice. For him:

> The discipline of clinical medicine is not a science, an art, or a craft. It is an integral, practical discipline rooted in the unchanging reality of the healing relationship between patient and physician. That is, clinical medicine is a relationship between one individual, a unique embodied self in need of healing, and another individual, who professes and promises to heal with knowledge, skill, experience, and commitment to the patient's good. Thus, the end or *telos* of this relationship is a right and good healing action for the individual patient.[278]

More so, the place of the role of the clinical encounter in the Physician-patient relationship cannot be ignored in medical inquiry. It goes as far as playing the role of ensuring that the telos of medicine is actualized and by defining the unique and special identity of the physician as a physician. Pellegrino writes: "Clinical medicine is the activity that defines physicians as physicians, and sets them apart from other persons who may have medical knowledge but do not use it specifically in clinical encounters with individual patients. Clinical medicine is the physician's *locus ethicus* whose end is a right and good healing action and decision."[279]

The anthropological dimension of the relationship between a physician and a sick person constitutes an essential element of Pellegrino's medicine theory. According to Pellegrino: "Clinical medicine centers on the clinical encounter, the personal interaction between someone who is ill and someone who professes to be a healer."[280] In the same vein, Joanna Żołnierz and Jarosław Sak argue vehemently: "A proper understanding of the purpose of medicine and its nature is possible only by looking at the anthropological basis of the doctor-patient relationship."[281] This is essential because illness and the act of profession create a healing bond that cannot be ignored in medical practice.

The centrality of the phenomenology of the clinical encounter in Pellegrino's philosophy of medicine cannot be overemphasized. Through it, Pellegrino explores the nature of the patient's and the physician's understanding of illness. Specific to his philosophy of medicine is his claim that medical event, as a unique human activity, derives their meaning and

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[277] Susan Budd and Ursula Sharma, *The healing Bond: The Patient-Practitioner Relationship and Therapeutic Responsibility*, (London: Routledge, 1994), 1.
[278] Davis, *Phronesis, Clinical Reasoning*, 175.
[279] Pellegrino, *The Philosophy of Medicine Reborn*, 66.
[280] Ibid, 72.
[281] Żołnierz and Jarosław, The *basics of Edmund D. Pellegrino's medical ethics*, 904.

sense from a phenomenology of a clinical encounter from which the moral nature of medicine stems. It stems from the fact that the patient and the physician mutually enter into a healing relationship, a relationship that is characterized by the "traits of responsibility, mutual trust, decision orientation, and the curative intention. These traits represent, though rather synthetically, the result of a phenomenological consideration of the clinical encounter. They emerge as formal characteristics of the experience lived by the individual consciousness involved in the clinical relationship."[282] Thus, "the primacy of the good of the patient is the *locus* of the relationship."[283]

The clinical relationship with its defined traits constitutes a moral fabric for medical practice and the basic unit in which the telos of medicine is actualized. In this sense, the clinical encounter becomes the fundamental element of Pellegrino's philosophy of medicine through which the physician contemplates and acts towards achieving the goal of medicine. Through his doctrine of the clinical encounter, Pellegrino attempts to respond to some fundamental questions such as "How are we to understand the rationality of clinical reasoning, that process of knowing and doing, experiencing and acting, undertaken by the physician on behalf of the patient? Moreover, how are we to conceive the nature and the ends of the discipline of clinical medicine?"[284]

Pellegrino gives central attention to the issue of physician-patient centered clinical medicine by arguing that significant contemporary challenges in medicine today revolve around it. He observes that the moral climate in medical ethics deals more with issues that arise because of the changes that have occurred in the recent past about the moral standard of clinical conduct. These issues, as we have already noted, are not only related to the changes in technological advancement and progress but also relate to the physician-patient interaction. Pellegrino highlights: "Nothing in medical ethics has changed so dramatically and drastically in the last quarter-century as the standards of ethical conduct governing the relationship between physicians and patients.''[285] Pellegrino conceives the clinical encounter as a forum for answering the four questions raised by illness. Pellegrino refers to these questions as inevitable in the clinical encounter. Each physician or specialist must answer the four questions that concern any human who is ill: What is wrong? What will happen to me? What can be done? What should be done? The answers to these questions lead to the right and good decision the

[282] Mordacci, *Medicine as a Practice and the Ethics of Illness*, 119.
[283] Pellegrino, *The Philosophy of Medicine Reborn,* 151.
[284] Davis, *Phronesis, Clinical Reasoning*, 173.
[285] Pellegrino, *The Philosophy of Medicine Reborn*, 188.

patient seeks. As such, the clinical encounter calls for mutual deliberation.[286] The four questions of the clinical encounter in one way or another demand both technical and moral results of the clinical activities. Pellegrino states: "Clinical encounter- that moment when a decision and action must be taken which will be for the patient, both technically and morally."[287]

The fourth question of the clinical encounter contains some ethical elements. It focuses on what ought to be done or on what should be done. While the first three clinical questions demand more of the physician's technical competence over the patient's unfortunate condition, the fourth establishes the moral basis of the clinical activity and interaction regarding the choices and decisions to be made in the process of helping him. It brings to light the morality of taking the right decision concerning the good of the clinical activity, namely the patient's interest. Furthermore, Pellegrino articulates the teleological structure of medicine to show that medicine requires patients and physicians to make shared decisions. The clinical encounter functions as a healing relationship. Pellegrino captures these moral obligations in his thesis on the clinical encounter: "My thesis then was, and remains, that the obligations specific to physicians arise from the special features of the personal relationship between the person who is sick and the person that the sick person seeks out for help. The resulting relationship has certain features that give it a special character that generates mutual moral duties."[288]

Pellegrino presents the clinical encounter as playing a significant role as a guiding force and path to medical practice. He writes:

> Moreover, clinical medicine is the final pathway through which public policies ultimately come to affect the lives of sick persons. Finally, no matter how broad or socially oriented we make medicine, the illness remains a universal human experience, and its impact on individual human persons remains the reason why medicine and physicians exist in the first place. All the members of the health care team who confront patients directly are also clinicians. Each is engaged in a special kind of human relationship with humans in distress, which defines their profession as a specific kind of activity, e.g., nursing, clinical psychology, dentistry, allied health, etc. Each aims at health as a good, ultimately, and at a specific need essential to health. They may overlap with each other and with medicine yet remain distinct. Each share with medicine a generic set of obligations as healers and helpers in addition to other obligations specific to the nature of their profession.[289]

In order not to create an impression that clinical medicine exists in contrast with other forms of medicine, Pellegrino clarifies that his choice of clinical medicine as a paradigm case for his theory of medicine is not to neglect the existence and the roles of the other branches of medicine, for each of which has its distinctive end. He outlines that each component of

[286] Pellegrino, *The Healing Relationship,* 166.
[287] Pellegrino, *The Philosophy of Medicine Reborn*, 150.
[288] Ibid, 149-150.
[289] Ibid, 66-67.

medicine has a specific contribution towards the effective functionality of clinical medicine. He says: "Thus, for basic science, the end is acquiring fundamental biological knowledge of health and illness. This knowledge becomes a part of clinical medicine specifically when applied to the needs of a particular human being here and now. Similarly, preventive medicine has as its defining end the cultivation of health and avoidance of illness. 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 to heal a particular person, then the ends of that branch fuse with the ends of clinical medicine. Each end is good in Aristotle's sense."[290]

One central area that has attracted much attention and has been the subject of debate in medicine among many scholarly literatures about Pellegrino and his thought is the encounter between patient and physician. The patient-physician relationship, or more accurately the conduct of patients and physicians as an essential aspect of medical practice, has been the subject of considerable comment, inquiry, and debate throughout the centuries. Contemporary scholars and laypeople have contributed to the long-standing discussions on the issues specifically related to medical theory and therapy, ranging from matters of etiquette to profound questions of philosophical and moral interest.[291] This aspect of medicine continues to attract attention as a result of those distinctively modern clinical challenges that have arisen due to increased medical knowledge, improved technology, and changing cultural and moral expectations.

The proponents of a phenomenological approach to medicine argue, "merely conceptual analysis would not serve the aim of rendering the essence of medicine, since such an inquiry should instead concern first of all those contents of the experience of the healing relationship relevant for the individual consciousness and not a formal definition derived from an abstract concept. What is at stake in the medical practice is the symbolic exchange effected in and through the actions performed by the physicians and patients, and recognized by the cultural context as having meaning."[292] The phenomenological approach to medicine enables us to comprehend better the reality of the human experience of illness and the desire for health. It is difficult to define health in practical terms because the concept of illness is a complex reality and presents an extensive display of aspects and possible appreciations. In its fundamental sense, illness has the kind of reality of a *human lived experience,* that is, of an

[290] Ibid, 67.
[291] Shelp, *The Clinical Encounter*, vii.
[292] Mordacci, *Medicine as a Practice and the Ethics of Illness*, 120.

existential experience that envelops the subject which lives it and which, therefore, cannot be exhausted by any of the aspects that characterize it.[293] This lived experience of the reality of illness can only be best captured within phenomenological expressions. We can compare this lived experience with other human activities, which demand interaction, and between the professional and the client. For instance, one who is in need of barber's services must make himself present to the barber in the barbing salon. He cannot send someone to go the salon on his behalf. The sick person must live out the experience of the sickness and have a face to face with the physician who promises to heal him.

One fundamental question, which seems to appear either explicitly or implicitly in almost every contribution to the debate on the clinical encounter, is about the "proper ends of medicine and how those ends may be achieved or approximated to individuals and the moral community. This recurring concern suggests that efforts to understand the patient-physician relationship, to conceptualize it, and to explicate its morality will require a prior consideration of the philosophy of medicine in particular and of moral theory in general."[294] This was exactly Pellegrino's aim; he presents a phenomenological model of the patient-physician relationship in a value-laden manner which demonstrates medicine as a moral enterprise.

Similar to Pellegrino's analysis of the clinical encounter is the presentation of Darrel Amundsen and Gary Ferngren. They first consider the clinical encounter as customary to the Western world and as essential to the patient-physician relationship within the western context as against the non-western world. Their analyses find a place in their definitions of the essential terms of the clinical encounter. For instance, they define patients as "those who suffer or experience some perceived illness or dysfunction or injury that causes them to seek help, succor, or relief. It is only when help, succor, or relief is sought and the sufferers enter into a relationship with those whose aid they have requested, that they can properly be called 'patients', for the term suggests those who are in a state of need vis-a-vis others who are in a position to render assistance addressed to that need."[295] While they refer to the physician as "anyone who is functionally and ideologically recognized as one to whom the potential patient may go, or one whom the patient may call for help, succor, or relief of physical or, perhaps, psychological illness, dysfunction, or injury."[296] These are the key features of the clinical relationship that constitute the bond between the patient and the physician.

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[293] Evandro Agazzi, *Illness as Lived Experience and as the Object of Medicine,* 3.
[294] Shelp, *The Clinical Encounter,* vii.
[295] Amundsen and Ferngren, *Evolution of the Patient-physician Relationship,* 3.
[296] Ibid.

The reality of illness and pain, which anchor the phenomenology of the clinical encounter, therefore becomes the bond that creates and binds the patient-physician relationship. In their relationship, the physician is a resource to which the patient turns and is, at least potentially, an authority, while the patient, within the relationship and insofar as the patient is willing, accepts the other's authority as being, at least ostensibly, for the patient's good. A relationship appears as the relationship between two unequal persons. Within the relationship, the physician is in a position of strength, while the patient is in one of weakness and vulnerability. This is true of the patient-physician relationship insofar as it deals with the presence to need on the part of the former and the capacity on the part of the latter of render assistance, because of special knowledge or skill, to that need, even when the patient is the social, economic; legal, or political superior of the physician.[297]

2.2 The history and Evolution of the Patient-Physician Relationship

A physician's ability to relate effectively with his patients plays an essential role in his clinical and healing roles. Francesca Albini and Adriana Albini argue that the nature of the doctor–patient relationship has gone through various phases in history because of the changing role of the physician in the community, as well as progress in medicine and increased choices of care, together with better-informed patients. They demonstrate for instance that within Europe, cultural changes over many decades have seen a significant shift towards mutual participation, with an emphasis on informed patients and shared decision making.[298] The brief historical survey of the doctor-patient relationship which we are about to delve into will demonstrate how this relationship between a patient and a doctor has changed throughout time, and how it is currently being redefined so that both the doctor and patient may have a mutual role in treatment decisions. Taking a brief look at the evolution of the physician-patient relationship will help to discover that man in every strived to survived in the universe. As Anton Sabastian puts it that the story of medicine is in essence a recapitulation o f mans attempts at survival since his first appearance on Earth.[299] This review helps to understand as well that the fundamental problems of disease are almost the same in all ages.

[297] Ibid, 4.
[298] Francesca Albini and Adriana Albini, Evolution of the Doctor-patient Relationship: from Ancient Times to the Personalised Medicine Era," https://cancerworld.net/evolution-of-the-doctor-patient-relationship-from-ancient-times-to-the-personalised-medicine-era/ accessed January, 2017.
[299] Anton Sabastian, *A Dictionary of the History of Medicine* (New York: Informa Healthcare, 2011), v.

Pellegrino and Thomasma lament that there exist conflicting conceptual conceptions of the healing relationship in the changing sociopolitical, economic, and scientific climates in which medicine is practiced today.[300] This fragment of their controversy over clinical medicine confirms that the doctor-patient relationship has undergone a transition throughout the ages. Pellegrino advances that one of the reasons for his choice of the physician-patient relationship, as a paradigm for his philosophy of medicine is the long history of the model. He writes: "It is true that I have focused on the physician-patient relationship. I have done so because it is in many ways paradigmatic and illustrative of a relationship pertinent for other health professionals as well. The physician-patient relationship has the longest history."[301] Pellegrino himself does not provide us with the history of the physician-patient relationship; he only admits its history it is long and that it cuts across every epoch.

Available literature shows that the doctor-patient relationship has undergone a transition and evolution throughout the ages and cultures of human existence. Prior to the present day, the relationship was predominantly between a vulnerable patient seeking help and a doctor whose decisions were silently complied with by the patient. In this paternalistic model of the doctor-patient relationship, the doctor utilizes his skills to choose the necessary interventions and treatments most likely to restore the patient's health or ameliorate his pain. To understand what led to the climatic changes in today's medical practice, we must take a brief review, a glance and a short survey at the history and evolution of the phenomenology of the clinical encounter and the physician-patient relationship. Amundsen, Ferngren, and many other scholars present us with some significant literature and information on the developments of the patient-physician relationship in Western civilization from Antiquity through the Renaissance. These historical sources suggest a variety of healing models and the nature of the relationship between physician or healer and patient, which is particular to each era. They reflect the multiple paths that have been employed to effect a cure or bring relief to the sick.[302] However, a full and detailed discussion of the evolution of the physician-patient relationship is beyond the scope of this work. We attempt there to take a brief history review of this special aspect of clinical medicine.

[300] Pellegrino and Thomasma, *The Virtues*, 104.
[301] Pellegrino, *The Philosophy of Medicine Reborn*, 55.
[302] This short review of the history of the development of the physician-patient relationship is not a comprehensive account of every age. It only provide some basic indications of some selected periods to demonstrate the gradual development of this clinical enterprise in medicine.

2.2.1 Primitive or Pre-literate Era

Historically, the primitive or pre-literate era marks the beginning of the evolution of the patient-physician relationship. The primitive account captures themes related to disease causation, the status of physicians, the role of philanthropy, attitudes toward physicians, duties of physicians, and considerations of medical etiquette. Modern scholars suggest that the contemporary concerns regarding knowledge, professional decency, motivation, and technical competence have precedent in the evolution of medicine and the contact of healers with sick people from primitive cultures to the Renaissance.[303]

The pre-literate or primitive people and society, as Amundsen and Ferngren explained, believed that religion and magic were one and that medicine was subsumed under them. When people experienced any physical or psychological illness or dysfunction for which the cause was not readily apparent, they turned to those members of their society who could determine which power caused the disease, how it was manifested, and how it might be removed. Those who helped the sick were almost without exception, the most learned men in the community who possessed an intimate understanding of the supernatural and the skill to use their knowledge to the advantage of members of the community. They were variously called 'medicine men,' 'shamans' or 'witch doctors' and native doctors.'[304]

Similarly, Daniel Sulmasy recounts that recorded history reveals how at its primitive stage, the clinical relationship between the sick and the professional healers when ill persons looked outside their families for help. They went to those they believed could offer them a socially mediated response to the predicament of illness that goes beyond the limits of family. In this primitive stage, the institution of the witch doctor or tribal healer stood as the first historical, social mediation between all the dialectically opposed moments that illness represented. The witch doctor, shaman, or tribal healer brought the patient a universal healing otherness, which the universality of the patient's need required.[305]

One can boldly say that this primitive system of the patient relationship is still dominant today in the African traditional and other non-western systems of healing, where most sickness is seen as caused by the spirits, witches, and wizards.[306] John Mbiti presents a beautiful

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[303] Cf., Shelp, *The Clinical Encounter*, vii.
[304] Amundsen and Ferngren*, Evolution of the Patient-physician Relationship*, 5.
[305] Cf. Daniel Sulmasy P., *The Rebirth of the Clinic: An Introduction to Spirituality in Health Care* (Washington, D.C: Georgetown University Press, 2006),71.
[306] It sounds incredible and ridiculous there are still today real cases of many people who go to the hospitals and to the physicians of western of the model of medicine to seek healing and at the end of the day, they are sent back home by the doctors or sometimes they decide on their own to go back home on grounds that their sickness or

narrative on the reality, nature, and the activities of primitive medical practice in African society. He acknowledges that the office of the medicine man is a prestigious one within the traditional African culture. The African professional medicine men (physicians) played an essential role, and they had a goal, namely, that of healing the sick or the vulnerable sufferer. These medicine men were found in every African society and villages. They may either be men or women. They carried out the work of healing the sick and putting things right when they went wrong. Primitive medicine men were considered extremely important. They came to the rescue of the individual in matters of health and general welfare. Medicine man prescribed a cure, including herbs, religious rituals, and the observance of specific prohibitions or directions.[307]

In many native African communities, many illnesses and troubles are usually regarded, treated, and explained as religious experiences. Minor complaints such as stomach upsets, headaches, cuts, and skin ulcers are usually treated with herbs and other medicines generally known to each community. Severe and persistent complaints require the knowledge and skill of the medicine man. The medicine man has to find out the religious cause of such illness or complaint. The reason is usually magic, sorcery, witchcraft, broken taboos, or the work of spirits or ancestral grounds. It is still common in most African communities, where a large number of people still believe and live under such perpetual fear and baseless panic that their lives and families are under ancestral causes or attacks that bring about all kinds of misfortunes such as sickness, death, poverty and a gamut of others. The superstitious atmosphere of the African society promotes medicine men to act in the same capacity as religious leaders or as priests in their communities. They prayed for their communities, took the lead in public and religious rituals, and in many ways symbolized the wholeness or health of their communities. It is believed that their medicine not only cures the sick but also drives away witches, exorcizes spirit, brings successes, detects thieves, protects from danger and harm, removes the curse, and so on. The mixture of medicine and traditional African religion is also evident in how the medicine men administered and conducted medication to the sufferers or the victims of misfortunes (patients). Some special prayers and incantations accompany such activity. Mbiti provides the following sample prayers and chants that accompanied the activities of the clinical encounter in traditional African society. For instance, in the prayer or the invocation of a

situation is spiritual and cannot be cured by western medicine except by the religious and fetish healers or diviners, spiritualists or native doctors.

[307] Cf., John Mbiti S., *An introduction to African Religion* (London: Heinemann Educational Books, 1975), 151-52.

medicine man, he prepares and connects himself with the divine to him, all healing comes. He does this in total dependence on God praying thus:

> O thou who rules, thou a spirit of virile energy, Thou canst do all, and without thee, I am powerless, I am powerless; I who am consecrated to thee, I who am pledge to thee, O Spirit, from thee, I get my strength, my power. Thou brought me the gift. Spirit of force I call thee. Acknowledge my call. Come, come. Thou must come, I gave thee what thou asked me. The sacrifice has been given, sacrifice has been given in the forest; Spirit, I am thine, thou art mine, come to me![308]

The prayer for seeking divine power by the medicine man is followed by another prayer, calling on God to make effective and powerful the medicine to be administered to the sick. In this prayer, he cries out: "I have no saliva in my mouth. Thou art the possessor of saliva. Come then and spit upon this medicine."[309] After the invocation and calling for the effectiveness of the medicine to be administered, he administers the medicine by rubbing it on the sick or troubled person praying: "Today we are losing you [i.e. freeing you from your sickness] in the homestead of your family. Blessing. May you be well."[310]

The common denominator in all these systems and models is that despite their different practices and approaches to medicine, they worked toward the same and singular goal- healing or health. Another visible point of convergence among them is that despite their divergent methods and cultural perspectives of healing, they all hold to the spirit of the clinical encounter: the sick person admitting his vulnerability and seeking help from the one who claims and acclaims himself as having the skill and knowledge to heal the victim. One can boldly in the spirit of Pellegrino's philosophy, conclude that both the Western and non-western models of medicine, irrespective of their cultural or scientific differences, possess the essential properties. These unique properties have remained the hallmark of Pellegrino's phenomenology of the clinical encounter -The fact of illness, the act of profession, and the act of medicine.

2.2.2 The Period of the earliest civilizations of the Ancient Near -East

This section provides us with an outline of ancient Egyptian civilization, history, and culture. It also captures and reviews the ancient Egyptian understanding of human health and disease and medical and herbal treatments for various conditions. This touches earliest civilizations of the ancient Near East, which is, Egypt and Mesopotamia (Sumerian, Akkadian, Babylonian, Assyrian, and Chaldaean). In this era, illness and injury were viewed as creating

[308] John Mbiti S., *The Prayer of African Religion* (New York: Orbis Books, 1975), 72.
[309]Ibid, 73.
[310]Ibid.

disharmony between the one afflicted and one's total environment. As conceived among pre-literate peoples, a disease generally was not considered symptomatically but etiologically. The cause was the disease since the disease itself was the supernatural being or force that had penetrated the afflicted person. Sometimes the gods were seen as the authors of illness, and the affliction was regarded as punitive. The linking of sin and disease was not uncommon; for example, in the Code of Hammurabi, a particular deity is said to inflict sickness on those who do not obey the law.[311]

An Egyptian surgeon, Ibrahim M. Eltorai, accounts that in ancient Egypt, the physician was a priest, a magician, and a doctor.[312] There were two types of 'physicians,' the *asipu* and the *asu*, who were invariably male. The *asipu* was an exorcist, magician, and priest. Concerned with diagnosis and prognosis, he sought to identify the demon that caused - or was - the disease and to determine its intention and whether the illness would be fatal. If his prognosis were unfavorable, he would withdraw from the case. The *asipu* seldom, if ever, used drugs but relied on chants, prayers, libations, and so forth. The *asu,* by contrast, was not a priest. On the one hand, he was closer to the primitive herbalist and, on the other, to what we would call a physician and surgeon. He was not concerned with etiology. He was both a pharmacist and prescriber of drugs and employed a wide range of empirical means. He was a craftsman who was concerned with therapy addressed to the relief of pressing and acute symptoms. His craft was entirely independent of the *asipu* and probably had its roots in earlier primitive empirical medical practices. When ancient Mesopotamians became ill, they could choose to be treated by either an *asipu* or an *asu.* In making their decision, they would be guided in significant part by whether the ailment was one for which, in our terms, a 'natural' cause was apparent. In such a case, they would probably directly consult an *asu.* Some probably went first to an *asipu* and then to an *asu*, either at the *aspu's* recommendation or because he refused to treat the case. Sometimes an *asipu a*nd an *asu* worked on the same patient together. In Egypt, the divisions were not as clear as in Mesopotamia.[313]

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[311] Amundsen and Ferngren*, Evolution of the Patient-physician Relationship* 7.
[312] Ibrahim M. Eltorai, A *Spotlight on the History of Ancient Egyptian Medicine* (New York: CRC Press Taylor & Francis Group, 2020), 45.

[313] Amundsen and Ferngren*, Evolution of the Patient-physician Relationship,* 7-8.

2.2.3 The Greeks of Homer's time and of the archaic period (ca. 800-500 B.C.)

Greek medicine dispelled the myths of medicine and started treating it as a science. Rational medicine began in the Greek world as a techne, a craft, and it never lost its identity in antiquity. Physicians acquired their skill and knowledge through an apprenticeship in which they learned traditional practices. They might then open their own shop or treat patients in their homes. Many physicians were itinerant and travelled from community to community. There were no medical schools, no examinations, and no procedures of licensure. Hence, anyone could practice medicine and there was no clear distinction between a physician and a quack, since there was no external authority to guarantee a minimum standard of knowledge or proficiency. Their prestige, even their ability to earn a livelihood, depended on convincing others of their skill and knowledge. Hence, they frequently sought out patients, engaged in competition with other physicians to prove themselves better physicians than others, and devised means of advancing their reputation[314]

The Greeks' attitudes toward disease were quite similar to those of the Mesopotamians and Egyptians. They generally attributed the illness to supernatural causes, i.e., *diamonds, alastores* and *Keres* (malignant powers or evil spirits), or the gods. When the affliction was viewed as coming from a god, attempts were made to determine the cause of the deities' displeasure and to placate them through sacrifice or purification. There were various healing shrines dedicated to gods or heroes to which the afflicted might go to pray and hope for supernatural healing. There was, however, no priestly class and thus no sacerdotal physicians, as such. In this regard, the Greeks of the archaic period were closer to pre-literate peoples than to ancient Near Eastern civilizations, as they had physician-seers, called *iatromanteis*. These were, in some ways, similar to medicine men, witch doctors, or shamans in their practices, since they used charms, various methods of purification, exorcism, and spells. They were itinerant, traveling from city to city, and employed religious means and magic to turn away pollution and disease. There were also *demiourgoi,* empirical medical craftsmen, similar to primitive herbalists and their ancient Near-Eastern counterparts, treaters of wounds and minor ailments, who relied on skill, observation, and experience.[315]

As it was true of craftsmen generally, their knowledge was passed on to a apprentices. It was in the fifth century B.C. that the Greek medical craft began to take on the form of science. While a good deal of empirical technique had previously been accumulated, no effort had been

[314] Ibid, 18.
[315] Ibid, 10.

made to formulate a body of theoretical knowledge within which to place empirically efficacious procedures, to develop theories of health and disease to explain disease in terms of natural causation. During the fifth century B.C., various medical craftsmen turned to philosophy, thinking that they could thereby gain because philosophy attempted universal formulation, a correct understanding of the nature of man. The Hippocratic Corpus provides our earliest example of this new medicine that developed a theoretical basis for medical practice. Greek medicine became at the same time both rational and empirical, broadening the scope of empirical or craft-medicine to include disease, which had previously been primarily within the purview of those whose competence and knowledge made them capable of dealing with conditions to which a supernatural etiology was attributed. Now medical craftsmen, explaining disease in terms of natural processes rather than mythological or religious categories, attempted to free the treatment of illness from magic and superstition.[316] The influence of Greek rationalistic philosophy serves as a foundational and definitional change, both functional and ideological, in the very basis of medical practice. It has provided distinctions that generally have remained fundamental in Western civilization.

The new type of medical craftsman or physician was significantly different from the earlier primitive categories of physicians. This category of physicians was more than merely craftsmen insofar as they possessed not only technical skills but theoretical and philosophical knowledge and understanding, which provided both explanations for their techniques and resources for expanding the range of their efficacy. They knew not only the part but also the whole.[317] The separation of medicine from religion did not denote an antagonism to faith.[318] This change in the history of medicine is due to the influence of Greek rationalistic philosophy. It is a foundational and definitional change, both functional and ideological, in the very basis of medical practice and determining who a physician is. It has provided distinctions that generally have remained fundamental in Western civilization.[319] As we have earlier noted, the physician doctor relationship find a more rational dimension within the Greeks who developed a system of medicine based on an empirico-rational approach, such that they relied ever more on naturalistic observation, enhanced by practical trial and error experience, abandoning magical and religious justifications of human bodily dysfunction. They were also among the first nations to evolve towards a democratic form of social organization, and consequently

[316] Ibid, 11.
[317]Ibid.
[318] Ibid, 12.
[319] Ibid, 13.

established equality among the electorate. The Hippocratic Oath established a code of ethics for the doctor, whilst also providing rules that codified the doctor's prescribed attitude towards his patient.[320] This oath provided a higher degree of humanism in dealing with the needs, well-being, and interests of patients in comparison with primitive approaches as we have seen already.

2.2.4 The Roman Medicine during the Ancient Republican Period

William Scott accounts and argues that in ancient Rome, as it was all primitive societies, the practice of medicine began as a mixture of magic and religion, and remained almost entirely so until the time of Cato. In the tame of the kings and of the early Republic medicin e was still almost entirely based upon magic. The idea of magician-priest-physician was a logical concept. If the magician-priest can foretell events and placate the gods, he should be able to diagnose disease, prognosticate its course, and bring divine intervention for its cure. This, of course, has to do with internal diseases, but as with external wounds and injuries which occur in all communities, and for the treatment of these diseases, empirical methods usually quickly evolved. [321] Scott acknowledges that although divination was employed as a clinical tool for the interpretation of the will of the gods and for prognosis in disease, some rational methods of treatment were as well also known.

The ancient Roman period was has more of pagan elements and it was primarily a combination of folk medicine and magical incantations. In the third century B.C., the cult of Asclepius (Aesculapius to the Romans) was introduced into Rome, providing a Greek alternative of religious healing to earlier Roman magico-religious practices and a quasi-rationalistic and practical alternative to traditional Roman folk medicine and incipient Greek rational medicine.[322] This was an era characterized by there was a considerable increase in the availability, variety, and popularity of magical and cultic healing practices, mostly of Oriental derivation and superstitious attitudes and practices that penetrated into all areas of life including philosophy and medicine, as evidenced by a frequent reliance on astrology and alchemy. Although medical practice became more and more superstitious, in some instances employing magical procedures, and although it became less rational, it did not return to magico-religious

[320] Kaba, R. and Sooriakumaran, P. "The Evolution of the Doctor-patient Relationship," *International Journal of Surgery* 5, (2007), 59.
[321] William A. Scott, "The Practice of Medicine in Ancient Rome," *Canadian Anaesthetists' Society Journal* 2, no 8 (1955), 281.
[322] Amundsen and Ferngren*, Evolution of the Patient-physician Relationship,* 14.

medicine, as typified by the medicine man of primitive societies, or the sacerdotal medicine of ancient Near-Eastern cultures.[323]

In contrast to the Greeks, the Romans depended largely upon freedmen and slaves for medical treatment. As late as the first century B.C. no Roman citizen practiced medicine and Pliny says that Romans seldom entered the profession. Most physicians in Rome were Greek or Oriental. The Romans seem to have preferred foreign physicians and Greek was the language of medicine.[324]

2.2.5 The Medieval Period

The European scholastic medicine or the medieval medicine was distinct from that of antiquity that we have seen previously. The Medieval Age describes the influence of religion on the practice of medicine. The Medieval Period, or Middle Ages lasted from around 476 C.E. to 1453 C.E, starting around the fall of the Western Roman Empire. After this came the start of the Renaissance and the Age of Discovery. It is important to note from the very that the practice of medicine within the medieval era was highly influenced by the Greek tradition of medical practice. The relationship between the physician and the patient in the medieval period is said to be inherently and intrinsically different from that which generally prevailed in the practice of medicine among primitive people, and in ancient Near Eastern or Greco-Roman cultures. The medieval period marks a turning point in the history of the development of the physician-patient relationship. The advent of Christianity ushered in a marked change in attitudes towards the sick and the afflicted. This period was characterized by Christian agape in medical care of the sick. Early Christian literature abounds with examples of the compassionate care of the sick, both Christian and pagan. As the new religion spread, it is inevitable that more Christians became physicians, and more physicians became Christians.[325]

A special feature of the Christian approach marks the medieval period to understanding reality. The period brings to light the integrality and the marriage of faith and reason. One intriguing thing about the medieval medicine is that it was characterized by a complementary relationship between religious and secular medicine. This complementarity depicts the spirit of the medieval era in which faith and reason or philosophy and theology were defined as complementary and as integral to understanding reality. Sometimes religious and secular

[323] Ibid.
[324] Ibid, 21.
[325] Ibid, 16.

medicines were employed in conjunction with one another, sometimes separately. Some Christians combined secular medicine and prayer, while others relied exclusively on prayer. Some turned to prayer only when secular medicine proved ineffective, while others resorted to secular medicine only when prayer seemed not to avail. Some sought divine intervention through faith healing and would have no recourse to physicians. Others would try faith healing only as an act of final desperation. Except for a few sources that show an utter hostility to, and contempt for, secular medicine, even a complete reliance on religious means of healing does not necessarily imply even a disparagement, much less an unequivocal condemnation, of secular medicine.

Amundsen and Ferngren argue that regardless of instances of compassion for the ill evidenced by society in aforementioned cultures and civilizations, Christianity indeed did introduce a marked and essential change in the attitude of society toward the sick, suffering, deprived, and destitute in general and the ill in particular. They also argue that the impact of the medieval attitude has undergirded the practice of medicine and the position of the patient in Western society ever since, if not always, or even predominantly, in practice, at least as an ideal such that any gross deviation from it is generally viewed as an unworthy or even reprehensible act.[326]

Historical analysis by Amudsen and Ferngren shows that throughout the Middle Ages there existed the clerical and monastic physicians, secular physicians and medical craftsmen. During the later Middle Ages secular physicians began to increase in number and importance and a secular medical profession emerged in a sense that had not existed before and with certain characteristics that have prevailed to the present. During the Middle Ages, and indeed during the Renaissance and Reformation, there were two distinct types of medical practitioners that existed side by side: the clerical or monastic physicians who did not practice supernatural but rational medicine, and secular physicians who also practiced rational medicine.

The major difference between these two aforementioned groups of medical practitioners in the medieval period lies in their motivation for practicing medicine. It is undoubtedly true that some secular physicians who pursued medical knowledge and practiced the art were motivated primarily by an intense desire to alleviate the suffering of humankind and, within the Christian context, to glorify God and show love for their fellow man through their medical practice. However, the general rule considers it as safer to declare that while the clerical or monastic physicians practiced the medical art as an extension of their Christian

[326] Ibid, 17.

commitment, secular physicians, pursued a medical career for economic reasons.[327] The two distinctive features of faith and reason in the medieval medical practice have remained important benchmarks of the Christian tradition and approach to medical practice, as we shall see it later in the fourth and fifth chapters of this work.

2.2.6 The Period of Renaissance

The type of medical practice presented in this section focuses on learned Western medicine. History has it that 12th century marked the rapid development of western European society. This took place between about 1050 and 1225 and this period is often referred to as the 'twelfth-century Renaissance. The development a population increase, economic growth, urbanization, the development of more sophisticated forms of secular and ecclesiastical government and administration, the growth of professional specialization and of occupations requiring literacy, the multiplication of schools, and the enlargement of philosophical, scientific, and technical learning were interwoven and interdependent phenomena.[328] The development had a huge impact on the study of and practice of medicine in relation to medical knowledge and it practice, the realities of health and disease, and the needs and expectations of patients from the medical practitioners and others.

The Renaissance period is a complex and fascinating period in the history of medicine. It is described as an epoch that witnessed groundbreaking developments in medical sciences, including advancements in human anatomy, physiology, surgery, dentistry, and microbiology. Since the later centuries of the Renaissance overlapped with the scientific revolution, experimental investigation, particularly in the field of dissection and body examination, it advanced the knowledge of human anatomy. Some other notable developments of the period also contributed to the modernization of medical research, including printed books that allowed for a wider distribution of medical ideas and anatomical diagrams, more open attitudes of Renaissance humanism, and the Church's diminishing impact on the teachings of the medical profession and universities. In addition, the invention and popularization of microscope in the 17th century greatly advanced medical research. During the Renaissance, experimental investigation, particularly in the field of dissection and body examination, advanced the knowledge of human anatomy and modernized medical research.[329] Katharine Park outlines

[327] Amundsen and Ferngren, *Evolution of the Patient-physician Relationship*, 17-18.
[328] Nancy G. Siraisi, Medieval *& Early Renaissance medicine* (Chicago: University of Chicago Press, 1990), 13.
[329] "The Medical Renaissance," https://courses.lumenlearning.com/suny-hccc-worldhistory2/chapter/the-medical-renaissance/ Accessed 25, January 2022.

that outline that the intellectual interests of early Renaissance physicians in most parts of Europe especially those of the University of Florence, as expressed in their reading and their writing, were largely shaped by their training in the theory and practice of medicine. [330]

Mehdin Munim Shah accounts that the French revolution and the emergence of the Renaissance period saw a decrease in strict Catholicism and an increase in Protestantism. The altered society was becoming more liberal and people were treated with more dignity. This era was characterized by strong political and societal protests throughout the Renaissance that altered medical attitudes and actions. The previous centuries of incarceration of the mentally ill had ended and the doctor-patient relationship become more humanized and shifted towards the patient-centered approach. However, even into the 18th century, there was still an inequality between the rich and poor. Only the rich could afford the few doctors that existed, therefore, majority of the patients were upper class. This meant that doctors rarely examined patients and focused more on being attentive to the rich patients' needs and doing what they requested. The short supply of doctors and the aristocrat patients meant that this period saw patient dominance.[331]

One of the features of early modern medicine was its deep embeddedness in the geographical and environmental or climatic context, by which early modern medicine was shaped. Sociologically, patronage and contracts between doctors and patients were essential in early modern medicine, as is an analogy between society (and its ruler) and the human body (and its doctor). Technological advances in refining glass-grinding, metal processing, and the construction of measuring apparatuses have an immediate effect on the efficacy of visual aids, the construction of surgical instruments and the feasibility of physiological experiments. Cultural practices, ranging from the way of living to gender roles, from giving birth to dying, from experiencing pain and impairment to instrumentalizing music and theatre for therapeutic purposes, complete the panorama of contexts that are constitutive of early modern medicine.[332]

[330] Katharine Park, *Doctors and Medicine in Early Renaissance Florence* (New Jersey: Princeton University Press, 1985), 151.
[331] Mehdin Munim Shah, "Doctor-patient relationship: History, current models and flaws," *Bart's & The London School of Medicine and Dentistry* (14 October, 2018):1-12.http://www.rcpsych.ac.uk Accessed 24 January, 2022.
[332] Thomas Rütten, "Early Modern Medicine," in The *Oxford Handbook of the History of Medicine*, ed., Mark Jackson, (2012), 3-4.DOI: 10.1093/oxfordhb/9780199546497.013.0004

2.2.7 The Period of the 18th and 19th Centuries

The eighteenth century has been described as a time of increasing medicalization of Western societies. The transformation of medicine at this century represents a shift both in the training of medical practitioners and in accounts of the body. The 18th and 19th centuries were characterized by rapid growth in science and technology. The physician's identity was more of an expert engineer of the body as a machine. This era witness massive advancements in microbiology and surgery, which improved diagnosis that is more accurate and improved treatments. There was a shift from treating symptoms to using symptoms as diagnostic tools, known as the biomedical model. Doctors now examined patients and used expert anatomical and clinical knowledge to form a diagnosis, as a result, patients became completely reliant on doctors. This also marked a return to a paternalistic approach.[333]

Laurence McCullough further extends the inquiry on the development of the patient-physician relationship from the Renaissance into the 18th and 19th centuries. He probes the Anglo-American history of medicine during this period to correct what he considers fundamental misperceptions about its ethical legacy, especially concerning the morality of the patient-physician relationship. He argues that during the 18th century, there is evidence of genuine medical ethics in addition to the much-discussed medical etiquette as found in the work of Thomas Percival and the first code of the American Medical Association. The work of Scottish moral philosophers, such as Francis Hutcheson, that focused on notions of benevolence and duty provided a foundation for a patient-centered account of the ethics of the patient-physician relationship represented in the writings of Samuel Bard. This beneficence-based medical ethics of the 18th century was displaced in the 19th century. Intra-professional concerns and conflicting views of the telos of medicine contributed to a severance of medical ethics from its ground in moral philosophy and substitution of self-interest for philosophical reasoning in medical reflection.[334]

In his study, McCullough advocates for expanding contemporary medical ethics and its plan, as it was taken seriously in the past. By doing so, it will come to appreciate how intra-professional concerns and matters of etiquette are not only intrinsically interesting; they frequently are the cause of ethical dilemmas in medicine. In this way, we will come to see that

[333] Mehdin Munim Shah, "Doctor-patient relationship: History, current models and flaws," *Bart's & The London School of Medicine and Dentistry* (14 October, 2018), 6-7.http://www.rcpsych.ac.uk Accessed 24 January, 2022.
[334] Cf., Shelp, *The Clinical Encounter,* viiii-ix.

these issues do not occur in isolation, but in fact, they are joined together through our attempts to resolve them in terms of an account of that telos of medicine.[335]

This historical review concludes with John Duffy's essay in which he lamented that the twentieth century presented the medical profession with a host of moral issues. Still, the American Medical Association (AMA) codes have little to say about them. Most of these ethical problems have been raised by developments in science, and the AMA, which speaks primarily for practitioners, has concerned itself more with professional etiquette and the economic welfare of the profession than morality.[336] Thus it seems that, if Duffy is correct, codes and statements of principles by professional organizations like the American Medical Association are of little help in defining morality for the patient-physician encounter or in resolving the seemingly countless moral disputes about the practice of medicine.[337] The lessons of Duffy's review point to the need for a more profound philosophy and ethics of medicine that can adequately address the modern challenges of medicine.

Having examined the evolutions and issues surrounding the doctor-patient relationships in the healthcare systems of antiquity, as well as those of the early and late Medieval period and renaissance, it reveals that the contemporary concept of the clinical encounter is one with roots throughout history. This historical review helps outline the tenets of the relationship between a patient and their healthcare provider. I also provide clear examples on how religious beliefs influence and interact with medical practice as we have seen show how bedside manner has been affected by changes in moral values across cultures.

2.3 The Tripartite Model of the Physician-patient Relationship

For Pellegrino, the three phenomena of the clinical encounter should constitute the structure of the clinical medicine and serve as the starting point for a definition of what makes medicine what it is. These healing relationship phenomena are characterized by the realities and actualities of the clinical encounter that establish medicine and nursing as particular kinds of human activity.[338] Pellegrino outlines the fact of illness or disease, the act of promise by a physician, who offers to help the patient caught in the predicament of illness and the act of

[335] Laurence Mc "The Legacy of Modem Anglo-American Medical Ethics: Correcting Some Misperceptions," in *The Clinical Encounter: The Moral Fabric of the Patient-physician Relationship* ed. Earl Shelp (Dordrecht: Reidel Publishing Company1983), 61.
[336] John Duffy, American Medical Ethics and the Physician-Patient Relationship," in *The Clinical Encounter: The Moral Fabric of the Patient-physician Relationship* ed. Earl Shelp (Dordrecht: Reidel Publishing Company1983), 83.
[337] Cf., Shelp, *The Clinical Encounter*, viiii.
[338] Pellegrino, *The Philosophy of Medicine Reborn,* 269.

medicine making the technically right and morally good decision that best serves the needs and the interests of the sick person as grasped by that person and their physician.[339] We now proceed to examine Pellegrino's argument that the close relationship of the three universal phenomena- being ill, promising to heal, and healing itself, provides a foundation in the real world for the obligations of the physician and the patient to each other.

2.3.1 The Fact of Illness

The concept of illness or disease[340] is an inevitable and inescapable reality in medical practice. The entirety of the medical enterprise - theoretical and clinical research, as well as actual medical practice, has human health as its ultimate end. Health, as well as disease and illness, must always be in the focus of medical attention. The primary medical activities such as prevention, diagnosis, therapy, and cure have as their starting points the phenomena of disease and illness and as endpoint of the ideals of health. Therefore, the concepts of health and disease have a self-evident locus in the center of medicine's conceptual network. The other medical notions are parasitic to health and disease. Satisfactory theories of the former presuppose a clear understanding of the latter.[341] By implication, without the concepts of health, diseases, or the sickness, medicine cannot exist since they constitute the fundamental factor for its existence.

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[339] Ibid, 151.

[340] I use the terms illness, disease, and sickness in this work interchangeably and with the same meaning. This does not ignore the fact that there exist discrepancies in their original meanings. For instance, Pellegrino makes a clear distinction between the meaning of the concept of health and disease in which he tends to attribute a subjective definition to illness and objective consideration to the meaning of disease. He explains this by giving the following example: "Let us say that one experiences a sudden pain in the chest. Most people today are well enough educated to know that this could be the beginning of a heart attack. That realization leads very quickly to the conclusion that one is no longer healthy, but is ill. Illness is a subjective definition made by the patient, not solely by the physician. The latter determines what is a disease, which is not the same as illness. It is the patient who determines that his or her customary balance the sense of wellness has been disturbed to the point where it is necessary to consult someone else for assistance." See Pellegrino, Toward a Reconstruction, 67; Reiss Julian, and Rachel A. Ankeny attempt this distinction by stating that: "The terms 'diseases and 'illness' often are used interchangeably, particularly by the general public but also by medical professionals. 'Disease' is generally held to refer to any condition that causes 'dis-ease' or 'lack of ease' in an area of the body or the body as a whole. Such a condition can be caused by internal dysfunctions such as autoimmune diseases, by external factors such as infectious or environmentally-induced diseases, or by a combination of these factors as is the case with many so-called 'genetic' diseases (on the idea of genetic disease and associated problems." They further describe the term sickness as carrying a more social connotation. According to them: "The term "sickness" emphasizes the more social aspects of ill health, and typically highlights the lack of value placed on a particular condition by society. Disease conditions are investigated to not only be understood scientifically, but in hopes of correcting, preventing, or caring for the states that are disvalued, or that make people sick. Reiss, Julian, and Rachel A. Ankeny, "Philosophy of Medicine," *The Stanford Encyclopedia of Philosophy* (Summer 2016 Edition), Edward N. Zalta (ed.), URL = <https://plato.stanford.edu/archives/sum2016/entries/medicine/>.

[341] Lennart Nordenfelt and Ingemar Lindahl B.B. Health, *Disease, and Causal Explanations in Medicine* (Dordhrecht: Reidel Publishing Company, 1984), xiii.

Despite the central role that the concept of illness[342] plays and the special place that it occupies in medicine, its definition remains difficult. Despite numerous efforts directed to clarify the concepts of health and disease, there is far from universal agreement about their nature. The controversies are profound. They concern such fundamental issues as whether or not 'health' and 'disease' are truly scientific concepts. There are good psychological and historical explanations for this state of affairs. Health and illness are facts of extreme importance to all human beings. We want to understand them as fully as possible and from as many aspects as possible. Consequently, individuals from different backgrounds and with very different approaches address the phenomena of health and illness. Thus, one encounters anthropological, sociological, psychological, and biological theories and combinations of these. The contents of the various approaches are quite different and often quite challenging to compare.[343]

Some writers define health in purely negative terms, as the absence of disease, and then analyze health by developing an account of what a condition is. Others argue that health is not merely the absence of illness, but has certain positive elements also. One example of a positive account is the well-known statement by the World Health Organization (WHO), which defines health very broadly as a state of complete mental, physical, and social well-being.[344]

It is obvious in modern era that the definition of health and its relationship with the disease has become more complicated. It is because of the dichotomy between the value-free scientific concept of disease and the large number of value-laden socially and culturally determined definitions.[345] However, it is not within the scope of this work to provide a detailed account of the meaning of the concepts of health and disease. We are primarily concerned with Pellegrino's approach and presentation of illness's phenomenology, nature, and meaning.

At the heart of Pellegrino's thought were the notions that medical ethics could not be separated from the philosophy of medicine. A phenomenological understanding of illness and the physician's response to the vulnerable patient's plight must provide a basis for medical ethics. He believed medicine had a definable *telos* — healing the sick — and that medicine,

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[342] The concept of illness as indicated is elusive and sometimes can result in the ambiguity of definition. To avoid ambiguity in its use to other related terms, I choose not to distinguish the little differences that exist in using the words illness and being ill from sickness and being sick or disease. They are used to mean the same thing here; both terms refer to the disruption of health as the person whose health has been disrupted experiences it. They both states of affairs that deprive man of his heath, as such they have the same reference in this work.

[343]Nordenfelt and Lindahl, *Disease, and Causal Explanations*, xiii.

[344] Cf. Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles* (New York: Cambridge University Press, 2003), 75-76.

[345] Edmund Pellegrino, Ben Mitchell C., Jean Bethke Elshtain, John Kilner F., and Scott Rae B. *Biotechnology and the Human Good* (Washing D.C.: Georgetown University Press, 2007),113.

therefore, had an internal morality based on the reality of the human experiences of illness and death and the goals of medicine as an enterprise established in response to these predicaments.[346]

The fact of illness is essential to understanding Pellegrino's theory of the patient-physician relationship in the clinical encounter. Pellegrino claims that the existence of illness is an inevitable universal human experience. What is illness, according to Pellegrino? For him: "Illness is the 'subjective state' of an individual who experiences some change in that pattern of existence that is defined and experienced by him as 'health.' This change is usually indicated by some sign or symptom, which the individual interprets as signaling an acute or chronic departure from his own experience of what it is to be healthy. And in the individual, this awareness of change, this perception of some departure from his 'normal' state of 'health,' is usually accompanied by some degree of anxiety and fear - that is, by some measure of suffering."[347] In Pellegrino's definition, we see illness as a negation or rather an absence of an already experienced state and health and seeking for healing and as aiming for a restoration back to that experienced state of a healthy body and spirit.

Pellegrino's theory of illness is captured within his phenomenology of the clinical encounter. He conceives illness not just in the biomedical sense as the dysfunctionality of the biological body but as a lived experience.[348] Similarly, Pope Saint John Paul II, in his apostolic letter *Dolentium Hominem*, argued about the Second Vatican Council's assertion in *Gaudium et Spes,* no 10, that "Illness and suffering are phenomena which, if examined in-depth, always pose questions which go beyond medicine itself to touch the essence of the human condition in this world."[349] Pellegrino evokes a compelling mental pitiable image, of which the ill person is described as 'wounded humanity.' Pellegrino writes: "I argued that illness wounded our humanity, challenged our self-image, and limited our freedom in special ways, made us vulnerable ontologically and existentially. A person who offered to help a human in this altered existential state incurred obligations to act in such a way that the purpose of the encounter, healing, helping, caring, and curing, could be achieved."[350]

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[346] Daniel P. Sulmasy, "The Good Doctor," *The New Atlantis*, Number 39, [Online] from https://www.thenewatlantis.com/publications/the-good-doctor retrieved on March 27, 2019.
[347] Edmund Pellegrino, *Toward a Reconstruction*, 44.
[348] Biomedicine classifies diseases and sometimes names such diseases after their symptoms, their causes, the places where they originated, and many after other factors. In biomedicine, the concept of illness is not built on any ontological definition. Pellegrino's definition of illness is ontological, in it, we see a universal and a more unified and transcendent conception of what the phenomenon of illness entails.
[349] John Paul II, 'Apostolic Letter,' *Motu Proprio Dolentium Hominum*, *Establishing Pontifical Commission for the Apostolate of Health Care Workers,* (Rome: Libreria Editrice Vaticana, 1985), no.2.
[350] Pellegrino, *The Philosophy of Medicine Reborn*, 151.

Hence, at the one pole of the clinical encounter is the vulnerable patient because he experiences the fact of being ill. He is losing the unrestricted use of his body; he feels pain and experiences disability; he lacks knowledge of what is wrong and what to do about it or how to repair it. Relatively helpless, he is dependent upon the attention and expertise of others. He is reduced to the role of a petitioner, his self-image threatened, his freedom to make decisions limited, and the maintenance of his values threatened. At the second pole is the physician, who is capable and willing to help the sick person at the other bar.

It is within these two poles that illness creates in the clinical encounter that Pellegrino establishes illness as the more authentically basis for contemporary medical ethics. He argues: "The most certain source of humanistic ethics is the extraordinary impact of illness (that is, the impact of being ill on the humanity of person) because it is a source which gives meaning to the whole of the physician's activities. It is the need to repair specific damage done to the patient's humanity by an illness that imposes obligations on physicians."[351] The healing profession aims to remedy the physical damages caused by the disease and the damage it causes to the humanity of the sick person. In this state of wounded society, we define its concrete features and then delineate the ethical imperatives that flow from it. For Pellegrino, "these imperatives cannot constitute anything but humanistic ethics because they are tied to a specific human experience, not to a social or historical role of the profession."[352] The essence of this humanistic experience relies on the fact that particular features of illness diminish and obstruct a patient's capacity to live a specific human existence to its fullest.

Pellegrino conceives illness as a universal human phenomenon, making medicine a special kind of human activity. Pellegrino avers, "the state of wounded humanity is common. The human experiences of being ill and being healed are ultimately common to all humanity. These experiences themselves help ground our moral commitments, our duties, and obligations to one another. The goal of medicine can be formed from what all human beings seek when they seek health."[353] Furthermore, illness places the sick person is in a uniquely dependent, anxious, vulnerable, and exploitable state. Ill persons must bear their weaknesses, compromise their dignity, and reveal intimacies of body and mind. The predicament of illness forces them to trust the physician in a relationship that they would prefer not to enter and in which they are relatively powerless. In this case, a disease also becomes an assault upon the whole person.[354]

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[351] Ibid, 93.
[352] Ibid.
[353] Ibid.
[354] Pellegrino and Thomasma, *The virtues*, 35.

Pellegrino's use of the word phenomenology in his philosophy of medicine to describe illness expresses the fact that that sickness is experiential. Phenomenology is an ambiguous term but the sense in which Pellegrino employs it reflects the Husserlian tradition of insights to the things in themselves and, from a moral philosophy that reflects a first-person study of the moral life experienced by a moral agent in which the cognition of moral values primarily begins with emotions and effects as they shape our experiences of the world.[355]

What qualifies a sick person as a patient technically speaking is the act of accepting that he is truly helpless and in need of help. Pellegrino puts it: "Persons become patients when they acknowledge that they are sufficiently concerned over a physical or psychological symptom to believe they need help."[356] They can only be helped, healed, and cared for if they seek out a health professional, someone who possesses the knowledge to accomplish these ends for, and with, and them.[357]

Another deficiency that flows from this imprisonment, as noted by Pellegrino, is that illness ceases man's freedom to make decisions. The sick man lacks almost all the information needed to make rational choices and decisions of the utmost importance of his life. "He does not know what is wrong, how he became ill or why; how serious his problem may be, whether he can recover, what treatments are available and whether they are effective, and what risk, cost, pain, or loss of dignity they may impose."[358] Illness impairs the most fundamental human prerogatives of ours, which enables us to make decisions concerning our well-being—lacking the knowledge to make decisions deprive the patient of his prime and intrinsic characteristics as a human agent.

The phenomenon of illness or disease has remained for humanity a dreaded reality. No good tidings can ever be attached to its concept because it targets our spiritual and physical unity and makes the body, which until the time of sickness served our goals, become an obstacle and a limitation. Disease distorts the harmony between the dimensions of our existence and our image, which previously maintained relative integrity. The disease appears as completely new unfavorable circumstances, disturbing and unwanted information about ourselves, information about our limitations and problems, and the risk of losing our lives.[359]

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[355] Simone Grigoletto, *Only Through Complexity: Morality and the Case of Supererogation* (Padova: Padova University Press, 2019), 24.
[356] Pellegrino, *The Philosophy of Medicine Reborn,* 270.
[357] Ibid.
[358] Ibid, 95.
[359] Cf., Ibid.

The global Covid 19 Pandemic is one of the most recent instances of the experience of how illness imprisons humanity and renders it vulnerable. In his analysis of the phenomenon of the human experience of illness and the vanity of human life, Paul Enenche uses the effect of the Covid 19 Pandemic to describe how a tiny virus has held the entire world at ransom by causing much of the world to come to a standstill. Enenche reads from a text message he received from his friend from the United Kingdom to describe the tremendous effect of the plague on the entire world. It reads:

> Just one plague! Only one plague and the world stood still. Only one plague and the world's government is humbled. Only one plague and the world's powers are confused. Only one plague and everyone, is scampering for safety. Only one plague and all economy is shutdown. Schools are shut down. Offices are shut down. The streets are deserted. Only one plague and Mecca sent back worshippers. Jerusalem turned back their tourists. And Vatican City shutdown. Only one plague, Churches are shut down. Mosques are closed up. All sports are postponed. Clubs are sealed. Only one plague and the entertainment industry is groaning mournfully. Just one plague, "Don't shake hands again!" "Don't hug each other again!" "Step away from a meters' space!" Just one plaque! Before the plague, there were nations threatening nations for war. There were countries bullying countries. There was war in Syria. There was war in Iran. There was a crisis in Turkey. There were protests and political unrest. Nevertheless, the plague surfaces and quieted everything. War ceased for the plague, Unrest stopped for the plague. Olympic is shutting down for the plague. Everybody ran into his or her house. Everyone is hiding away for just one plague![360]

The above citation on the effect of the coronavirus strongly captures in almost every ramification the threat of sickness on humanity.

Similar to Pellegrino's phenomenology of illness is the position of Kay Toombs. Toombs believed that patients experience illness because "the act of healing requires an understanding of illness-as-lived."[361] This phenomenological analysis provides the insight that illness is fundamentally experienced as the disruption of a lived person rather than as the dysfunction of the biological body. The phenomenological analysis indicates that the prevailing biomedical model of disease, which tends to focus exclusively on the dysfunction of the biological organism and the pathophysiology of the disease state, is an incomplete model for medical care. Rather, an adequate account of illness must include not only a construal of illness in terms of clinically definable disease states but also an understanding of illness as lived.[362]

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[360] Enenche Paul, The Effects of Covid-19, March 27, 2020, https://www.youtube.com/watch?v=dZOusCgUWHQ&t=2s Accessed 11/08/2020 3.35am

[361] Kay Toombs S., *The Meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient* (Dordrecht: Springer Science+Business Media, 1992), 90.

[362] Toombs, The *meaning Illness*, xvi.

2.3.2 The Act of Profession

The profession is the promise that health professionals make every time they offer to help a sick person. It declares implicitly to the patient and family that they are competent, that they will use that competence in the interests of the patient, and that they can be trusted not to abuse the privileges that promise entails to help to manage some of the most significant events in any person's life. It allows them, in the patient's interests, to learn all the weaknesses and foibles, to probe, palpate, prick, and incise the body to a degree of intimacy one does not accord strangers. Sometimes there is more intimacy than there might be in a marriage or other strong bond in society.[363] One of the qualities or roles played by the phenomenology of the clinical encounter, as we had earlier noted, is that it gives the physicians a sense of identity to their professional roles. It sets them apart from others by publicly declaring them as devoted to healing the sick.

The fact of the illness generates a need for healing to which the act of profession responds—the front of profession springs from the primary reality of the presence of the patient. Without the patient, there is no profession because the work arises in response to the patient's health needs. Illness threatens the patient's life and lifestyle because it amounts to an ontological assault on the patient's existence as a person. Thus, by professing medicine, the physician adopts the patient's good as the end of medical practice. We find it somewhere in the Holy Scriptures where Jesus uses this concept of the fact of illness analogically as generating a need for healing. The act of medical the profession responds to pass his message as one who came to into the world to heal sinners. He came because the world was rotten by sins (disease), there was a need for his coming: "They who are strong have no need of a physician, but they who are ill; I came not to call righteous men, but sinners to reformation" (Mark 2:17).

Furthermore, Pellegrino argues that it is because patients need medical help that the medical profession exists. If the patients could handle or solve their problems alone and in their way, using their resources, the profession of medicine would not exist, and they would not have come to the physician for any help since they could take care of their health issues. As it is, those patients must come to the health professionals for assistance. The act of profession requires that physicians must possess certain professional qualities. To be capable of curing and helping patients, Pellegrino, in his regular use of the 'clinical encounter,' emphasizes the

[363] Edmund Pellegrino and David Thomasma, *Helping and Healing* (Washington D.C: Georgetown University Press, 1997), 27.

interactive roles of the patient and physician in the medical decision-making process and the inseparability of medicine and philosophy. This encountering enables a forum where the patient is empowered to define the good of treatment with their physician.[364] We must take into account that both the physician and the patient are both experts in their capacities. The physician possesses the knowledge of the diseases, which he promises to assist the patient in getting a cure. The patient in his capacity possesses the knowledge of the sickness based on his personal experience of the sickness as a patient. This mutual interaction and dialogue between the physician and the patient helps them to deliberate and exchange ideas on the possible ways of achieving healing. This must be done with mutual respect and trust.

Pellegrino advocates that in the clinical encounter, physicians must be sure to define the problem correctly. The physician must speak the patient's language, not vice versa. What physicians say to patients must be comprehensible. The physician must start where the patient is, not the other way around. The patient's needs are to be met, not the physician's, though doctors need to be happy in their work. The patient's problems are the subject of the transaction. They are not interested in hearing a parallel story from the physician's life.[365]

Two things Pellegrino advances as crucial and implicit in the act of profession: "The first implication is that the physician possesses the necessary knowledge—that he is competent. The second is that he will use that competence in the patient's interest and not his own for the patient's good."[366] Meeting the sick person in that vulnerable condition, the physician or nurse accepts the responsibility of helping and caring, he adopts the patient's good as the end of medical practice.

2.3.3 The Act of Medicine

The act of medicine is the culmination of the process of clinical reasoning. It is the stage of moving a sick person from a state of illness and vulnerability to a state of health and freedom. It involves those actions on the part of the physician that will lead to a correct healing decision. A healing decision will make the patient whole again, restore bodily wholeness only if possible, and perhaps even make it better than before the illness occurred. A healing decision is consistent with the knowledge that we have of scientific medicine—in other words, a medically competent decision. However, it must also be a good decision. A good decision will fit this

[364] Bain, *Revisiting the Need for Virtues*, 4.
[365] Laurence Savett A., *The Human Side of Medicine: Learning What It's Like to Be a Patient and What It's Like to Be a PhysiciaN* (London: Auburn House, 2002), 163.
[366] Pellegrino, *Toward a Reconstruction*, 67.

particular person, at this age and situation in life, with this person's aspirations, expectations, and values.[367]

However, how is this act integrally related to the other two constitutive elements of the fact of illness and act of profession? The existence and experience of disease are inseparable from the ontological need for healing. With the hope of fulfilling this need, the patient seeks help by initiating a relationship with one who professes to help and heal. The patient seeks something particular to him and him alone: a return to, restoration of, health or wholeness, as he has experienced this existential state. In addition, what the physician promises to do is to decide and act to fulfill this need of this patient.[368] In response to this need, the physicians, in dialogue with the patient, set the four questions of the clinical encounter into action as tools that guide him in achieving the aim of the clinical encounter.

Pellegrino explains further that what the physician, as a professional, promises is not simply to provide theoretical responses to the clinical questions but to answer them in praxis, by acting first, to diagnose the patient's illness and identify the possible and appropriate therapy and then, most importantly, to do what should be done for this particular patient. What should be done is what every patient seeks, and every physician promises to do to initiate a right and good healing action on behalf of the particular patient. Thus, what the patient seeks and the physician professes to provide is not simply the scientific explanation presented in a diagnosis, although, to be sure, there is some measure of relief from the anxiety of illness in knowing what was previously unknown, that is, in knowing what may or may not be the 'underlying' cause of illness. Nor is it the clinical knowledge of what may be done to treat the symptoms and/or the cause of disease. What the patient seeks and the physician promises to provide is not knowledge or theory but an individualized praxis of healing, an answer to the question of what should be done, and the fulfillment of that answer in a decision to act accordingly.[369]

Pellegrino insists that the diagnostic, prognostic, and therapeutic acts that are manipulative, judgmental, and cognitive, and so on must be directed to what is necessary to heal and help the dependent patient to a technically correct and morally good decision and action.[370] The possibility of healing taking place outside of the clinical setting or outside of the medical profession is not denied in Pellegrino's analysis of the patient-physical healing relationship in the clinical encounter. His unique submission is that the ultimate *telos* of health

[367] Ibid.
[368] Davis, *Phronesis, Clinical Reasoning*, 179.
[369] Davis, *Phronesis, Clinical Reasoning,* 179-180.
[370] Pellegrino, *The Philosophy of Medicine Reborn*, 270.

care- the cultivation and restoration of health and the containment or cure of disease-specific to health professions, must be in accord with the tripartite feature of the clinical encounter through the science and art of medicine. This belongs to medicine as a specific human activity.[371]

One exciting and remarkable feature of Pellegrino's doctrine of the clinical encounter is its significant boundary in scope; it is open and applicable to clinical settings of other disciplines and professions of healing kind. It is not limited to the medical profession alone. Pellegrino clarifies: "It is important to note that while I am speaking of the physician, the same approach applies to the nurse, dentist, and psychologist—any of the professions that offer themselves as healers. There are three phenomena that we must consider: the first is the fact of illness; the second is the act of profession; the third is the act of medicine."[372] The theory of the clinical encounter, one may say, has a universal character and application for healing professions. Through it, Pellegrino offers a versatile working tool or a methodology to medical health care practice.

2.4 Reconciling the Principle versus the Virtue-based Ethics

The bond of the physician-patient relationship which involves moral choices in health care, makes the clinical encounter. To ensure an effective practice of clinical medicine, four guiding principles to biomedical ethics were put into a theoretical framework and published by Tom Beauchamp and James Childress to direct and assist medical health care professions.[373] These principles are: "Beneficence (the obligation to provide benefits and balance benefits against risks), Non-Maleficence (the obligation to avoid the causation of harm), Respect for autonomy (the obligation to respect the decision-making capacities of autonomous persons), and Justice (obligations of fairness in the distribution of benefits and risk)."[374]

Beauchamp's and Childress's intention was that of working out a modality through which these principles can come together to work effectively within the framework of the physician-patient relationship of the clinical encounter. These principles became so central to medical practice to the extent that they served as the cardinal points from which every health

[371] Ibid.
[372] Pellegrino, *Toward a Reconstruction*, 66.
[373] Pierre Mallia, *The Nature of the Doctor-Patient Relationship Health Care Principles Through the Phenomenology of Relationships with Patients* (Springer: New York, 2013), 2.
[374] Mallia, *The Nature of the Doctor*, 2.

rule or ethics was expected to depart from.[375] He meant these principles to be understood as the standards of conduct on which many other moral claims and judgments depend. He conceived a principle to be "an essential norm in a system of moral thought, forming the basis of moral reasoning. More specific rules for health care ethics can be formulated by reference to these four principles, but neither rules nor practical judgments can be straightforwardly deduced from the principles."[376]

In the 1970s, issues of physician-patient relationships and the resolution of practical clinical dilemmas brought to the forefront of medicine urgent normative challenges. Consequently, clinicians and some bioethicists began to criticize principlism, claiming that it "does not respect the particularities and the emotional, personal, professional, and cultural content of ethical cases and dilemmas."[377] However, while these principles remain valuable in contemporary practice, many criticisms have, over time, been advanced against their efficacy to resolve most of the modern dilemmas that arise within the doctor-patient relationship. Pellegrino observes that the appearance of the shortcomings of 'principlism' started when experience in the use of the four principles framework, and its application to the realities of the doctor-patient relationship became widespread. Some moral philosophers called for its abandonment or its replacement by alternative theories based on virtue, feminist psychology, casuistry, or experience.[378] The controversy between principle and virtue-based ideas is what Gillon describes as the tension between traditional medical ethics and contemporary critical medical ethics.[379]

Despite the criticisms against the principle-based approach to biomedical activities, Pellegrino maintained that the four principles should neither be alternated nor abandoned. While he argues that the four principle approach does have theoretical and practical inadequacies, he insists that "it should not be abandoned because it still has much to offer. Its shortcomings can be remedied."[380] On the four principles, he argues further "they need to be redefined and grounded in the reality of the doctor-patient relationship."[381] By proposing a redefining and grounding of these principles in the reality of the physician-patient relationship,

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[375]Ibid, 2.
[376] Tom L. Beauchamp, "The Four Principles Approach to Health Care Ethics," in *Principles of Health Care Ethics*, Second Edition, eds., Richar.E. Ashcroft, Angus Dawson, Heather Draper and John R. McMillan (England: Wiley & Sons, Ltd, 2007), 3.
[377] David Thomasma, "Virtue Theory, Social Practice, and Professional Responsibility," in *Advances in Bioethics: Critical Reflection on Medical Ethics,* ed. Martyn Evans (London: Jai Press Inc., 1998), 326.
[378] Pellegrino, *The Philosophy of Medicine Reborn*, 187.
[379] Gillon, *What is Medical Ethics' business*?, 46.
[380] Pellegrino and Thomasma, *The Virtues*, 51.
[381] Pellegrino, *The Philosophy of Medicine Reborn*, 187.

Pellegrino expects that this "can provide a standard against which the fundamental conceptual problem of conflict among prima facie principles can be resolved."[382] The act of fine-tuning the four principles and grounding them in the reality of the clinical encounter appears for Pellegrino the best option of moral insight compared to any other non-principled based ethical perspective. The process of fine-tuning the principles creates an avenue for a dialogue with non-principled-models and provides a forum for a better linkage between them.

For Pellegrino, the issue of abandoning or replacing the principle-based approach to medicine with an alternate ethical theory has no basis at all. It should not even arise in the first place. Redefining the principles flows from the fact that just as society continues to evolve, changes in the internal morality of professions occur. The need for a paradigm shift becomes a necessary tool for confronting changes in careers because of the society's dynamic and pluralistic nature. In this context, Pellegrino argues for the beauty of pluralism by saying that, "it is a good thing because it helps us to reestablish and reform those cherished values that ought to persist throughout civilizations, no matter what their form."[383] He strongly advocates for respect for the patient's self-determination, and his integrity as a person, as a moral necessity in the doctor-physician relationship.

As earlier stated, Pellegrino's view is quite different from other scholars who opposed and suggested that the four principles should be abandoned. Pellegrino aimed to create a cordial and healthy linkage between the four principles and other ethical theories sources. He stated succinctly: "My purpose in reciting some of these difficulties is not to suggest that the four principles should be abandoned-as others have suggested. It is rather to point to some important philosophical questions that arise from the experience of applying principles in the decisive moment, that is, in the actualities of the doctor-patient relationship. These experiences indicate that the four principles cannot stand alone, that they need linkages with other sources of ethical insight, and that they need a closer grounding in the phenomena of the relationship itself."[384] This statement is an invitation for a conceptual link between the principle-based models of ethics with the non-principle-bases sources of ethics. He refers to this task of modifying principles as the "most serious conceptual task biomedical ethics faces in the immediate future."[385] Like Pellegrino, Gillon posits, "Thus, there is no inherent conflict between virtue ethics and principle-based ethics, on the contrary, each needs the other."[386]

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[382] Ibid.
[383] Pellegrino and Thomasma, *The Virtues*, 51.
[384] Pellegrino *The Philosophy of Medicine Reborn*, 197.
[385] Ibid, 199.
[386] Gillon, *What is Medical Ethics' business?,* 46.

Pellegrino's primary aim is to integrate and bring the four principles of biomedical practice into closer congruence with some of the practical realities of clinical decision-making within the doctor-patient relationship in the clinical encounter and to link these principles to other ethical theories. It is very clear, therefore, that Pellegrino was not in any way *anti-principlism*. One could rather describe him as a mediator between *principlism* and non-principle-based ethical views. He distances himself from the anti-principlists who advocate for the substitution and replacement of principles with the non-principle-based framework as a basis for medical ethics. He regards any attempt to substitute the principles with other non-principle-frameworks such as virtue, feminist, or experiential systems as dangerous and disastrous because as valuable as they are, they could also lead to that danger to which non-principle-based are susceptible like subjectivism, emotivism, and egoism.[387]

Putting together some of the contributions of the four principles in medical ethics, Pellegrino describes the four principles as irreplaceable. He argues that it would be a retrogressive step indeed to drop the principles and return to some simplistic conviction of the sufficiency of the Hippocratic Oath, which all physicians take.[388] Pellegrino praises principle-based ethics as very useful because it has enriched medical practice by putting the whole process of moral decision-making on a more orderly, less idiosyncratic, and more explicit basis. More so, it has raised sensitivities to ethical issues among all health care workers, patients, and their families. Above all, it has provided a universal medical language (lingua franca) that serves as a unique tool for communication among physicians and ethicists, whose moral presuppositions might otherwise have been incommensurable with one another.[389] Principles, therefore, become universal or general guides to actions. Francis Parker argues that regulations are significant in life because life has no sense; without principles, the world will be incomprehensible. Without them, life is impossible, either literally or conceptually, and that life will be meaningless.[390]

Pellegrino proposes the principle-based model as irreplaceable, inevitable, and indispensable to medical ethics. He acknowledges the authenticity of the varied criticisms leveled against principle-based ethics by some protagonists of a virtue-based model approach to ethics, feminist psychology, casuistry, or ethics as narrative, experiential, or existential phenomena. They commonly describe principlism as too abstract, too removed from the moral

[387] Pellegrino and Thomasma, *The Virtues*, 59.
[388] Pellegrino, *The Philosophy of Medicine Reborn*, 197.
[389] Pellegrino and Thomasma, *The Virtues,* 58.
[390] Francis H. Parker, *The Aquinas Lecture, 1971, Reason and Faith Revisited* (Milwaukee: Marquette University Press, 1971), 36-37.

and psychological realities of actual people making actual choices, and too male-oriented in its psychology and reasoning and as ignoring the character, gender, life stories, and cultural identity of moral agents. He however, disagrees that these criticisms could "do away with principles or are themselves fully adequate replacements."[391] Thus, integration and a suitable linkage between the principle-theoretical ethical framework and the non-principle-based ethical sources should be the hallmark of the ethics that will resolve the modern moral and professional challenges in medicine.

In search for a suitable ethical model that will help us to confront the problem of social and moral pluralism and to help us resolve moral dilemmas more efficiently in medical practice, Pellegrino suggests that instead of looking up solely to moral principles, we should also examine the virtues that have spanned the history of medicine to this day. He describes these virtues as reliable because they are built on the teleological structure of medicine. They look into the healing ends of medicine, which create the bond of healing in the doctor-patient relationship, which is still the ultimate goal of the profession of medicine.[392]

How does Pellegrino approach this project of linking and integrating principles and grounding them more firmly in the phenomena of the doctor-patient relationship? He does this in two ways: One is external, "by the application of an already developed philosophical or ethical system to the medical relationship."[393] In this first approach, Pellegrino suggests using principle-based ethical systems like consequentialism and deontologist in judging moral actions in clinical decision-making. The second approach is teleological in the classical context, oriented to the ends and purposes of the doctor-patient relationships, which determines the rightness and wrongness of actions within the clinical setting. Thus this second method is an invitation to "examine the doctor-patient relationship with the method of philosophy (critical reflection) but without the content of a specific philosophy to drive from the relationship what is required ethically and what principles best exemplify what is required."[394] This approach appears more objective and universal, as it is not tied to any particular view. It gives room for critical appraisal based on a universal goal of the profession of medicine. Thus, the ends of restoration, improvement, and curing illness become the moral scale for determining and judging right and wrong clinical actions and decisions.

[391] Pellegrino, *The Philosophy of Medicine Reborn*, 199.
[392] Pellegrino and Thomasma, *The Virtues*, 60.
[393] Pellegrino, *The Philosophy of Medicine Reborn*, 200.
[394] Ibid.

Pellegrino's project of linking principles or the prima facie with non-principle-based ethical theories by grounding the phenomena of the physician-patient relationship has remained, despite its inadequacies, one of the most influential contributions to the development of medical ethics in contemporary society. His struggle to merge principle-based ethics with non-principle-based ethics in the medical profession led him into propounding his famous virtue-based model ethics in medical practice. A theory in which he formulated a scale of balance between principles and virtues as suitable pillars for medical ethics. He emphasizes the indispensability of both principles and virtues by balancing the role of principles and virtues as complementary ethical forces in medical practice. He considers and describes both principles and virtues as immensely valuable in medical professional roles. Pellegrino seeks common grounds between principles and virtues or a non-principle-based ethical framework.

Consequently, none of them is expendable from medical ethics because both principles and character or the agent is crucial and essential for medical professionals. In his argument and proposal for the necessity and complementarity of virtues and principles in medical practice, Pellegrino summits: "It is the agent who interprets principles, selects the ones to apply or ignore, puts them in order of priority, and shapes them in accord with his life history and current life situations. This reality has been too often ignored in past biomedical and clinical ethics explorations. A proper balance must be struck between rule-based and virtue-based ethics for the health of both."[395]

Pellegrino attempted to reconcile and initiate a link between the principles and non-principle-based ethical models by arguing that each of the approaches has "something to contribute to medical ethics and must be taken into account in any attempt to formulate an integral or comprehensive moral philosophy of medicine."[396] Pellegrino amalgamates the two models as he contends strongly "virtue-based ethics, as well as the newer alternatives to principle-based ethics, must somehow be joined to principle-based ethics if the limitations of each approach are to be balanced by the strengths of the other."[397] He discourages any attempt to argue about the superiority of a virtue-based ethic over the principle-based model by seeking to spell out more clearly the relationship between principles and virtues in such a manner that the weakness and nuances of the approaches can be accommodated.

The major problems that Pellegrino wrestles with in his theory of medicine are apparent. He set out to resolve the issue of socio-political and moral pluralism. He intended to

[395] Pellegrino and Thomasma, *The Virtues*, 19.
[396] Ibid, 20.
[397] Ibid, 19-20.

use his teleological theory of mercy to harness and resolve the clash of the conceptual problems in medicine and to resolve the ethical dilemmas between the principle and non-principle-based ethical theories. On the need to harmonize the role of principle and non-principle ideas, Pellegrino argues that it is one thing to have, and know the moral principles while applying them to particular situations is another. According to Pellegrino: "One may have a good grasp of ethical principles and yet not apply them correctly or dependably; on the other hand, there are persons of character who may not be aware of moral principles or may even reason incorrectly about them but are of such character that they can be depended upon to act rightly."[398]

It follows that it is not sufficient to settle for character alone as a basis for ethics; neither is it enough for principles alone as foundations for medical ethics. Good dispositions or good character alone will not ensure that the act or moral choice is good. It can provide good intentions and motives. However, the moral quality of actions and persons depends on how preferences, circumstances, and acts relate to each other. Ethical principles alone cannot be used as the basis for moral philosophy. This does not deny that moral principles are the benchmarks against which we may assess the moral quality of these relationships. Pellegrino avers: "A complete moral theory must, at a minimum, tie some conceptual knots between duty, principles, and virtue."[399] We shall see more of these specifications in chapters three and four.

2.5 Fourfold Components of the Patient's Good

The theme of the patient's good remains central to Pellegrino's medical ethics. It is an obligation and the responsibility of all health care providers in their capacities as healers to prioritize the Hippocratic Oath. He acknowledges that acting for the patient's good is the most and universal principle of medical ethics.[400] For Pellegrino, working for the good of the patient "is the ultimate court of appeal for the morality of medical acts."[401] From this moral perspective, Pellegrino argues that sound medical ethics must be characterized by a distinctive concept of the definition of the good of medicine. He writes: "Any ethics of the process of the

[398] Ibi, 20.
[399] Ibid, 21.
[400] The complexity surrounding the journey to the telos or the good of the patient as the maybe is mattered most at this point to Pellegrino. The fact that medicine has an internal morality does not necessarily mean that every decision made by a physician in the clinical encounter is good and that it will necessarily lead to the good of the patient. However, the fact that physicians can also make bad decisions in clinical deliberations does not vitiate the internal morality of medicine but invites health professionals to be attentive and sensitive to the need for prudent clinical judgment.
[401] Pellegrino, *The Philosophy of Medicine Reborn*, 163.

clinical decision must begin with a clear notion of the good of the patient."[402] As earlier discussed in section 1.5 of the first chapter of this work, Pellegrino identifies the patient's good as the *telos* of medicine.

However, Pellegrino laments that there is no agreed-upon philosophical anthropology or metaphysics in our pluralistic society upon which some shared idea of the good for humans could be based.[403] Just as general differences exist and relativized and subjective theories towards the meaning of good, the different parties in the clinical encounter also hold opposing views about the meaning of the patient's 'good' or the 'good of the patient.' There are divergent interpretations that engender some of the most vexing ethical dilemmas in clinical decision-making that cannot be solved without a clear understanding of the meaning of the patient's good.

Focusing on the traditions of the Hippocratic corpus' elaborations of the benefit of the patient as the good of medicine and the Aristotelean teleological explications of the goal of medicine as the healing of the sick person, Pellegrino succinctly asserts: "The first principle of medical ethics, the end to which it is directed, is the good of the patient."[404] This good, in clear terms, is the restoration of health to a sick person or "a particular kind of good that pertains to the human person in a particular existential circumstance –being ill, and needing the help of others to be restored or to cope with the assault of illness."[405] This resilient claim has remained undoubtedly stable for ages in the history of medical debates. No school of thought has been able to refute the fact that medicine exists for the patient's good.

We are however, confronted here with the long and unsettled perennial philosophical issue of the indefinability of 'good.' Katz argues that the question of what constitutes the meaning of the concept of good is a problematic one in both semantics and philosophical quarters. Katz suggests that the helpful way we may accomplish or arrive at meaningful subcategorization of the meaning of good is by adhering to the evaluation of the semantic markers characterized with symbols representing the concepts of use, function, duty, and purpose.[406] The topic around the concept of the good, in general, revolves around the question

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[402] Edmund Pellegrino, "The Caring Ethic: The Relation of Physician to Patient" in *Coping, Curing, Caring: Patient, Physician, Nurse Relationships,* eds., Anne H. Bishop and John R. Scudder (United States of America: The University of Alabama Press, 1985), 20.
[403] Pellegrino and Thomasma, *The Virtues*, 18.
[404] Pellegrino, *The Philosophy of Medicine Reborn,* 69.
[405] Ibid, 164-65.
[406] Jerrold Katz J., "Semantic Theory and the Meaning of `Good," *The Journal of Philosophy* 61, no. 23 (Dec. 10, 1964), 739.

of the constitutive elements of the good, the criteria for deciding what qualifies a person or a thing to be good, or an event or an action to be good.

The Greek word αγαθός (*agathos*), and the Latin word *"bonum*" literarily express the English word good connoting being beautiful, nice, and kind and many more pleasant expressions about good. While the word 'good' connotes different meanings ranging from economic and other dimensions. Andrej Marniarczyk underlines its moral connotation and significance, which is connected to the moral qualification of acts. In this sense, we speak of right or good acts, decisions versus evil, wrong, or bad acts and decisions.[407] In an aesthetic sense, we speak of good in terms of pleasure and appearance such as good paintings, good work, or good music. In the court of metaphysics, the term 'good' primary connotes "a mode of the existence of a being that is in agreement with the will of the maker or creator".[408] This metaphysical dimension provides us with the sense of the end-purposefulness of things and persons in the universe.[409]

A long time ago, Aristotle wrestled with the problem of the multiplicity and the relativity that surround the variety of our uses of the concept of 'good'. He argued that the meaning of good varies significantly, as it applies to each category of being. He considers good to be spoken of in varied ways as it is in the case of being, which is considered to be understood in multiple ways. In this manner, he classifies good in a hierarchical order, such as the honest, utilitarian, and pleasurable good.[410] Aquinas' *Commentary on Ethics* also emphasized the multiple, complex, and varied nature of the notion of the good. More recently, some scholars like Georg Henrik von Wright and Alasdair Macintyre[411] have tendered beautiful philosophical submissions concerning the multi-dimensional nature of the use of the 'good.'

Idris Murdoch has observed that philosophy, moral philosophy, in particular, demonstrates the sovereignty of good over other concepts. Ethics describes the good as

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[407] Andrzej Marniarczyk, *Rationality and Finality of the World of Persons and Things, Metaphysics Notebooks 4* (Lublin: KUL, 2007), 62.
[408] Marniarczyk, *Rationality and Finality*, 62.
[409] This conception or view called finalistic (teleological) which is found in the tradition of Aristotelean philosophy brings out the basis of our work on the teleological identity of medicine as an art that is purposeful and end-oriented to a certain goal, namely the good of the patient. As already cited in the first chapter of this work, Aristotle in his Nicomachean Ethics Book I, 1094a1-4 wrote: "Every art and of all inquiries, and likewise all actions and conduct, seem to strive after some good and therefore the good is rightly described as the end-purpose of all appetite."
[410] Cf. Aristotle, *Nicomachean Ethics*, 1096a23.
[411] His emphasis is on the fact that the use of good applies to a variety of contexts and uses. In multiple ways, as he puts it "we speak of god knives, good jam, good poems, and good kings, but also of a good time to apply for a job or to make oneself scarce, a good place to take a vacation or to build a prison, and good qualities to look for in candidates for public office. We may say of someone that she is good with children, good at tennis, or good for nothing." Alasdair Macintyre, *Ethics in the Conflicts of Modernity: An Essay on Desire, Practical Reasoning, and Narrative* (Cambridge: Cambridge University Press, 2016),13.

sovereign over other concepts such as courage, freedom, truth, and humility and with the power to unify them.[412] Apart from the difficulty in finding the criteria of deciding what qualifies something or an event to be termed as good, another critical characteristic of the concept of good is its applicability to several different classes of objects and events that demand descriptive and evaluative interpretation of the meaning of good.[413]

Similarly, the problem of the meaning of good in medicine poses a severe challenge to understanding the patient's good, which medical enterprise strives to achieve. Pellegrino was so preoccupied with the fact that in morally diverse society exists opposing views of ultimate and immediate good held by parties in a clinical decision involving moral voice. He argues that the problem of conflicting opinions about the patient's good, which he describes as "the most ancient and universally acknowledged principle of medical ethics,"[414] must be clarified. The role of the concept of the patient's good is that it grounds ethical theories and shapes how these principles are applied in particular cases. Therefore, the notion of the patient's good becomes a concrete point of reference for all medical acts.

The only possibility for which, on rare occasions, this principle can be set aside must be in exchange for the common good, and this is done with trepidation and in only the most urgent circumstances. In an attempt to resolve the problem of the plurality of good, Pellegrino proposes and examines four interpretations or meanings of the patient's good and suggests a general hierarchy or ranking of them. It is through the instrumentality of this compound theory of the good as Xavier Symons observes "Pellegrino argued that medicine is a social practice with its unique goals-namely, the medical, human, and spiritual good of the patient and that the moral norms that govern medical practice are derived from these goals."[415]

The above listed four components of the patient's good are related to each other but distinct that the physician is obliged to respect each level of patient good. The hierarchy of patient's good enables the physician to determine how moral conflicts should be resolved concerning the patient's good.[416] For Pellegrino:

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[412] See, Iris Murdoch, "The Sovereignty of Good Over Other Concepts" in *The Virtues: Contemporary Essays on Moral Character* eds., Robert B. Kruschwitz and Robert C. Roberts (California: Wadsworth Publishing Company, 1987), 83.

[413] See, Hare R, M. "Good" as a Commending Word" in *The Virtues: Contemporary Essays on Moral Character* eds., Robert B. Kruschwitz and Robert C. Roberts (California: Wadsworth Publishing Company, 1987), 234.

[414] Edmund Pellegrino, Moral Choice, the Good of the Patient, and the Patient's Good in Ethics *and Critical Care Medicine* eds., John C. Moskop and Loretta Kopelman (Holland: D. Reidel publishing company, 1985), 117.

[415] Xavier Symons," "MacIntyre, and the internal morality of clinical medicine" *Theoretical Medicine and Bioethics* (2019) 40:243–251 https://doi.org/10.1007/s11017-019-09487-8

[416] Pellegrino confined himself to the patient's good as perceived by the patient and avoided the more profound issues of the good of the patient metaphysically. He used the example of decisions not to resuscitate as a paradigm case for the issues involving the patient's good though the analysis applies to most clinical decisions involving

> The good of the patient is a particular kind of good that pertains to a human person in a particular existential circumstance -being ill, and needing the help of others to be restored, or to cope with the assault of illness. In a general way, the good the patient seeks is the restoration of health - a return to his or her definition of what constitutes a worthwhile way of life - one that permits the pursuit of personal goals with a minimum of pain, discomfort, or disability. This is the end the patient seeks in the medical encounter, and the physician promises to serve by his act of "profession" - his promise to help with the special knowledge at his disposal. The physician thus becomes an instrument for the attainment of the good the patient seeks.[417]

Pellegrino finds the phenomenology of the clinical encounter as a suitable ground for exploring the concept of the patient's good in concrete terms. He clarifies that there is a distinction between the good as perceived by the participants in clinical decisions and the ontological nature of good. He explains that his aim is to neither answer the prickly questions on the objectivity or non-objectivity of the good, nor point out whether particular interpretations of patient good are metaphysically sound or not. Instead, his focus is on the fact that widely divergent interpretations do occur. Even though physicians, patients, and families must make decisions together, and that the conflicts, when they occur, must be dealt with in a morally defensible way.[418]

Pellegrino's theory of the patient's good takes a quadripartite structure. He arranges a hierarchical and complex inter-relationship that exists between medical, personal, human, and spiritual good. Pellegrino aims to provide a clearer vision and identification of each component of the patient's good, clarify the use of this universal notion, and understand the conflicts that can result from its varying interpretations.[419] We now proceed to examine Pellegrino's account of the four levels of the patient's good.

2.5.1 The Medical Good

The 'biomedical' or 'techno-medical' good is the lowest in ranking among the four components of Pellegrino's theory of the hierarchy of the patient's good. It is viewed as what medicine can achieve technically. It is the good that is achieved through the knowledge, science, and technique of medicine. According to Pellegrino:

> The medical good relates most directly to the aim of the art of medicine, that part which is based on the knowledge, science, and technique of medicine. The medical good aims at the return of physiological function of mind and body, the relief of pain and suffering, by medication, surgical interventions, psychotherapy, etc. At this level, the patient's good depends on the right

moral choice. Finally, he suggested that a proper analysis of the patient's good will make for an ethical sounder physician-patient relationship and a clearer interpretation of the usual principles of medical ethics. See Pellegrino, *Moral Choice,* 136.

[417] Pellegrino, *Moral Choice*, 118.

[418] Ibid, 119.

[419] Pellegrino, *The Philosophy of Medicine of Reborn*, 81.

> use of the physician's knowledge and skill, which is the first step in the fulfillment of the moral obligations of his or her promise to help those, which are intrinsically part of the medical *techne.*[420]

Pellegrino argues that medical good is fundamental and must be brought into proper relation with the other levels of the patient's good. It encompasses the effects of medical interventions on the natural history of the disease being treated and can only be achieved by applying expert's technical, medical knowledge, cure, containment of the disease, prevention, amelioration of symptoms, or prolongation of life.[421] This good is born out of the physician's artisanship, his capacity to make the technically correct decision and carry it out safely, competently, and with minimal discomfort to the patient. Biomedical good is usually captured under the phrase 'medically indicated.'[422] Matters surrounding the medical good are best described as matters of scientific judgment proper to medicine.

However, Pellegrino cautions physicians about the danger associated with medical good. He claims that most physicians make two errors concerning medical indications: The first is to reduce patient's good to medical indication. This leads to the fallacy of the medical imperative: if any good can be achieved by a procedure, that procedure must be done. With this view, medical ethics is reduced to doing whatever is medically indicated; and any other sense of the patient's good is ignored.[423] This error may arise because of excessive or myopic dependence on medical goods as the source of professional judgment to the detriments of the other sources of the decision in clinical decision-making. The second error is the mistake of measuring the value of someone's life as worth living on the scale of biomedical good. According to Pellegrino, the physician makes this error when they try to "mix quality-of-life assessments with medical indications."[424] The human life is too complicated to be assessed as worth living based on medical good alone because it entails more than just a physical being.

2.5.2 The Patient' s Perception of the Good

This theory of the patient's good places the right and freedom of the patient at the center of every medical intervention. The patient's autonomy stands as a crucial prerequisite for determining the good of the clinical encounter. The essential point made by Pellegrino on the patient's good states: "Biomedically or techomedically, good treatment is not automatically a

[420] Edmund Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions" *Journal of Medicine and Philosophy* 26, no. 6 (2001):569.
[421] Pellegrino, *Moral choice*, 121.
[422] Ibid.
[423] Ibid.
[424] Pellegrino, *The Caring Ethic*, 21.

good from the patient's point of view."[425] This theory prioritizes the patient's decision concerning the choice to be made regarding his health. It emphasizes that this choice must be examined in the context of the patient's life situation and their value system.[426] Hence, the concern is with the patient's personal preferences, choices, values, and the kind of life he wants to live, and the balance between the benefit and burdens of the proposed intervention.[427] This requires the patient's personal decision on the good of health, choosing from the different available options of the medical good.

The patient's age, gender, social status, and many more can influence the patient's decision. The patient, as Savett describes, is both the starting point and the center of the drama of the clinical encounter. Consequently, medical care starts from the patient's story, and without it, "one cannot be a good physician without understanding what it is like to be a patient."[428] While the physician may have every good intention to bring about the wellbeing, the perfection, or the wholeness of the patient, the patient who goes through the pain of the diseases, that he is being treated for, also stands in a better position to determine what constitutes his good in a particular situation. The need for a physician for a physician to take into account the preferences of a particular was highly recommended in the e structures of ancient Greek medicine. The Hippocratic physician needed to know his patient thoroughly with respect to what his social, economic, and familial circumstances were, how he lived, what he usually ate and drank, whether he had travelled or not, whether he was a slave or free, and what his tendencies to disease were. The theoretical reasons for this were embedded in the Hippocratic writings.[429]

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[425] Pellegrino, *Moral Choice,* 123.

[426] Besides the patient's preferences, Eric Cassel argues for the role of the patient's social affiliation in clinical medicine where the patient is seen as a sociologic person. According to this view, certain diseases have sociological variables or background, which affect the patient simply because he belongs to a particular social group or family. This awareness largely enables the physician or the parties in clinical encounters to judge wisely about the person's condition. He averts for example that: "Diseases as disparate as tuberculosis and coronary heart disease are influenced in their occurrence by the life history of the person who has them. The malnourished black child from a large ghetto family has a much higher probability of acquiring tuberculosis than the white suburban child of a Bell Telephone supervisor, especially if there is an old person with tuberculosis in the crowded ghetto apartment. And the Bell Telephone supervisor has a greater probability of dying of myocardial infarction than the unemployed father of the black child, especially if the supervisor smokes cigarettes, is sedentary and has a family history of coronary heart disease". Eric Cassell, "The Subjective in Clinical Judgment" in *Clinical Judgment: a Critical Appraisal* eds., H. Tristram Engelhardt, Jr. and F. Spicker (Holland: Reidel Publishing Company, 1979), 200.

[427] Pellegrino, *The Philosophy of Medicine Reborn*, 73.

[428]Laurence A. Savett *The Human Side of Medicine: Learning What It's Like to Be a Patient and What It's Like to Be a Physician,* (London: Auburn House, 2002), 3.

[429] William Bynum, *The History of Medicine: A Very Short Introduction.* (New York, Oxford University Press, 2008), 6-7.

2.5.3 The Good for Humans

This element demands special attention because the problem of the meaning and definition of the concept of the human person has become an exciting area of study. Debates on the concept of the human person have continued to be a subject that attracts the attention of scholars in every era. Battista Mondin laments that the dissolution of the concept of person has found room in modern thought and that it has had frightening consequences on the political and social plane. Such frightening consequences include monstrous activities like the extermination of the Jews and Gypsies in Europe of Nazi period, racial discrimination, the manifold manipulations of man through science and technology, barbarous and iniquitous laws such as the legalization of abortion, are due not only to human wickedness but, but also to the dissolution of the concept of the human person on the philosophical plane.[430] This new barbarism that has hit humanity has provoked and propelled many contemporary philosophers to reflect on the dignity and value of the human person.

Adequate definition and understanding of the anthropology of the human person are so essential to ethics that its lack can lead to a shallow concept of ethical theories and moral judgment. A wholistic and integral and approach to medical practice is indispensable.This is to say that ethical analysis relies heavily on anthropology for its justification. To this end, an understanding of the concept of the human person becomes a prerequisite for the formation of every philosophical theory and its application to existential human phenomena. Since professions are framed towards the good and the gratification of the human person, it demands that the concept of the human person be fully understood within the context of these professions. Pellegrino does this in the medical profession through his theory of the good of the patient as a human person. The president of the Pontifical Council for Pastoral Assistance to Health Care Workers, Archbishop Zygmunt Zimowski, beautifully brings to light the Church's call on the centrality of the dignity of the human person in health care. He highlights the fact that medicine's response to human suffering concerns the good of the human person and society. He also points out that those fundamental human phenomena, such as suffering, sickness, and death, rest together with the related questions about the role of medicine and the mission of physicians concerning sick persons.[431]

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[430] Mondin Battista, *Philosophical Anthropology, Man: An Impossible Project?* translated by Miroslaw A Cizdyn (Rome: Urbaniana University Press, 1985), 253.
[431] Zygmunt Zimowski, 'Preface' *New Charter for Health Care Workers* (Citta` del Vaticano: Liberia Editrice Vaticana, 2017), vii.

The human person is the centre of everything. It is argued that the human person is the most appropriate point of departure for elaborating on the meaning of morality in general and providing the fundamental criteria necessary for dealing with specific moral questions. In this sense, the human person serves as the best criterion for determining proper ethical behaviour because it is from the concept of the human person that moral philosophy derives its absolute and universal norms. Thus, morally correct actions are done in accord with the natural end of each faculty.[432] This implies that a personalistic foundation of morality expresses the anthropological foundations of morality and adequately captures the uniqueness of the human person without abandoning those features of the shared human condition and the moral demands founded upon them.[433]

In the first part of the document, *Gaudium et Spes*, of the Second Vatican Council, a personalistic foundation of morality is advocated for catholic moral thinking. The second part of this same document employs this personalistic criterion as a tool for resolving or dealing with moral issues and moral dilemmas related to marriage and the family. The Council Fathers advocate: "Therefore when there is a question of harmonizing conjugal love with the responsible transmission of life, the moral aspect of any procedure must be determined by objective standards, and these are based on the nature of the human person and his acts."[434] Personalistic morality suggests that human actions should be judged in such a manner that integrally and adequately considers the human person's nature as a criterion for justifying the rightness or wrongness of a particular action.

Pellegrino argues that medical ethics cannot stand apart from some explicit theory of human nature and the good. The more vague our definitions of human nature and its telos, the more difficult it is to keep virtue from becoming a vice.[435] This is based on the emphasis that medical ethics focuses more on the agent's character since medical practice deals with the human person. It, therefore, requires consistent philosophical anthropology to prevent it from becoming merely subjective, relative, and self-destructive.

The sense of the patient's good as a human person is that which is most proper to being a human person. This theory seeks and finds its roots from the personalist anthropological and humanistic philosophical trends that propagate personalistic norms regarding the integrity and the dignity of the human person. It puts human rights and dignity at the helm of medical

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[432] Richard M. Gula, *Reason Informed by Faith: Foundations of Catholic Morality* (New York: Paulist Press: 1989),73.
[433] Ibid.
[434] *Gaudium et Spes*, n.5.
[435] Pellegrino and Thomasma, *The Virues*, 152-153.

intervention. At this level, Pellegrino advocates that both the medical good and the patient's perception of good must align with the good for humans as humans. This refers to that good that is peculiar or unique to humans as human persons. This good calls for the preservation of the dignity of the human person, respect for his rationality as a being who is an end in himself and not as a mere object or means, whose value is intrinsic and not extrinsic or determined by external attributes such as one's wealth, education, position in life and a gamut of others.[436] Roman Darowski states that the contemporary definitions of a human person as an independently existing rational substance that can act rationally and freely manifests in man's distinctive ability of intellectual cognition, the ability to choose values, and a subject of rights and duties.[437]

The peculiarity of this humanness or humanity is derived from the anthropologies of some scholars like Boethius, Aquinas, Karol Wojtyla and many more others. They emphasize the rational nature of man and differentiate him as a distinctive being from the world of objective entities. It is on this definition of the human person that Karol Wojtyla classifies the human person as "an objective entity, which as a definite subject has the closest contacts with the whole (external) world and is most intimately involved with it precisely because of its inwardness, its interior life".[438] Wojtyla adds that what makes the human person more unique than other creatures lies in the fact that apart from his ability to communicate with the visible, he communicates his inner self, the invisible world, and most importantly, with God.[439] For him, the assertion that a human being is a person is undoubtedly, it is universal, and everyone agrees with this assertion despite differences in worldviews.[440]

In this anthropology of the human person as self-transcendent, self-determined and self-possessed,[441] Wojtyla argues further that since the human person lives according to his reason and freedom, from his interior,[442] a person should not in any form of human relationships be used by another human being as a means to an end.[443] It is on this fundamental principle that

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[436] Pellegrino, *The Philosophy of Medicine Reborn,* 73.
[437] Roman Darowski, *Philosophical Anthropology Outline of Fundamental Problems* translated by Łukasz Darowski, (Cracow, Publishing House WAM, 2014), 88-89.
[438] Karol Wojtyla, *Love, and Responsibility* translated by H.T. Willets, (San Francisco: Ignatius Press, 1993), 23.
[439] Ibid.
[440] Karol, Wojtyla, *Person and Community: Selected Essays*, translated by Theresa Sandok, OSM). (New York: Peter Lang, 1993), 178.
[441] Karol Wojtyla, *The Acting Person*, Translated by Andrzej Potocki (Dordhrecht: Reidel Publishing Company Dordrecht, Holand, 1979),106.
[442] Acosta Miguel and Rimers Adrian J., *Karol Wojtyla's Personalist Philosophy: Understanding Person and Act*, (Washington, D.C: The Catholic University of America Press, 2016), 69.
[443] Karol Wojtyla, *Love, and Responsibility*, 26.

Karol Wojtyla builds his personalistic norm.[444] Deborah Savage comments that Woytyla dwells largely on the truth and meaning of personhood and human life and the problem of the subjectivity of human beings,[445] which forms the basis of human praxis, morality, culture, civilization, and politics.[446] Thus, a personalistic norm serves as a veritable tool for recovering the eroded personalistic values. It helps to establish cultural values in the human being as an autonomous subject, and as a rational being.

Battista Mondin argues that using the named person to address a human being expresses man's entire reality in a precise and unequivocal way since we never use this term for plants or animals, but only for man.[447] Through his theory of the generic good of humans, Pellegrino acknowledges having been influenced by the classical natural law view, in which "the good for humans is not subject to social construction."[448] Due to the rational nature and the dignity of the human person, Pellegrino argues that physicians must take into account that the patient, whose good the clinical encounter seeks to achieve, possesses the capacity to use reason to make choices and to communicate those choices through speech and the capacity to establish a life plan. The human person also can select from a variety of goods those things that are preferred for reasons that are unique and personal. Humans might not reason wisely, prudently, or correctly, but the freedom to do so is a good without which it is impossible for the mentally competent person to live a good life.[449]

Pellegrino states that in the clinical encounter, both the medical and the patient's good- must protect and be in alignment with the good for human beings as humans. Like Pellegrino, James Marcus adds that in humanistic or humane medicine models, the patient is viewed as an organism, composed generally of two separate parts: one physical and the other psychological or mental. In the light of this humanistic view, instead of reducing the patient to the physical body alone, the humanistic practitioner encounters the patient as an organism composed of both body and mind within an environmental context.[450]

Any physician who ignores the patient's notion of the good automatically violates the patient's good as a self-determining rational being. No situation or condition can devalue a human person from being a human being, and this fact must never be neglected in the healing

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[444] John Paul II, *Man and Woman He Created Them: A Theology of the Body*, translated by Michael Waldstein (Boston: Pauline Books and Media, 2006), 23.
[445]Deborah Savage, "The Centrality of Lived Experience in Wojtyla's Account of the Person," *Roczniki Filozoficzne*. Tom LXI, no. 4 (2013),19.
[446] Wojtyla, *Person and Community,* 220.
[447] Mondin, *Philosophical Anthropology*, 243.
[448] Pellegrino, *The Philosophy of Medicine Reborn*, 74.
[449] Pellegrino*, Moral Choice,* 125.
[450] Marcum, *An Introductory Philosophy*, 53.

relationship. Pellegrino argues: "Denial of care to the poor violates their dignity and value as human beings. Devaluing the lives of the disabled does the same."[451] Poverty or being handicapped does not imply the loss of humanity and what makes the patient human. Pellegrino considers the patient's good as a human person as more general good than the other components of the good.[452] The Catholic Bishops of Nigeria have argued that sickness is part of the human nature. The phenomenon of sickness does not diminish the sick person's value as a human being. It does not reduce or take away one's rights a human person.[453] Human nature is universal, and it remains the foundation on which familiar ethical principles are philosophically rooted. The dignity of the human person as a self-determined, accessible, and thinking serves as the bedrock for morality.

It is possible to argue that any ethical theory not founded on the human person paves the way to ethical dilemmas. Thus, to possibly resolve any ethical dilemma, contemporary ethics must return to the personalistic foundation of morality as the basis and nucleus of modern approach normative ethics. We have seen earlier that humanity and human nature are one. We have also seen that morality is not conceived in isolation but about human phenomena. It follows that medical ethics, like other branches of philosophy, should spring from seemingly simple questions that surround the meaning of human existence and human experience. What makes honest actions right and dishonest ones wrong? Why is death a bad thing for the person who dies? Is there anything more to happiness than pleasure and freedom from pain? These questions are common and universal to humans of every historical period of different cultures. Therefore, personalistic morality is an ethic for corporate existence since it reflects on human experience and his quest for meaning and purpose in life.

2.5.4 Spiritual Good

Pellegrino classifies this spiritual component of the patient's good as the ultimate or the highest form of interest in the clinical encounter. It holds good of the patient as a spiritual being, that is, as one who, in his way, acknowledges some end to life beyond material well-being.[454] According to Pellegrino, this spiritual dimension of man or the realm of the spirit gives ultimate meaning to human lives. It is that for which humans will often make the most

[451] Pellegrino, *The Philosophy of Medicine Reborn*, 74.
[452] Pellegrino, *Moral Choice*, 126.
[453] Catholic Bishops Catholic Nigeria, *Handbook for Catholic Medical Practitioners in Nigeria* (Abuja: Catholic Secretiat of Nigeria, 2021), 29.
[454] Pellegrino, *The Philosophy of Medicine Reborn*, 74.

significant sacrifices of other good things.[455] He identifies the realm of the spirit for many people to be religion. People are guided by specific religious beliefs or doctrines that carry ultimate weight in their decisions. Thus: "From the perspective of natural law, the spiritual destiny of man is his highest and ultimate good."[456]

History provides us with a picture of the powerful influence of religion on people's decision-making. Stories about religious figures like the saints and other heroes of faith who gave their lives to be burnt to death because of their uncompromising religious beliefs and convictions which they consider as of highest value are all instances of how the ultimate good supersedes all other forms of good. Adherents of different religions cannot compromise their religious values for any of the goods in this life. The entire idea of the ultimate or spiritual good in the clinical encounter as advocated by Pellegrino stipulates that physicians must ensure that:

> Whatever the origin and content of one's spiritual beliefs, the three lower levels of good I have described must accommodate the spiritual good. For example, a blood transfusion might be medically 'indicated' for the Jehovah's Witness, abortion of a genetically impaired fetus for a Catholic, or discontinuance of life support for an Orthodox Jew. But in these cases, the mere medical good could never be a healing act since it would violate the patient's highest good. Similarly, the Muslim, the Buddhist, the Hindu, or the humanist patient has his spiritual good, which must be encompassed within a clinical decision if it is to serve the 'good' of the patient.[457]

The central claim here is that the ultimate good, or the good of last resort, must take precedence over the other forms of patient good.[458] Pellegrino states forcefully:

> Strong paternalism concerning a patient's choice of ultimate good is morally offensive. The ultimate good is the starting point of a person's moral reasoning, his first act of intellectual faith so to speak. If he or she is competent, it must be respected over medical good, and the physician's, society's, the family's, or the law's construal of ultimate good.[459]

We must note that while Pellegrino uses the spiritual good or religion here as an instance to demonstrate the primacy of the highest good over other forms of good in medical practice, he should not be misunderstood as suggesting religion to be the determinant scale of the good in medical practice.

Pellegrino's theory of the four components of the patient's good reveals the complexity surrounding the nature of the good and the complexity over the choice of the good in medical practice. In every clinical decision, these four senses of the good are intermingled since the

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[455] Ibid.
[456] Ibid.
[457] Ibid, 74-75.
[458] The challenge here is that of a universal ultimate good in the context of the clinical encounter. Pellegrino clarifies this by stating: "There has never been, nor is there likely ever to be, universal agreement on the ultimate good. Societies that wish to be homogeneous in their choice of ultimate good usually do so by some form of coercion. In democratic societies, it is a civic right of competent persons to choose their belief systems. To pursue a moral life we are under compulsion to act with fidelity to some ultimate source or concept of good though our choices of that source or concept may vary widely." See Pellegrino, *The moral Choice*, 130.
[459] Pellegrino, *The moral Choice,* 130.

notion of the good involves a variety of interpretations and connotations. Pellegrino proposes a rational organizing principle as a veritable tool for resolving the dilemmas surrounding the choice of the good in clinical encounters. He states: "Conflicts between good things can only be resolved according to some rational organizing principle."[460] Mainly, Pellegrino places the human good at the heart of every choice we make regarding good, especially in clinical the encounter. He argues that the combination of our choices at each of these levels and the way we relate one to the other essentially defines us as persons.[461]

The theory of good in medicine has some limitations. Pellegrino admits the weaknesses and limitations of his theory of the good of the clinical encounter by humbly acknowledging:

> At the outset, and throughout this discussion, we must remain clear about the distinction between the good as perceived by the participants in clinical decisions, and the ontological nature of good. This essay cannot presume to deal adequately with the prickly question of the objectivity or non-objectivity of the good. The point of this essay is not whether particular interpretations of patient good are metaphysically sound. Rather its focus is on the fact that widely divergent interpretations do occur, that despite that fact, physicians, patients, and families must make decisions together, and that the conflicts, when they occur, must be dealt with in a morally defensible way.[462]

However, while Pellegrino acknowledges that the use of the four theories of the patient's good serves as a powerful tool for effective clinical exercise, he humbly admits that its application to practical circumstances or cases in the clinical encounter results in some existential complexities, dilemmas, and difficulties. He admits: "Ethical conflicts between and among patients, physicians, families, and other health workers are a growing problem in clinical ethics."[463]

The first difficulty identified by Pellegrino is that of the inaccessibility and identification of the four levels of the patient's good and the inability to establish this quadratic order of priorities among them. For instance, a physician dealing with infants, children below the age for responsible decision-making, the intellectually retarded, the elderly, or those in permanent vegetative states may lack complete knowledge about the patient's personal preferences or spiritual beliefs.[464] In this situation of the lack of the patient's preferences and individual good, what can the physician do? Pellegrino suggests that since "clinical ethics imposes the duty to come as close as circumstances permit for an estimate of the patient's good as a whole,"[465] the physician can estimate. Meanwhile, the medical good and the good of the

[460] Ibid.
[461] Ibid, 126.
[462] Ibid, 119.
[463] Pellegrino, *The Philosophy of Medicine Reborn,* 81.
[464] Ibid, 75.
[465] Ibid.

patient as a human being will remain accessible without the patient's preferences. It is entirely impossible to know about the personal preferences of the infants. Still, in the case of adults, surrogates, and others, the physician relies upon the prior knowledge of the patient's preferences to act.

Another challenging conflict arising from applying the theory of the four levels of the patient good in clinical encounter is what Pellegrino refers to as the clash of interest between the patient's and the physician's preferences. This "centers on the degree to which a particular patient's preferences, world-views, and religious practices impinge on the physician's own beliefs about what is good for the patient."[466] What makes the clinical encounter very challenging in a pluralistic society is that it is a conglomeration of different kinds of people who have diverse views about morality and various preferences for the notion of good. Pellegrino's admonition is that the good as perceived by the patient and the physician himself in a clinical encounter must be respected. There should not be a one-sided consideration to the ultimate or total good. He argues: "the summation of the four levels of good must not be equated with the patient's perception of the total good."[467] It is commonly a misunderstood notion that the internal morality of medicine is based on the patient's good with the assumption that the physician is bound to do whatever the patient defines as good.[468]

The above claim does not deny that the patient's preferences and experiences do not play a central role in the clinical encounter. It is easy to claim that the patient remains the best book that guides the physician's activities. A physician who possesses good knowledge and understanding of his patient stands the chance of being effective and successful in achieving the goal of the clinical encounter. The need for deliberation between the parties of the clinical encounter should be guided by the hierarchical levels of the patient good. This deliberation between the parties of the clinical setting, especially between the patient and physician, demonstrates that they have come together for the sake of healing and that they work toward the same end: the patient's good. It is expected that they deliberate and work together until a right and good healing action is chosen at the end.

[466] Ibid.
[467]Ibid.
[468]Ibid.

2.6 Medical Expertise and the Role of the Clinical Judgement

The problem of judgment in the professions is not limited to only medical practice; it is a problem that occupies a central stage in professional practice. Susan White and John Stancombe contend that judgment problems are intrinsic and inescapable imperatives for clinicians and most professional roles. According to them: "Professionals are routinely faced with having to decide which diagnosis, or whose version or account of the troubles, they find most convincing and/or morally robust."[469]

Judgment in professional roles rests on how professionals use or put formal knowledge into professional contexts and on the kinds of reasoning they use, especially about individual situations, cases, and professional dilemmas. Judgment in professional roles also becomes the basis for moral decisions in professions as social roles, which are value-laden and demand choice-making in occupations. As Robin Downie and Jane Macnaughton argue, "it is also characteristic of doctors to be decisive."[470] Similarly, Pellegrino asserts, "medical and clinical decisions generally require the closest integration of scientific and moral reasoning and judgment."[471]

From the general point of view, judgment or judging involves an evaluation or assessment of evidence, data, or observations, to discern or decide a path of action.[472] In medical practice, clinical judgment refers to the range of complex reasoning tasks and activities performed by clinicians in the context of offering diagnosis, therapeutic options, and prognosis to patients regarding their health and illness. The philosophically relevant aspects of clinical judgment relate to the status of the reasoning and logic that inform clinical assessment.[473]

The clinical encounter requires a lot of judgment as the physicians encounter divergent peculiarities in their clinical activities. The clinical decision reflects how the doctor or physician thinks in his exercise of clinical judgment as he works out what is best to do for the good of a particular patient. These particularities of the clinical encounter demand that the physician act, not just act, but rightly. As Pellegrino describes clinical judgment as essentially an exercise of prudence, the need to act rightly requires wisdom and reasoning.[474]

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[469] Susan White and John Stancombe, *Clinical Judgement in the Health and Welfare Professions Extending the Evidence Base (*Philadelphia: Open University Press, 2003), viii.
[470]Robin Downie and Jane Macnaughton, "Can We Teach People to be Morally Good Doctors?" in *Advances in Bioethics: Critical Reflection on Medical Ethics* ed. Martyn Evans (London: Jai Press Inc., 1998),87.
[471] Pellegrino and Thomasma, *The Virtues,* 90.
[472] Marcum, *An Introductory Philosophy of Medicine*, 122.
473 Ross Upshur and Benjamin Chin-Yee, "Clinical Judgement," in ***T****he Routledge Companion to Philosophy of Medicine* eds., Miriam Solomon, Jeremy Simo and Harold Kincaid (New York: Routledge, 2016), 363.
[474] Pellegrino and Thomasma, *The Virtues*, 86.

According to Arthur Elstein, clinical reasoning begins with the fact that "the physician encounters problems or situations that seem somehow indeterminate. Selectively collecting information and combining it into a judgment or decision can only resolve these problems. Questions such as "what is wrong with this patient?", what are the causes of these symptoms? or what should we do about this situation"?[475] are useful for clinical judgment. Diagnosis is just a first step that sparks the clinician into a deeper level of the clinical exercise as Savette underlines: "a diagnosis dictates decisions and action."[476] Thus, diagnosis becomes an ongoing process of defining and refining what actions and decisions should be taken for the patient's good. It stings the physician to ask repeatedly vital and logical questions about the diagnosis presented. It is often believed that good thinking results in good output, just as sound and logical reasoning or judgment are expected to lead to good decision making.

Clinical judgment is a reflection of what Kurt Baier describes as reasoning in practical deliberation. For him, practical reason seeks answers to what should be done at each particular instance. The question of what shall I do or what is the best thing I can do requires value judgment for an answer. This question surfaces mostly when there are different aims and ends from which one must be considered and chosen as the ultimate to aim or end*, summum bonum,* to which all ordinary ends are merely means.[477]

For Pellegrino, clinical judgment is a specific activity. What physicians do most clearly distinguishes them and their enterprise from other human activities. Therefore, for a medicine theory, an understanding of clinical judgment must be taken as a central element. According to him: "clinical judgment ends at establishing the most probable diagnosis or at the best selection of a treatment."[478] It is deliberately aimed at some specific purpose or goal. This goal is not unconnected with the goal or end of medicine; that of being healed, of being restored, and of being made whole or relieved of some noxious element in the physical or emotional life of the patients which they define as a disease that distorts their accustomed perception of what is a satisfactory life.[479]

Further still, Pellegrino argues that clinical judgment remains the cornerstone of sound medical practice despite the technological progress and scientific advancements of the last

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[475] Arthur S. Elstein, "Human Factors in Clinical Judgment: Discussion of Scriven's Clinical Judgment," in *Clinical Judgment: A Critical Appraisal* eds., H. Tristram Engelhardt, Jr. and F. Spicker (Holland: Dordrecht Reidel Publishing Company, 1979), 19.
[476] Savett, *The Human Side of Medicine*, 81.
[477] See Kurt Baier, "Reasoning in Practical Deliberation," in *The Virtues: Contemporary Essays on Moral Character* eds., Robert B. Kruschwitz and Robert C. Roberts (California: Wadsworth Publishing Company, 1987), 277-278.
[478] Pellegrino *The Anatomy of Clinical Judgements*, 191.
[479] Ibid, 172.

decade. Through it, the physician can interpret the patient's condition, and it is through clinical reasoning that the use of advanced technology can be appropriately applied to particular clinical cases. In line with Pellegrino, many scholars argue that despite the medical advancements, progress in science and technology, many diseases remain disabling or lethal. Thus, the clinician's judgment of the patient's situation and his ability to make the right decision and take reasonable action for the patient's good is of paramount importance for effective medical practice.[480]

Susan White and John Stancombe describe the nature of medicine as consisting of "both practical-moral and rational-technical activities."[481] Pellegrino states that technical knowledge alone is not enough to lead the physician along the long way of the clinical setting, because "the subjects of medical decisions are humans, and humans in a special state of vulnerability - anxious, in pain, and dependent upon the physician's knowledge, skill, trustworthiness, and responsible management of the power that professional status confers."[482]

Pellegrino attempts not to revoke the utility of scientific medical formulations but to locate more precisely the several reasoning modes, which he refers to as the anatomy of clinical judgment helpful at each of the sequential and simultaneous steps, which eventuate ultimately in a clinical action.[483] Each of these several reasoning modes is, by its nature, an end-oriented interconnected series of decisions demanding different types of reasons and reasoning which will justify a particular course of action, for a specific patient, given that patient's specific existential situation at the time of the decision.[484]

In this case, the clinical action or decision must be harmonious as possible with a particular patient's clinical context, values, and preferences.[485] Clinical judgment embodies many components. While contextually determining a specific patient's situation, it employs science, language, social interaction, history, emotion, and moral judgment as essential elements of clinical decision-making. Pellegrino's doctrine of clinical judgment as determining the condition of each particular patient does not promote relativism of any sort. It only emphasizes the particularistic and contextual dimension of the nature of clinical reasoning in bringing about the peculiarity of each patient's experience in the face of sickness despite the universality of the phenomenon of illness and disease. This reflects in all ramifications

[480] Peter Devitt, Juliet Barker, Jonathan Mitchell and Christian Hamilton-Craig, Clinical *Problems in General Medicine and Surgery* (USA: Elsevier Science Limited, 2003), x.
[481] Susan White and John Stancombe, *Clinical Judgement*, back cover page.
[482] Pellegrino and Thomas, *The Virtues*, 53.
[483] Pellegrino, *The Anatomy of Clinical judgments*, 170.
[484] Ibid.
[485] Ibid, 172.

Pellegrino's position: "the primary end of clinical judgment - a right healing action for a particular patient."[486]

The case of a particular or single patient is an essential element and a starting point or the first-hand information for clinicians in clinical practice, and its importance cannot be overemphasized. It is customary and logical as Montgomery argues:

> Start from the demands of the patient's condition and not from the need for generalizable knowledge, and their goal is just as particular: to treat the patient's illness, not to test the therapy. They cannot begin by reasoning from the general rule to the specific case because biological laws are too abstract and imprecise to be applied uniformly to every patient. Instead, they must reason from the particular to the general and then (for confirmation) back again.[487]

The above fragment of Montgomery's view clarifies that medicine is far more than just a body of scientific knowledge and a collection of well-practiced skills, although both are essential. Instead, it is the conjunction of the two: the rational clinically experienced and scientifically informed care of sick people.[488]

Interestingly, Pellegrino argues that in the end, it is the clinical judgment, in the strict sense of the word, which gives authenticity to the physician's professional identity and medicine as medicine. This is so because medical decision harmonizes the technical expertise of medicine with reason, science, and philosophy. The clinical judgment provides an enabling atmosphere for physicians to transcend from the level of mere scientific conformity and from all its limitations of solving particular cases in the medical encounter. Pellegrino affirms: "Medicine qua medicine is then more than a clinical or basic science applied to individual cases. It is a particularized knowledge of prudent healing actions, dependent upon scientific methods and art but not synonymous with them. Truth, for the practical intellect, is rightness concerning human deeds, those dependent upon human will and intention. It differs thus from the truth of science which is certain conformity with the reality; it seeks to explain science and art, with the product it wishes to produce."[489] Since medical practice deals with human beings, it cannot be limited to scientific diagnosis because it serves the human being, who is not a machine and cannot be reduced to the scope of mechanical and scientific conformity.

The integral nature of medicine where scientific knowledge blends with reasoning are expressed in the triad of questions of the clinical encounter: "What can be wrong? What can be done? What should be done for this patient?"[490] When answering the third triad clinical

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[486] Ibid, 173.
[487] Montgomery, *How Doctors Think*, 32.
[488] Ibid, 33.
[489] Pellegrino, *The Anatomy of Clinical judgments*, 173.
[490] Ibid, 177.

question, the physician goes beyond the boundaries of mere scientific diagnosis in search of answers. To make the right decision or take a prudent action for an individual patient, the physician must take into cognizance the patient's personal, social, economic, and psychological characteristics. According to Pellegrino: "The reasoning at this stage is mainly dialectical, ethical, and rhetorical. Physician and patient together must clarify the relationship of one recommendation with its opposite and weigh the reasons for each action."[491] Similarly, Montgomery Kathryn states that sound medical practice "is a rational practice based on scientific education and sound clinical experience. It is neither an art nor a science."[492]

2.7 Chapter Summary

This chapter has explored the essential themes of Pellegrino's philosophical theory of medical practice. The center and summit of his thought advance the centrality and indispensability of the phenomenon of the clinical encounter of the physician-patient relationship and the theory of the good in medicine. It demonstrated the wonder of the clinical encounter as a special kind of human activity through which of all kinds medical enterprises take place as a reaction to the reality of the existing pain, suffering, illness, and disease in human life and are facilitated toward the health of the patient which is the goal and the good of medicine as a healing enterprise. The chapter provides the good that is sought in medical practice, namely, the good of the patient.

The clinical relationship between the patient and the medical professional, which involves a long process, engages, and employs skills and clinical judgment, are intrinsic and inescapable imperatives for clinicians and most professional roles. This is so because sickness or diseases and the medical good or health that medicine seeks to restore goes beyond the concept of biomedical definition and understanding, which requires that both technic and judgment be married for the competent practice of marriage.

We simply argue that this chapter brings into perfect integration the various complementing elements of medical practice. This is subsumed in Pellegrino's primary aim to integrate and bring the four principles of biomedical practice into closer congruence with some of the practical realities of clinical decision-making within the doctor-patient relationship in the clinical encounter and link these principles to other ethical theories. He attempts to connect virtues with principles and skills with reasoning.

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[491] Ibid, 181.
[492] Montgomery, How *Doctors Think*, 30.

Chapter Three: A Virtue-based Approach to Professional Ethics

Introduction

This chapter focuses on the role and relevance of virtues in moral philosophy and on the resurgent interest in virtue ethics in making moral decisions. It explores the various dimensions of virtue ethics' contribution to other ethical systems in building a guiding moral philosophy that leads to human flourishing and social well-being. The chapter pays attention to the conceptual clarification of the meaning of virtues and the historical development of virtue ethics with all its trends and approaches. It also relates the role of virtues to professional roles by arguing that a detailed account of Aristotelian virtue ethics could be applied to a range of ethical concerns in medical and other professional activities.

The entire discussion centers on a proposition that the virtuous agent will always act rightly in all circumstances. This claim is justified by demonstrating how virtue ethics differs from and improves upon utilitarian and Kantian accounts of the character traits needed for moral actions concerning professional roles. Again, because of its teleological structure, Aristotelian virtue ethics provides a natural basis for developing an ethical theory of professional roles. Thus, this chapter prepares a solid ground for a better and smooth understanding of virtues as guides to human actions and professional positions.

3.1 Professional Ethics

Professional ethics is one of the attractive areas of research today. It is a relevant subject of today's environment of conflicts and stress in the profession, with obligations to be met by one person in many directions.[493] In a like manner, Pellegrino laments that professions today are afflicted with a species of moral malaise that may prove fatal to their moral identities and dangerous to our whole society. This contemporary moral decay in professions manifests in a growing conviction even among conscientious doctors, lawyers, and ministers that it is no longer possible to practice their professions within traditional ethical constraints. Worse still, these professions are on the verge of being crushed by the forces of commercialization, competition, government regulation, malpractice, advertising, public and media hostility, and a host of other inimical socio-economic forces.[494]

[493] Naagarazan R.S., A *Text Book on Professional Ethics and Human Values* (Bangalore: New Age International (P) Ltd., Publishers 2006), i.
[494] Edmund Pellegrino, "Character, Virtue, and Self-Interest in the Ethics of the Professions," *Journal of Contemporary Health Law and Policy* 5, no. 53 (1989): 53.

Pellegrino thinks that nothing is wrong with the professions themselves but with the attitudes and formation of professionals. Consequently, he calls for an urgent recast of the contemporary ethics of professions to prevent them from being crushed. Pellegrino avers: "The fault lies not with the professions. Unless there is some upheaval in conventional morality, professional ethics as we have known it has no future. Indeed, perhaps given the realities of professional practice, professional ethics has rested on faulty philosophical foundations from its very beginnings." [495]

We admit that there is much literature today on the study surrounding professions and professional ethics. Professional ethics is now acknowledged as a field of study in its own right. A recent development, advancement, and globalization have resulted in a rethinking of traditional ethics that guides moral conduct in the light of the new moral problems arising out of advances in science and technology. This challenge affects the general ethical behavior of the people in the society across the culture and the values and principles surrounding professions. Considering the significant role of professionals in our society, the need to integrate ethical responsibilities into the science curriculum and mastery of a specific field becomes paramount. This is because scientists or professionals must make decisions, and every decision has a moral value or moral face in it. Applied philosophers, ethicists, and lawyers have devoted considerable energy to exploring the dilemmas emerging from modern professional practices such as the healthcare practices and their effects on the practitioner-patient relationship and other professional groups have begun to think critically about the kind of service they offer and about the nature of the relationship between provider and recipient.

Andrew Belsey opines that technological advancement has challenged traditional ideas of professional roles in many areas of life. In his view, one visible sign of these developments have been the proliferation of codes of ethics or professional conduct. The drafting of such a code provides an opportunity for professionals to examine the nature and the goals of their work and offer information to others about what can be expected from them. If a code has a disciplinary function, it may even protect members of the public.[496] It becomes evident that professional roles cannot be satisfactorily sought only in their legal structures because certain professional circumstances warrant individual judgment, which the professional legal codes are incapable of providing since judgment is not always a matter of technicality and codification. Personal judgment in professions suffices to meet the demands of new

[495] Pellegrino, *Character, Virtue and Self-Interest*, 53.
[496] Andrew Belsey and Ruth Chadwick, foreword to *The Ground of Professional Ethics.* ed. Daryl Koehn (New York: Taylor & Francis e-Library, 2001), x.

professional situations that arise from the latest knowledge about professions. Individual judgment in the profession is the bedrock from which the themes of freedom and responsibilities emerge in professional evaluations.

Our discussion on professional ethics is shaped by some intriguing questions: What exactly is a profession? Why do professions require particular ethics? Do we need ethics for professionals? In the first place, we cannot deny that ethics is necessary as a guide for professions because it is connected to those social expectations that define professions and their values. Almost every profession is of social trust and expectation. They need ethics each profession is expected to have an impeccable moral, social, ethical attitude and high personal culture or integrity; compliance and respect for clients, and professional secrecy. Professional values reflect the social expectations of the people towards these professions primarily. Professions are structured in such a manner that they provide and render social services.

On the social significance of professions and on the need to secure their progress, Howard Gardner and Lee Shulman refer to professions as a high point of human achievement because there is little or no question that they have played a dominant role in postindustrial industrial society. According to them: "It is difficult to envision our era without the physicians, lawyers, and accountants to whom we turn for help at crucial times; or the architects and engineers who shape the environments in which we live; or the journalists and educators to whom we look for information, knowledge, and, on occasion, wisdom."[497] It is difficult to imagine a society without professions and professionals. Therefore, the status of the occupations generically consists of individuals vested with a certain amount of prestige and autonomy in return for performing for society a set of services in a disinterested way. They are decorated with these powers for the common good of society and its development.[498]

The social impact of professionals cannot be overemphasized. John Kutghen describes them as occupying a strategic position in modern society and as providing services that are unavailable from other quarters, and these services are vital to those who receive them. Furthermore, he argues that professionals purport to choose the best means for their clients and the public; they help define the limitations themselves: the lawyer and accountant shape our ideas of security; the physician, of health; the priest, of salvation. Because the services of the professions are highly valued, they enjoy status, prestige, and influence.[499]

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[497] Howard Gardner and Lee S. Shulman, "The professions in America Today: Crucial But Fragile," *Journal of the American Academy of Arts & Sciences,* Dædalus Summer *(2005):* 13.
[498] Howard Gardner & Lee S. Shulman, *The professions*, 14.
[499] John Kultgen, *Ethics and Professionalism* (Philadelphia: University of Pennsylvania Press, 1988), 9.

The theme of profession or professional ethics is significantly featured in Pellegrino's thought. As we shall see subsequently, he attempted a definition of professions and professional ethics and proposed a humanistic or virtue based model approach to professional ethics for medicine[500]. He believed that one of the requirements for reconstructing a medical ethic capable of confronting some of the dilemmas of today's clinical decisions and professional ethics is the need to define the conditions for the effective rebuilding of the edifice of medical ethics refurbishing the concept of the profession.[501] He advocated for the construction of different professional ethics for medicine since "it was important to distinguish the ethics of the professions of healers: doctors, nurses, dentists, psychologist and so forth- from the ethical issues of particular dilemmas like euthanasia, withdrawing treatment, reproductive technologies and the like. There seemed more likelihood of agreement on the former than the latter."[502] Pellegrino was projecting systematic and organized professional ethics so that it would enable professionals of every field to confront their unique professional dilemmas.

The heart of Pellegrino's argument for the refurbishment of the concept of professional ethics rests on his claim that the traditional medical professional ethics,[503] which is derived from an overemphasis on what the physicians are, and on what they ought to do for their patients because of their special position in society, require a serious reappraisal. He goes further to note that "the most crucial dilemmas of medical ethics today are not those arising from medicine's scientific progress alone. They are dilemmas of professional ethics, those that go to the heart of what it is to be a physician."[504] Pellegrino affirms: "Each of these dilemmas, although occasioned by technology, arises from changing roles of the profession in response to public and private expectations."[505] Most professionals confront ethical issues concerning

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[500] From Pellegrino' thought, we see an unquenchable invitation to respond to the need for a more authentically humanistic basis for professional ethics, one more suited to contemporary society and less dependent on changing interpretations that physicians or society place on the role of medicine. The most certain and authentic of humanistic ethics is the unique impact of illness (that is the impact of being ill on the humanity of a person) because it is the source that gives meaning to the whole of the physician's activities. See Pellegrino, *The Philosophy of Medicine Reborn*, 93.

[501] Edmund Pellegrino, "The Caring Ethic: The Relation of Physician to Patient," in *Coping, Curing, Caring: Patient, Physician, Nurse Relationships*, eds., Anne H. Bishop and John R. Scudder (United States of America: The University of Alabama Press, 1985), 17.

[502] Pellegrino, *The philosophy of Medicine Reborn*, 50.

[503] The traditional medical professional ethics for most parts of its history presents the feature of the physician-patient relationship as dominated by the physician's point of view. More so, ethical codes were established more based on the obligation physicians feel than those patients may impose. In this physician-dominated image, physicians are depicted and represented as noble and learned men, members of a select brotherhood, which is largely self-regulating and autonomous. To recast this traditional image is to contextualize professional ethics within a democratic framework or society in which we expect everyone to participate in decisions that will affect them. See Pellegrino, *The Philosophy of Medicine Reborn,* 89.

[504] Pellegrino and Thomas, *The Virtues,* 31.

[505] Ibid, 31-32.

their proper roles and how they should carry out those roles. This arises because some professional issues are "value judgmental."[506]

Pellegrino advocated for a more reliable source for humanistic professional ethics that resides in the existential nature of illness and in the equality between the physician and patient intrinsic to that state.[507] He also calls for a fundamental recasting of the traditional image of the physician to suit the need expressed by patients who call for more humanistic professional roles.[508] Without this redefinition or recasting of the professional ethics, "it will be impossible to close the widening gap between what physicians conceive themselves to be and what increasingly large segments of the public expect them to be."[509] Furthermore, he holds that to resolve the major dilemmas of professional ethics, we must draw on the idea of the profession as a moral enterprise, which will use its moral power to stand against the forces eroding professional integrity and will encourage and support physicians to have the will and the courage to adhere to traditional standards of ethical behavior.[510] Pellegrino derives a suitable conception of the ethics of professions: "By ethics of the professions, I do not mean the norms followed by professionals, or the professional codes they espouse, but rather the moral obligations deductible from the kinds of activity in which they are engaged. Therefore, the ethics of the professions consist of a rational and systematic ordering of the principles, rules, duties, and virtues intrinsic to achieving the ends to which a profession is dedicated. This is the internal morality of a profession."[511] From the above vision of professional ethics which is based on internal morality and not just on the sociology of professions of as if professions as mere social roles, we get the issue of moral obligations in professional.

Still from a moral point of view, the intriguing questions on whether the label 'professional' has implications and why professions require exceptional ethics also find their justifications from this pillar. The moral obligations of the professional arise from the moral imperative of the humanistic aspect of the act of physician's profession to heal the wounded or

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[506] Peter Davso-Galle, *Reason and Professional Ethics* (Farnham: Ashgate Publishing limited, 2009), 1.
[507] Pellegrino, *The Philosophy of Medicine Reborn*, 87.
[508] Attention must be given to the view that the concept of professions can be taken narrowly to refer to the traditional 'learned' professions: medicine, law, architecture, and sometimes, the ministry. These professions have a long history as open to gentlemen and involving intimate relationships with individual clients. 'Profession' also can be taken broadly to embrace the literally hundreds of occupations that so label themselves and fret over their professionalism. In this work, we will use the term narrowly by limiting our scope to only members of learned professions without including other occupations like scholars and teachers, engineers and scientists, accountants and business specialists, and even varieties of psychotherapists and counselors, journalists, government officials, and military officers and a gamut of others. John Kultgen, *Ethics and Professionalism* (Philadelphia: University of Pennsylvania Press, 1988), 5.
[509] Pellegrino, *The Philosophy of Medicine Reborn*, 88.
[510] Pellegrino and Thomasma, *The Virtues*, 32.
[511] Pellegrino, *Character, Virtue and Self-Interest,* 56.

the vulnerable patient, which he professes to help by restoring them. They also arise from the fact that every clinical decision involves technical and values choices.[512] This imposes on the physician the moral obligations to consider the degree to which the patient wishes to exercise his moral prerogatives and to provide the entire exposition, which will enable those privileges to be exercised. Pellegrino recommends that those obligations, which the physician owes the patient, should be conditioned by the acuteness of the clinical situation and the patient's physiological state.[513]

3.2 Virtue Ethics

According to Liezl Van Zyl, virtue ethics[514] is now widely recognized, alongside consequentialism and deontology, as a significant normative theory.[515] Renewed vigor in the current revival of philosophical interest in the resurgence of virtue ethics is one of the most noteworthy developments in contemporary ethical theory.[516] Stanley Hauerwas and Stanley Pinches think that reconsidering the role and significance of virtues is long overdue and that its talk and appearance among moral philosophers have helped things a bit.[517] Virtues are not only essential and significant to ethical systems but also necessarily indispensable in every aspect of human life. An ardent virtue ethicist, Deirdre N. McCloskey, has argued that virtues are intrinsic to ethical systems and inseparable from ethics. According to her: "Ethics is a system of virtues. A virtue is a habit of the heart, a stable disposition, a settled state of character, a durable, educated characteristic of someone to exercise their will to be good."[518] By equating ethics with character, Aristotle was faithful to the Greek meaning of the word *ethike*, which means character.[519] They all argue that virtue is a fundamental moral phenomenon.

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[512] Pellegrino, *The Philosophy of Medicine Reborn*, 98.
[513] Ibid.
[514] We must pay attention to the issue here that a frequent source of misunderstanding in the use of the term virtue ethicist derived from virtue ethics flows from the fact that the term is sometimes used very broadly to include anyone interested in examining philosophical questions about the nature and role of virtues and vices (or character more generally). Consequently, the problem with this usage is that a virtue ethicist might be someone who concludes, after much careful thought, that the virtues do not play an important role in morality. This problem is however avoided by making a distinction between virtue theory, which refers to the broader field of inquiry that focuses on philosophical questions about virtues and vices, and virtue ethics, which is a normative theory that claims that the virtues and vices play a central role in ethics. The distinction between virtue theory and virtue ethics was first suggested by Julia Driver in 1996. Liezl van Zyl, *Virtue Ethics: A Contemporary Introduction* (New York: Routledge -Taylor & Francis Group, 2019),1-12.
[515]Liezl van Zyl *Virtue Ethics*, 1.
[516] Justin Oakley and Dean Cocking, *Virtue ethics and Professional Roles* (New York: Cambridge University Press, 2003), 7.
[517] Stanley Hauerwas and Charles Pinches, *Christians Among the Virtues: The Theological Conversations with Ancient and Modern Ethics* (Notre Dame: University of Notre Dame Press, 1997), 55.
[518] Deirdre N. McCloskey, *The Bourgeois Virtue Ethics, Ethics for an Age of Commerce* (Chicago: The University of Chicago Press, 2006), 64.
[519] Pellegrino and Thomasma, *The Virtues*, 20.

David Papineau observes that there has been in the late 20th and early 21st centuries a return to the idea that moral questions should be approached by focusing on virtue, character, and integrity. While acknowledging that contemporary virtue ethics is influenced by the traditions of the classical virtue theories of Plato and Aristotle, he argues that modern virtue theory differs slightly from the classical tradition in relating virtue more closely to its social and temporal setting. According to Papineau: "Both Plato and Aristotle offered a universalistic account of human good. They believed in a *summum bonum* (highest good) common to all human beings, based on a conception of human nature not bound to time and place. The version of virtue theory now favored by several writers reverses these underlying assumptions, seeking to locate morality in a tradition."[520] Papineau substantiates this claim by outlining the trend in Alasdair MacIntyre's attacks on Kantian and Utilitarian traditions for placing individual preferences over and above substantial social and moral traditions[521]. He also attacks MacIntyre's attempt to limit his virtue theory to the Western world.[522]

Justin Oakley and Dean Cocking highlight that most accounts hold that the current revival of virtue ethics as a theoretical approach to moral theory began with the influential 1958 publication of Elizabeth Anscombe's paper, provocatively entitled *Modern Moral Philosophy*. It is held that Anscombe argued that both the deontological and utilitarian approaches to ethics relied upon teleological derived notions of obligation, which many people no longer found compelling, and that the only alternative to such theories was virtue ethics.[523] According to them, Anscombe's contribution was merely a modest re-awakening call for the revival of Aristotelian moral philosophy, weighing on the modern ethical climate. She did not propound any unique virtue theory. However, her call for the restoration of the Aristotelean ethical tradition ignited the contemporary virtue debate which generated momentum during the 1980s, largely through the works and contributions of philosophers such as Philippa Foot, Bernard Williams, and Alasdair MacIntyre.[524]

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[520] David Papineau, *Philosophy*, (London: Duncan Baird Publishers, 2009), 159.
[521] Gertrude Himmelfarb has presented an analysis of the contemporary problem of moral fragmentation from the humanistic point of view to cultural morality which she claims originates from the problem of class segregation which permeates through religious, racial, ethnic, political, and sexual lines. She argues that class segregation also leads to moral divides among cultures which he refers to as ethics of gap. This cultural divide is evident in moral disarray and religious-cum-moral revival and normative conflicts in personal morality, public policies, religions, institutions, and interests. Cf. Gertrude Himmelfarb, *One Nation, Two Cultures* (New Year: Alfred A. Knopf, Random House, Inc., 1999), 96.
[522] Papineau, *Philosophy,* 159.
[523] Rebecca Walker and Philip Ivanhoe, Virtue *Ethics and Contemporary Moral Problems* (New York: Oxford University Press Inc., 2007), 2.
[524] Oakley and Cocking, *Virtue ethics*, 7.

There exists great variety of views on what constitutes virtue ethics and its relevance to ethical thinking. Among these diverse views are those who hold and argue that virtue ethics can stand as a rival train to Kantianism and utilitarianism as comprehensive normative ethical theories while some argue for its complementarity to these other principle-based ethical approaches. Our primary concern in this section, therefore, is to reflect on what exactly virtue ethics is, its historical development; to outline the central claims which the variants of virtue ethics share, and to show the affiliation and the distinction between virtue theory and the more familiar ethical theories such as Kantianism and Unitarianism. Above all, we aim to reflect on virtue ethics as providing the foundational pillar for professional ethics in which professions are seen as moral communities and as moral enterprises that guided by some shared source of morality, some fundamental rules, principles, or character traits that define the moral life consistent with goals, ends, and purposes of such professions.

What then is the meaning and nature of virtue ethics? Swanton avers that an explication of the concept of virtue ethics plays an essential function in ethics. This clarification helps to reveal a space for a type of theory that makes a distinctive contribution to the solution of problems in theoretical and applied ethics.[525] Pellegrino argues that our understanding of the meaning and nature of virtue ethics derives from the general meaning of the concept of virtue itself. Most contemporary definitions of virtue recourse to the Greek notion of Virtue as a character trait. This definition became more comprehensive in Aristotle's ethics. The description of Virtue, the virtues, and the virtuous person has occupied philosophers since Plato first raised the question of Virtue, its nature, number, and teachability. Since then, no one has improved on Aristotle's imperfect but still helpful definition despite the numerous efforts.[526]

Aristotle identifies moral virtues as states of character, by which he means "the things in virtue of which we stand well or badly regarding the passions."[527] Further, "the virtue of a man also will be the state of character which makes a man good and which makes him do his work well."[528] Plato, Aristotle, and the Stoics were in general agreement, as was Aquinas (with the additional consideration of man's spiritual nature) on a comprehensive moral philosophy of which Virtue was a part. The post-medieval dissolution of this moral philosophy has left the idea of Virtue without roots.[529]

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[525] Christine Swanton, "The Definition of Virtue Ethics" in *The Cambridge Companion to Virtue Ethics* ed. Russell Daniel (New York: Cambridge University Press, 2013), 319.
[526] Pellegrino, *Character, Virtue and Self-Interest*, 55.
[527] Aristotle*, Nichomachean Ethics,* 1105b.
[528] Aristotle*, Nichomachean Ethics,* 106a.
[529] Pellegrino, *Character, Virtue and Self-Interest*, 56.

In line with the Aristotelian concept of Virtue, C.S. Lewis captured his idea of a person of good or virtuous character with a good tennis player: "What you mean by a good player is a man whose eyes and muscles and nerves have been so trained by making innumerable good shots that they can now be relied on. They have a certain tone or quality, which is there even when he is not playing, just as a mathematician's mind has a certain habit and outlook, even when he is not doing mathematics. In the same way, a man who perseveres in doing just actions gets, in the end, a certain quality of character. Now it is that quality rather than the particular actions which we mean when we talk of a virtue."[530] Another helpful definition offered by James Rachels says that Virtue is "a trait of character, manifested in habitual action, which is good for a person to have."[531] This definition places character as the true mirror of who we are, and by indicating that who we are shapes what we should do, it gives a solid footing on that which we can stand, even in the most complex of areas of life and daily phenomena.

For Pellegrino, the term character may be taken in two ways: "In a general sense, it summates the kind of person one is, as revealed by the virtues and vices we exhibit in our attitudes and actions. More specifically, a person of character can predictably be trusted to act well in most circumstances, consider others in his or her decisions, look at the long-term meanings of immediate impulses, and order those impulses according to the canons of morality. In Aristotle's sense, a person of character (and here I mean virtuous character) is one who 'stands well' concerning the passions, who does not yield to extremes of self-interest, pleasure, or desires for power."[532]

The concepts of character and virtue play an essential role in ethics. Debates over their significant role in ethics have a long history. Pellegrino admits that the concepts of virtue and character are two of the oldest and most slippery in moral philosophy. He laments that contemporary professional ethics still lacks a coherent moral philosophy to locate the concept of character.[533] Pellegrino's call for a restoration and return to the practice of virtue in professional medicine is a reaction to this lack. His thought and proposal for virtues in professional life are built on the belief that a virtue-based model approach to professional life will provide us insights into the central notions of professional detachment, professional integrity, and moral character in professional life and that it will help us to better understand what ethical professional-client relationships would be like. With this motivation, Pellegrino

[530] Lewis C.S., *Mere Christianity* (HarperCollins e-books, 2001), 79-80.
[531] James Rachels, *The Elements of Moral Philosophy 4th edition* (New York: McGrawHill Companies Inc.1999), 178.
[532] Pellegrino, *Character, Virtue and Self-Interest*, 56.
[533] Ibid, 54.

developed a rigorous articulation and defense of virtue ethics in medical practice, contrasting and merging it with other types of ethical theories such as principle-based ethical theories. He showed virtue ethics as supplementary to other ethical theories but decorated it as offering a promising new approach to the ethics of professional roles.

Ethics considers the relative value of personal character and the virtues, which constitute them. People's judgments, choices, and decisions are informed or influenced by their character traits. The problem of the true moral ideal is a question of the relative value of different types of character. The effect on the person's character of a particular form of conduct is universally accepted as a test of its moral quality. For instance, Naagarazan R.S argues, "different systems of ethics emphasize other virtues in constituting the ideal moral character. With the utilitarian, who places the ethical end in the maximum happiness for the whole community, benevolence will form the primary element in the exemplary character. For the stoic, fortitude and self-control are the chief excellences. In all conceptions of ideal character, firmness of will, fortitude, constancy in adhering to principle or in pursuit of a noble aim are paramount. A man of character is frequently equivalent to being capable of adhering to a fixed purpose. Another essential is the Virtue of justice, recognizing the rights, duties, and claims of others. The richer the culture of the mind, the larger the intellectual horizon, the broader the sympathies, the more will the character approximate to the ideal of human perfection."[534]

The view that the richer the culture of the mind and the larger the intellectual horizon, the broader the sympathies, the more will the character approximate to the ideal of human perfection, is quite appealing. It promotes the claim that people's judgment, choices, and decisions are primarily informed or influenced by their character traits. Stanley Hauerwas prioritizes considering moral agent's fundamental constitution, or character, instead of focusing upon the content of their specific decisions and actions-guiding norms.[535] It is believed that people with good character formation will always be the moral beacons of the society or professions, as we shall see later in Pellegrino's argument on the virtuous physician as the moral icon. That is to say that in a gathering of holy people, we get pious practices as we find corrupt practices in a group of dishonest people. Cocking and Oakley's interpretation of professional roles as what counts as acting well in the context of a professional role is determined by how well that role functions in serving the profession's goals and by how those goals are connected with characteristic human activities. That is, good professional roles must

[534] Naagarazan, *A Text Book on Professional Ethics*, 18.
[535] James Tubbs B., Christian *Theology and Medical Ethics* (Dordrecht: Kluwer Academic Publishers, 1996), 96.

be part of a good profession, and a good profession is one, which involves a commitment to a critical human good. This good plays a crucial role in enabling us to live a humanly flourishing life.[536] Similarly, Peter Geach understands and describes human nature as intrinsically teleological and thus argues that men need virtues because of what men are for, their inbuilt teleology.[537]

However, an appropriately action-guiding professional ethic cannot be generated on this broad or general concept of the teleological notion of virtues without specifying the appropriate orientation and essential guiding concerns of the particular profession. It must reflect how each unique professional, ethical role contributes to the overall goal of that profession. For example, we have taken Pellegrino's virtue in medicine, as appropriate for serving health as the central goal of medicine, and then given the importance of health for human flourishing; medicine would count as a good profession on this virtue approach. Pellegrino uses the teleological model of medicine to demonstrate the proper goals of medicine.

Oakley and Cocking have argued that an essential way of distinguishing virtue ethics from the Kantian and utilitarian character-based forms of ethics is by bringing out the differences in how each theory grounds the relevant normative conception that would govern the character of a good agent. Kantian deontologists claim that the goodness of an agent's character is determined by how well they have internalized the capacity to test the universalizability of their maxims, while utilitarian consequentialists claim that a person with a good character is disposed to maximize utility. Virtue ethicists, however, reject both Kantian universalizability and the maximization of utility as the appropriate ground of good character and instead draw on other factors in substantiating the appropriate normative conceptions of a good agent.[538]

What distinguishes virtue ethics from these other significant theories is that deontology considers moral duty as primary. An action is right if it is following duty. It follows that a virtuous person acts from a sense of duty, and the moral knowledge they have is knowledge of a set of ethical rules or principles that specify what is required by duty. Consequentialism, in turn, takes good consequences to be primary and defines right action in terms of actual or expected outcomes. By contrast, the central concept in virtue ethics is a virtue rather than duty or good consequences. Accordingly, it evaluates actions in Virtue, for example, by holding that an effort is right if, and only if, it is what a virtuous person would characteristically do in the

[536] Oakley and Cocking, *Virtue ethics*, 74.
[537] Peter Geach, *The Virtues* (Cambridge: Cambridge University Press, 1977), 18.
[538] Oakley and Cocking, *Virtue Ethics*, 15.

circumstances.[539] It means that the critical difference between Kantians and Aristotelians rally around the role and nature of practical wisdom. In Kant's view, reasonable judgment is the ability to discern what moral principles require in a particular case. It is a capacity distinct from Virtue, which consists in strength of character in following ethical principles.[540]

Oakley and Cocking outlines some claims, which seem to be essential features of any virtue ethics view. The first and perhaps the best-known claim, which is central to any form of virtue ethics, states that an action is right if and only if it is what an agent with a virtuous character, would do in the circumstances. This is a claim about the primacy of character in the justification of right action. Right action is following what a virtuous person would do in the circumstances, and what makes the action right is that it is what a person with a moral character would do here.[541]

Another feature of virtue as advanced by Oakley and Cocking, claims that goodness is before rightness. That is, the notion of goodness is primary, while the idea of rightness can be defined only concerning goodness: no account can be given of what makes an action right until we have established what is valuable or good. In particular, virtue ethics claims that we need an account of human good or what is commonly regarded as admirable human traits before we can determine what it is suitable for us to do in any given situation of ethical theories. The virtuous physician seeks after the good.[542]

What then can we term as the distinctive characteristics of the virtuous physician in medical practice? Principles, then, are general statements of what guides the actions of a good person. Pellegrino and Thomasma argue: "A person is not virtuous because he follows the principle or does his duty, as Kant would have it. Instead, the principle derives its validity from the moral relationship between rational beings capable of choosing their values, ends, purposes, and life plans. In possession of phronesis, the virtuous person has the necessary intellectual capacity to discern what is right and good in a particular case. His actions grow out of practical wisdom and are generalizable. The founders of moral philosophy, Socrates, Plato, and Aristotle, were more concerned with the good and the virtues, those traits that habitually dispose the honest agent to the good."[543]

For Pellegrino, virtuous persons are distinguished as agents and their acts as well, by a capacity to be disposed of habitually not only to do what is required as duty but to seek the

[539] Zyl, *Virtue Ethics*, 12-13.
[540] Ibid, 32.
[541] Oakley and Cocking, *Virtue Ethics*, 9.
[542] Ibid, 19.
[543] Pellegrino and Thomasma, *The Virtues*, 24.

perfection, the excellence, and the *arête* of a particular virtue. Virtuous persons see themselves as bound to act as excellently as possible in achieving their ends. The virtuous person is impelled by his virtues to strive for perfection, not because it is a duty, but because he seeks perfection in pursuit of the telos of whatever it is he is engaged in. He cannot act otherwise. It is part of his character. The virtues dispose him habitually to fill out the potential for moral perfection inherent in his actions because he wishes to be as close to perfection as possible. The virtuous person will interpret the span of duty, principle, or rule more inclusively and in the direction of perfection of the good end to which the action is naturally oriented.[544]

Some virtue ethicists hold that principles are too abstract to be of use in context. They also argue that the use of principles in moral judgment is too formularized and far removed from the concrete human particulars of moral choice. Three reasons have been advanced to demonstrate that virtue ethics provides a more realistic, practice-focused way of meeting substantial professional, ethical issues than rule-based approaches. The first reason by Pellegrino states that rules or principles by themselves are too abstract and general to guide moral action.[545] This argument is built on a logic that rules or principles need to be interpreted in context and, to do that, virtue ethicists stress for instance, that the good doctor must acquire virtues such as perceptiveness and good moral judgment. Pellegrino advocates for the complementarity of principles and virtues.

The second reason states that rules or principles typically set a minimum standard for what counts as good practice and risks encouraging an attitude of mere compliance with such standards. Barilan and Brusa in contrast argue that virtue ethics offers the antidote to the above view since it is excellence oriented. To achieve the demanding good of the patient in medicne, for instance, the physician cannot only rely on satisfying principles or abiding by rules instead, but the physician must also demonstrate his virtues in medical practice.[546]

Third, many authors underline the similarities between wise ethical judgment in medicine and the real practice of clinical judgment. According to Kaldjian Lewis, "there are strong similarities between wise ethical judgment in medicine and what we would ordinarily call clinical judgment. Both of these require repetitive and supervised practice over years of training so that trainees can learn a skill that comes by experience."[547] A virtue-based thinking

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[544] Ibid, 167.
[545] Ibid, 19.
[546] Barilan Michael Y.and Brusa M., "Deliberation at the Hub of Medical Education: Beyond Virtue Ethics and Codes of Practice," *Medical Health Care Philososophy* 1, no. 6 (2013): 4. doi: 10.1007/s11019-012-9419-3. PMID: 22740074.
[547] Kaldjian Lauris C., "Teaching practical wisdom in medicine through clinical judgment, goals of care, and ethical reasoning," *Journal of Medical Ethics* 36, no.9 (2010), 560. DOI: 10.1136/jme.2009.035295.

ties medical ethics more closely to the ideal of medical practice compared to deontological or consequentialist thinking. James Rachels claims that virtue ethics is more appealing and superior to other ways of thinking about ethics because it provides a natural and attractive account of moral motivation.[548]

3.3 History of Virtues Ethics

We intend here to provide a brief historical sketch on the development of the concept of virtue as shaped by the dominant moral philosophies of the ancient past, whose remnants are found in the contemporary refurbishment of the idea of virtue. It is arguably agreed among many contemporary scholars, as we shall see later on, that the central notion of virtues, even today, is rooted in the classical medieval synthesis, particularly its roots in the Nicomachean Ethics, the *Eudemian* Ethics, and the Magna Moralia of Aristotle.[549]

We must, however, from the beginning acknowledge that the concept of virtue is as old as humanity itself. According to David Thomasma: "Virtue practices go as far back as the earliest moral shaping of a child by the community."[550] This flows from the argument that anyone who grew up in a strong community would have been shaped in virtue, through training by parents and community, secular and religious. Mchael Novak argues that the civil society has the special task of repairing the moral fabric of the democratic society and serving as the seedbed of virtue. It is within those institutions of the society such as families and communities that character and virtues take, children become civilized and socialized, people acquire as sense of social as well as individual responsibility.[551]

The cultures of almost every community are painted with languages and arts that are filled with stories of, and pictures of, moral virtues essential for a decent human society. For example, courage, honesty, trust, love, friendship, responsibility, truth-telling, faithfulness, and wisdom. These stories are meant to promote the integrity of the person and society as well. This method of teaching virtue was customary in most African cultures, where before the advent of colonialism, the system of education was purely informal and traditional.[552] The

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[548] James Rachels, *The Elements of Moral Philosophy* 4th edition, (New York: McGrawHill Companies Inc., 1999), 189.
[549] Pellegrino and Thomasma, *The Virtues*, 3.
[550] David Thomasma, *Virtue Theory*, 330.
[551] Michael, Novak. *Free Persons and the Common Good*. (Maryland: Madison Books, 1989),35.
[552] This type of education is usually described as an unplanned process of education that includes all agencies outside the formal school system which influence the learner. Informal education covers all experiences the learner has in the home, places of worship, mass media, folktales, etc, as well as those cultural values that he or she is

method of teaching or instruction in this informal system of education was more of an indoctrination. As Vincent Kabuk describes it, indoctrination involves some activities that convey some unquestionable dogmas into the minds of the learners. To be brainwashed is to hold on to some beliefs, creeds, and doctrines whose truths are shut to any possible doubts, questioning, or modifications either through the light of natural reasoning as in philosophy or by scientific evidence.[553]

We are not concerned with indoctrination as a type of inculcating virtues but with the systematized version of the development of virtue, how it originated through the writings and thought of the ancient Greek philosophers. This takes our minds back to the writings of Cicero on ends, in the first century BCE, which saw a close connection between virtue, comprising wisdom, courage, justice, and moderation, and the end happiness. The fifth century BCE world represented in Plato's dialogues changed the philosophical thinking by assuming that the various virtues, or Virtue as a whole, lead to happiness, *eudaimonia,* or living well *'eu zen¯'*, and tried to determine what Virtue must be if it is to be so related to happiness.[554] Most ancient virtue ethicists share this *eudaimonistic* approach and are still prevalent today in which the virtues are those character traits that are essential to living a fulfilling human life, a life in which one both cares about the right things and has the wisdom and skill to act intelligently about those things.[555]

Since we cannot provide this historical account in its full details here, we shall conveniently limit our reflection to the confines of the classical-medieval tradition in which virtues were central to all moral philosophies. The practice has gained longstanding approval as the source for contemporary ethical reflections and on virtue ethics theories. This historical review offers an instructive way to understand different ancient traditions in virtue ethics and to illustrates where those traditions resonate with their modern counterparts. Aristotle's and Thomas Aquinas's account of virtue theories provide a solid background for our reflection on the contemporary resuscitation of virtues as a basis for professional morality. The resurgence for virtues in modern ethics is advocated for in the writings of some of its leading figures like Alasdair Macintyre, Philippa Foot, Julia Annas, Rosalind Hursthouse, Christine Swanton, and

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exposed to in a given environment where he or she found himself/herself. Vincent S.Kabuk, *A Fundamental Approach to Philosophy of Education* (Port Harcourt: Ushie &Associates Publications, 2017), 31.

[553] Vincent S.Kabuk, *A Fundamental Approach to Philosophy of Education.* (Port Harcourt: Ushie &Associates Publications, 2017), 27.

[554] Cf., Rachana Kamtekar, "Ancient Virtue Ethics: An Overview with an Emphasis on Practical Wisdom," in *The Cambridge Companion to Virtue Ethics* ed. Russell Daniel C., (New York: Cambridge University Press, 2013), 29.

[555]Russell Daniel C., *The Cambridge Companion to Virtue Ethics*. (New York: Cambridge University Press, 2013),3.

Michael Slote until names are few. These leading figures advocate for virtue ethics to be taken seriously as an alternative to deontology and consequentialism. A critical look at the literature of the last two or three decades on virtue ethics shows that it has grown substantially. This is most obvious in normative and applied ethics. Still, the interest in the virtues has also spread to other areas, such as metaethics, epistemology, philosophy of education, psychology, and theology.[556]

3.3.1. Classical-Medieval

Ideals and theories of the virtues played a central role in the moral discourse of the classical, medieval Western Europe. This period is shielded in the ancient Greece theory of Virtue. All of the major camps in moral philosophy, Platonists, Aristotelians, Epicureans, Stoics including *eudaimonists,* whose influence in virtue ethics is still strong today. This *eudaimonistic* trend features an ethic that guides humans in their search for the good that enables them to flourish or find happiness as free, rational beings. This dominant view in the classical understanding describes moral virtues as characteristics of the disposition of human persons, to whom what is really and rationally good also seems subjectively good.[557] In this classical view, Virtue serves as an adequate condition for the rationality of acting subjects because they empower and guide the acting subject effectively toward the good and in this way empower the practical reason, especially its ability to recognize what is morally right concretely and in detail, and effectively to carry it out.[558]

We have already noted that the systematic development of the concept began in Athenian society in about the fifth century BCE. The virtues, which developed in the warlike culture of archaic Greece, were gradually transformed into virtues more appropriate to a settled, urban existence. This process led to the first attempts to provide systematic accounts of the nature of Virtue. These accounts, in turn, helped to crystalize the idea of a distinctively human form of excellence that is proper to the human being as such, without reference to particular

[556] Zyl, *Virtue Ethics*, viii.
[557]Let us consider the sense from which "philosophers evaluate habitus based on the perfection which it achieves in human nature. Human nature refers to the form life takes in a human being; as embodied spirit, each person enjoys the powers of human life—the characteristic human abilities or capacities—as well as the exercise of these powers— human activity. A good habitus makes an agent tend to act by the agent's nature, whereas a bad habitus makes the agent tend to act against the agent's nature." Romanus Cessario, *The Moral Virtues and Theological Ethics,* second edition(Notre Dame: University of Notre Dame Press, 2009),46.
[558] Martin Rhonheimer, *The Perspective of Morality Philosophical Foundations of Thomistic Virtue Ethics*, trans. Gerald Malsbary (Washington D.C. The Catholic University of America Press, 2011),188.

circumstances or roles.[559] This served as a departing point from which onward, reflection on virtues was intimately bound up with more fundamental questions about the purpose of human life, as philosophers and other reflective thinkers attempted to determine the place of virtue in a well-lived life. The concept of virtue shifted to that of conceiving virtues as moral guides.

The role of moral virtues as rationally guiding the acting subject occurs in a twofold sense: On the importance of universal principles, they provide a practical orientation toward what is rational, while on the level of concrete, particular action, they provide cognitive empowerment through the proper motivational, affective disposition of the subject.[560] In the Aristotelean or classical tradition, we see a marriage between theory and practice or the connection between the *dianoetic* intellectual and the moral-ethical virtues.[561] Let us capture the view of this period within the accounts of the Aristotelian Thomistic tradition.

3.3.1.1 Aristotle's Account on Virtues

We have already established in the previous paragraphs that the systematic development of the concept of virtues found its expression in the ethics of Aristotle. Aristotle considers humans as beings who are to be oriented to their telos, or end, of happiness. From this frame of reference, Aristotle's ethics stresses the development of moral virtues to direct and lead us to this end within the context of our relationship with one another.[562] Aristotelian virtue ethics provides a natural basis for developing an ethical theory of professional roles. Character traits that count as virtues in everyday life are determined by their connections with *eudaimonia,* the overarching goal of a good human life. Romanus Cessario opines that the Aristotelian conception of excellence of character, namely, that state of human perfection, which belongs to the complete and well-formed human person, has remained the philosophical basis for virtue theory.[563]

Aristotle expressed this teleological structure of ethics thus: "Every art and every inquiry, and similarly every action and choice, is thought to aim at some good, and for this reason, the good has rightly been declared that at which all things aim."[564] Pellegrino's thought

[559] Jean Porter, "Virtue Ethics in the Medieval Period," in *The Cambridge Companion to Virtue Ethics* ed. Russell Daniel (New York: Cambridge University Press, 2013),71.
[560] Rhonheimer, *The Perspective of Morality*, 188.
[561] Ibid. 190.
[562] Smith, *Virtue Ethics and Moral,* 14.
[563] Romanus Cessario, *The Moral Virtues, and Theological Ethics,* second edition(Notre Dame: University of Notre Dame Press, 2009),173.
[564] Aristotle, *Nichomachean Ethics*, 1094a 1–3.

is highly inspired by this teleological identity of Aristotelian ethics, which he adopted and used in his teleological approach to the philosophy of medicine in which he defines the professional end of medical practice as the good of the patient. He follows Aristotle's argument that "the excellences of man also be the state which makes a man good and which makes him do his work well."[565] Aristotle believed that everything has a *telos,* an aim or point to its existence. The telos of human beings is something that follows from their essential nature. Moreover, it is only when that nature is fulfilled that happiness is found.[566] Virtues in the context of professional roles can be derived through a similar teleological structure.[567] This derives from the Aristotelian definition of morality as the achievement of an end.[568] This Aristotelian tradition forms a background from which *eudaimonists* take the starting point for ethical reflection as dwelling on: "How can I live well? Or: What is the best life for human beings? And their answer, in short, is: A good or happy life is a virtuous life."[569]

From the Aristotelian traditions and ethical writings, virtue ethicists acquired various positions, interests, distinctions, and concepts, which were all quite alien to modern analytical philosophy until virtue ethics became established. After many centuries, Aristotle's influence on our society's moral thinking remains profound, and he continues to be a significant contributor to contemporary debates in philosophical ethics. His ethics provides a relatively comprehensive and classical picture of what constitutes virtue ethics. Bertrand Russell describes Aristotle's ethics as presenting "the prevailing opinions of the educated and experienced men of his day."[570]

Zyl sees the Aristotelian virtue tradition as possessing both an emotional and an intellectual aspect: "it involves feeling and reasoning in certain ways. The virtuous person is committed to certain things because she judges them to be worthwhile, and this motivates her to act in ways that protect or promote these things."[571] The point here is all about acting with and through practical reason, which involves working for the right reasons and emotions. Zyl explains this compatibility between logic and feelings with an example of acting courageously. He states for instance, that a courageous police officer values human life and that is why he can bravely take every form of risk to save a vulnerable man's life as a strong reason for acting.

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[565] Aristotle, *Nichomachean Ethics*, 1106a 22–4.
[566] David Papineau, *Philosophy* (London: Duncan Baird Publishers, 2009), 168.
[567]Oakley and Cocking, Virtue *Ethics*, 205.
[568] Simone Grigoletto, *Only Through Complexity: Morality and the Case of Supererogation* (Padova: Padova University Press, 2019), 16.
[569] Zyl, *Virtue Ethics*, 21.
[570] Bertrand Russell, *History of Western Philosophy* (London: The Bertrand Russell Peace Foundation Ltd., 1996), 168.
[571] Zyl, *Virtue Ethics*, 23.

Virtue ethics, as Koehn puts it, "focuses on the conformity between right thinking and desire. In this respect, it differs from a deontological ethic, which always runs the risk of developing schizophrenic agents who are compelled to do what duty dictates irrespective of whether they want to perform that act. The virtuous agent simply is the person habituated to desire to do what is good and noble."[572]

The point of acting well with and through right reasoning reflects in all clarity what is contained in the famous doctrine of the golden mean that virtue lies in the middle. Through this doctrine, Aristotle provides an account of the virtues to prove his position that right or virtuous actions are those, which are by the correct course of conduct, which is a balance or rational regulation. According to the doctrine of the golden mean, "every virtue is a mean between two extremes, each of is a vice."[573] An examination of every virtue is proof of this doctrine. The example of the courageous police officer, which we previously cited, is an expression of what Aristotle meant when he taught that courage is a mean between cowardice and rashness; liberality, between prodigality and meanness; proper pride, between vanity and humility; ready wit, between buffoonery and boorishness; modesty, between bashfulness and shamelessness.[574]

Aristotelian tradition holds firmly that virtues are beneficial to the well-being of their possessors and their communities. Individual and social virtues both form the foundation of society. We need virtues for the well-being of the human person and the upkeep of society. The benefits of virtues are enormous such that they enable their possessors to flourish, to attain their happiness and their goals in life. It follows that "if a virtuous person has a correct grasp of what is important in life, is motivated by the right reasons, and has the appropriate emotions when she acts, we would expect things to go well for her."[575] For Alasdair MacIntyre, virtues, as interpreted by Aristotle, play an indispensable role in our lives by enabling us to move from dependence on the reasoning powers of others, principally our parents, teachers, to independence in our practical reasoning.[576] By implication, virtues liberate us from the slavery of the common opinion and of traditions or myths.

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[572] Daryl Koehn, "A Role for Virtue Ethics in the Analysis of Business Practice," *Business Ethics Quarterly* 5, no. 3 (1995):535.
[573] Bertrand Russell, *History of Western Philosophy*, 169.
[574] Aristotle, *Nichomachean Ethics,* 1108a5-9.
[575] Zyl, *Virtue Ethics*, 24.
[576] Alasdair MacIntyre, *Dependent Rational Animals, Why Human Beings Need the Virtues* (Chicago: Carus Publication Company, 1999), 120.

3.3.1.2 Thomas Aquinas's Virtue Ethics

The doctrine of the virtues is central to Thomas Aquinas's moral theology and moral philosophy. It is believed that his (c.1225–1274) task was that of synthesizing and refining Aristotle's ethics and metaphysics with Augustine's theology by reconstructing both positions within the framework of a unified metaphysical theology.[577] Aquinas adopts and draws freely on Aristotelian terminology and themes in developing his theory of the virtues. Aquinas's account is often described as a synthesis of Christian theology and Aristotelian philosophy. Thomas Aquinas distinguished four types of virtues, namely: The theological virtues, which relate man directly to God, the intellectual virtues which perfect the speculative while the moral virtues assist in the making of good moral choices and the placing of good human acts.[578]

Smith situates the points of convergence between Aquinas and Aristotle's theory of virtues by outlining that Aquinas' virtue ethics revolves around his agreement with Aristotle that while there are many kinds of good in life, there is a telos for the human being to be valued for its own sake. Smith holds that Aquinas agrees with Aristotle's analysis of the process of deliberation by which practical reason is to achieve a given good by the best means. He concurs with Aristotle that the right action is based upon premises given by affirming the good to be realized and recognizing the person's present situation.[579] Aquinas subscribes to Aristotle's explication of virtues as a mean between two extremes. He thinks, like Aristotle, that people become virtuous by performing acts that develop the disposition of the soul of the individual to act virtuously habitually. Finally, he agrees with Aristotle on the indispensability of the exercise of prudence as required for the operation and proper functioning of the other moral virtues. However, his modifications reflect his need to account for the addition of the supernatural, or grace, and the Augustinian and Pauline doctrine of the will.[580] This we shall see further at Aquinas' attempts to integrate the dichotomy between the cardinal and theological virtues.

In Aquinas' account, we see a distinctive extension of the scope of the concept of virtue theory in his seemingly innovative synthesis of Christian theology and Aristotelian philosophy. In this synthesis, Aquinas integrates the Aristotelian claim that the virtues are perfections, singly, the perfection of the faculties of the soul that comprise the subject of the particular

[577] Smith, *Virtue Ethics and Moral*, 17.
[578] Thomas Aquinas, *Summa Theologiae I-II; qq. 90-97 The Treatise on Law* ed. R.J. Henle (Notre Dame: University of Notre Dame, 1993), 67-69.
[579] Smith, *Virtue Ethics and Moral*, 17.
[580] Ibid, 17-18.

virtues and taken together with a model of the human agent. For Aquinas, virtues are perfections of the faculties, with his overreaching metaphysical and theological systems of intelligibility, goodness, and causality analysis. Porter argues powerfully that this systematic extension and synthetic integration of the Aristotelian virtue ethics gives Aquinas' thought a unique feature. According to Porter: "Aquinas' systematic analysis of the virtues in terms of a metaphysics of perfection is the most striking aspect of his distinctive theory of the virtues. Nearly every scholastic theologian up to Aquinas' time would have agreed that the virtues are perfections of the agent. Still, Aquinas stands out for the systematic way in which he interprets and integrates this claim in the light of his general metaphysics."[581]

This synthetic task leads Aquinas to posit the existence of two realms, namely, the earthly and the heavenly, or that of grace and nature, and these realms exist for each other.[582]Aquinas' synthesis and integration revolve the problem of the dichotomy which existed in the relationship between cardinal or (classical) virtues versus theological virtues, acquired versus infused virtues. According to Porter:

> Most of Aquinas' predecessors and interlocutors organized their accounts of the virtues by a dichotomy between the theological virtues, which are necessary to salvation and depend on God's grace, and political or (later) acquired virtues, which are appropriately directed towards human flourishing in this life and can be attained through human effort. The latter can be said to serve as a preparation for the theological virtues, and they provide a medium through which the theological virtues are expressed in external acts. Nonetheless, scholastics up to this point typically hold that the theological and the political or acquired virtues remain in an external relation, with the former directing the latter.[583]

In the *Summa Theologiae*, Aquinas interestingly resolved the problem of this existing dichotomy by replacing it with a more complex set of distinctions between the theological and the cardinal virtues, on the one hand, and between infused and acquired virtues on the other, with specifically distinct forms of the cardinal virtues falling on either side of this line.[584] The immediate reaction would be how Aquinas reconciles this dichotomy with a more complicated set of distinctions between the identified forms of virtues? Correlatively, for an action to be meritorious, it must stem from grace in some way.[585] By implication, the view of his predecessors and interlocutors that theological virtues direct the political or cardinal virtues is inadequate. Thus, for grace to be operative and productive in every dimension of human life, it must transform all the faculties of the human soul involved in the processes of deliberation

[581] Ibid, 81.
[582] Smith, *Virtue Ethics and Moral*, 17.
[583] Jean Porter, *Virtue Ethics*, 84.
[584] Ibid, 85.
[585] Aquinas, *Summa Theologiae*, I-II 114.2

and action.[586] Here Aquinas adds the concept of grace as a superior force and guide to the theological virtues. Thus, it is not enough that the theological virtues should command the acts of the other virtues; instead, grace must be expressed directly through virtues appropriate to every faculty of the soul, which is to say, through infused versions of all the cardinal virtues.[587]

It is worth noting that growth in character within classical ethics refers to a progression toward the fulfillment of our *telos,* which involves a proper ordering of the soul and relationships.[588] Aquinas identifies two distinctive kinds of *telos,* namely, the natural and the supernatural; the former is realized in the relative fulfillment of our human nature's natural capacities, while the latter which is our ultimate happiness is found in the realization of the *summum bonum*, which is found only in God and the beatific vision of God's glory.[589] By implication, the cardinal virtues enable us to attain our natural *telos,* while the theological virtues help us to achieve the supernatural *telos.*

In contrast to Aristotle, Aquinas holds that cardinal virtues are inadequate for developing fully matured human beings because they cannot direct us to God. After all, the cardinal virtues themselves can only be perfect when informed that *Caritas* is a gift of grace.[590] Thus, the cardinal and theological virtues also impact and interact with each other in a distinctive way. They integrate by complementing each other for a perfect union and function. The theological virtues are needed to enable the human being to perform good deeds indeed aimed at God. Thus, to truly please God, the moral virtues must integrate with the theological virtues. Aquinas holds that the cardinal virtues must be fused with a charity in the believer to truly please God since charity is the source of all good works ordered toward God, but it is through the cardinal virtues that people perform good works.[591] This clarifies the binding force and the bond of unity between the different kinds of virtues that lead to deep interaction since they are all rooted in the soul's structure. Smith puts it: "In terms of character, the soul provides the boundaries for the virtues of a mature person."[592]

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[586]Aquinas, Summa *Theologiae* I-II 63.3, ad 2, 65.3.
[587] Jean Porter, *Virtue Ethics,* 85.
[588] Smith, *Virtues Ethics and Moral*, 19.
[589] Ibid.
[590] Ibid.
[591] Aquinas, *Summa Theologiae*, 1a2ae 65, 3.
[592] Smith, *Virtue Ethics and Moral*, 15.

3.3.2.1 Alasdair MacIntyre's Virtue Ethics

One of the famous accounts of virtue ethics in Western thought is the MacIntyrean proposal on the need to return to virtues. His account is widespread, and it has attained a far-reaching influence on western moral discourse. This account emerged as a response and a solution to the ethical dilemmas that eroded the Western moral climate between the 19th and 20th centuries. MacIntyre describes this era as a disaster in contemporary moral discourse. Pellegrino describes MacIntyre as most genuinely and successfully building on the Aristotelian notion of Virtue and reformulating in more modern terms by considering the erosion of the tradition and the moral consensus that gave the classical doctrine its normative strength.[593] While describing and lamenting about the moral disorder, the collapse of tradition, culture, and of the Western virtues, MacIntyre wrote: "Some large degree in the practice of morality today is in a state of grave disorder. A society in which the belief in Aristotelian teleology was discredited."[594] This brought about the state of the society to what MacIntyre describes as characterized by a fundamentally antipathetic culture to the quest for Virtue.[595]

MacIntyre's account represents one of the most significant proposed solutions to western ethical dilemmas. McIntyre developed this solution in his, *After Virtue*, as well as in its sequels. For him, the answer to the moral decay and the loss of moral knowledge of his time lies in large part in a return to the virtues ethics of Aristotle and Aquinas as the only key to recovering what has been lost in modern moral philosophy: namely, an overreaching goal, or telos, for human life.[596] The call to return to a character, agent-based model of ethics and the call to move away from liberalism and the more principled-based ethical framework of the Enlightenment helped fuel the resurgence of interest in virtue ethics more than any other contemporary author.

While MacIntyre constantly refers to the Aristotelean Thomistic virtue tradition, he quickly shifts from Aristotle and Aquinas by employing the significant modifications to suit his interpretation of the context of contemporary moral decadence. From the start, MacIntyre traces the origin of the moral catastrophe and breakdown in modern moral discourse to be an effect of not just the Enlightenment but also of the blatant secular rejection of both Protestant and Catholic theology and the scientific and philosophical rejection of the classical ethics, such

[593] Pellegrino, *The Philosophy of Medicine Reborn,* 263.
[594]Alasdair MacIntyre, *After Virtue*, 264.
[595] Alastair Campbell, "Toward A Culture of Caring' in Medical Ethics Education" in *Advances in Bioethics: Critical Reflection on Medical Ethics* vol.4 ed. Martyn Evans (London: Jai Press Inc., 1998), 99.
[596] Smith, *Virtue Ethics and Moral*, 2-3.

as Aristotelean and Thomistic ethics, which emphasized the notion of humans as they could be, if they realized their *telos.*[597] In his review of MacIntyre's virtue ethics, Smith observes that MacIntyre attributes the cause of the failure of the Enlightenment's project to attempt to truncate the essential nature of humans, the loss of a *telos.*[598]

Following the claim that the indispensable basis for justifying those virtues was the human telos, which was grounded in the human being's essential nature. MacIntyre argues that we must return such an ethic that emphasizes the centrality of the flourishing human person to correct the ethical errors of modern moral philosophy. He advocates a quick return to a philosophy that underlines human nature and its telos to achieve thi*s.* He writes: "the Aristotelian tradition can be restated in a way that restores intelligibility and rationality to our moral and social attitudes and commitments."[599] For him, "the whole point of ethics is to enable man to pass from his present state to his true end."[600]

Furthermore, MacIntyre argues strongly that practices require Virtue, and training will make one better at Virtue, which will ultimately develop into a habit. This is what is normative; the virtuous habit that is created will guide one's action. Thus, "practices then might flourish in societies with very different codes; what they could not do is to flourish in societies in which the virtues were not valued, although institutions and technical skills serving unified purposes might well continue to flourish."[601] MacIntyre proposes a system based on Virtue developed and enhanced through practices that are then converted into traditions of the society. Practices require Virtue, and training will make one better at the Virtue, which will ultimately develop into a habit. This is what is normative; the virtuous habit that is generated will guide one's action. According to him: "Practices then might flourish in societies with very different codes; what they could not do is flourish in societies in which the virtues were not valued, although institutions and technical skills serving unified purposes might well continue to flourish."[602]

MacIntyre strongly believes that virtue ethics, the study of moral character, constitutes an essential tool for moral formation and building a just and morally sound society. He defined Virtue as: "an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such goods."[603] MacIntyre proposes that virtue ethics, the study of moral

[597] Ibid. 50.
[598] Smith, *Virtue Ethics and Moral*, 52.
[599] MacIntyre, *After Virtue*, 259.
[600] Ibid, 54.
[601] Ibid, 193.
[602] Ibid.
[603] Ibid, 191.

character, constitutes an essential key for moral formation and building a just and morally sound society. For him, Virtue is "an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such goods."[604]

MacIntyre's conviction about the possibility of virtue ethics and his anticipation of its good moral impact on the ethical culture of western society is expressed his expectation of a different St. Benedict:

> What matters at this stage is the construction of local forms of community within which civility and the intellectual and moral life can be sustained through the new dark ages which are already upon us. In addition, if the tradition of the virtues was able to survive the horrors of the last dark ages, we are not entirely without grounds for hope. This time however the barbarians are not waiting beyond the frontiers; they have already been governing us for quite some time. And it is our lack of consciousness of this that constitutes part of our predicament. We are waiting not for a Godot, but another-doubtless very different-St. Benedict.[605]

3.4 Chapter Summary

We have investigated the understanding of the nature of virtue ethics, its relevance to contemporary moral discourse, conceptual/historical development, and its distinctiveness and plausibility compared with its consequentialist and Kantian rivals. It is established in this chapter that Virtue had its most developed concept in the ancient Greek classical period in the person of Aristotle and its eventual synthetic refinement in the Aquinas' philosophical-theological appraisal. Aquinas gave virtue ethics a broader and broader interpretation in his attempt to integrate faith and reason. We cannot exhaust the various arguments regarding virtue ethics with the other ethical frameworks and normative theories in European moral thinking. The classical-medieval ethical tradition propounded the teleological structure of virtues, which provides a background key for developing a contemporary virtue theory and demonstrates how virtue ethics provides a valuable account of the nature and moral significance of virtues for professional roles. In a more specific manner, this section serves as a strong foundation for our discussion in the next chapter. We intend to concretize our analysis on virtues for professions by using Pellegrino's virtue ethics in medical practice.

[604] Ibid.
[605] Ibid, 263.

Chapter Four: Application of Virtues in Medical Profession

Introduction

This chapter centers on Pellegrino's advocacy for a humanistic, virtue-based normative ethics for the health profession. It brings us to the primary and concrete situation of the application of virtues in medical practice. This chapter can simply be described as Pellegrino's fusion of theory and practice. This is demonstrated by how he proposes particular virtues and links their roles as practical guides to the physician's actions and decisions in the context of the clinical encounter.

Chapter four attempts to respond to the question as to whether virtue ethics in medicine as a profession provides action guidance or informs our decision-making on how virtue is dev eloped. Our primary concern is to analyze Pellegrino's argument that applying particular virtues in medical professional roles can lead to fruitful clinical practice. What we mean by providing actionable guidance to the physician should be understood as helping them pick out the right ones from a list of possible actions.

We will examine particular virtues that Pellegrino selects and considers as of special importance in the medical relationship. Pellegrino emphasizes how the virtues work in the medical practice and are particularly important in clinical care and judgment, especially in end-of-life decision-making. Virtue ethics provides a set of rules to help decide the moral justifiability about deliberately terminating or shortening a patient's life. Virtue ethics guides the professional toward judging and deciding under the morality of the profession's end and structure. For example, one of the solid ethical objections against doctors performing voluntary euthanasia is incompatible with their oaths not to harm a patient.

This chapter also concentrates on the contemporary philosophers' discourse on the indispensability of virtuous character traits on good medical practice and on the renewed attention to revive a distinctive medical ethic in response to the shortcomings of broad-based ethical theories like Kantian and utilitarian to the need to integrate virtue theory. It reviews Pellegrino's interest in professional virtues or the professions' goals that developed a detailed account of virtues such as compassion, fortitude, courage, and justice in medical practice. These and other character traits count as virtues that Pellegrino proposes and offer as features to help doctors achieve medicine ends. So on this context, what counts as virtue in a medical context is determined by the ends or goals of medicine, and thus by the nature or philosophy of medicine as a practice.

4.1 The Humanistic Ethics of Medicine

The use of the term humanism can be ambiguous if not adequately defined before its application. It is a word with a very complex history and an extensive range of possible meanings and contexts.[606] An ardent theorist of humanism, Jeaneane Fowler in her work, *Humanism: Beliefs and Practices*, admits that due to the elusive nature and of the existence of the many facets of the term humanism, there arise many difficulties and complexities surrounding both the historical and the modern day concept of the theme of humanism. Consequently, this results in the emergence and the diversity of humanist theories and different varieties and grades of humanism.[607] It requires, therefore, that in every situation or context, the use of the concept of humanism should be accompanied with an operation or functional definition of the sense in which it is being employed since is so largely broad and elusive to be grasped in a single scope and dimension.

Similarly, Pellegrino observes that anyone who uses the noun humanism or the adjective humanistic is compelled at the outset to at least provide a working definition. This clarification is necessary because these terms have become veritable shibboleths. They sometimes refer to a challenge, claim, or an ideal, justifying all sorts of diverse and contradictory human activities.[608] Pellegrino uses the term in a loose sense that most people apply today to the health professions and other professions. In this open sense, "humanism encompasses a spirit of sincere concern for the centrality of human values in every aspect of professional activities. This concern focuses on respect for the freedom, dignity, worth, and belief systems of the person and it applies sensitive, non-humiliating, and empathetic of helping some problem or need."[609]

The above operational definition of this term humanism serves as a benchmark of which Pellegrino considers what might be the most compelling derivation of a specifically humanistic professional ethics. His inquiry proceeds from examining the more traditional source in the image and ethos of the physician to a head in the specifically human dimensions of being ill and in distress. In this light, Pellegrino argues for a more sensitive and compelling guide to the care of the sick, which is found in the fact of human illness as a human experience, rather than in the assigned role of the professional. On the need for greater sensitivity, he strongly argues: "Without supplanting traditional professional ethics, the intrinsic dehumanizing nature of

[606] Tony Davies, *Humanism* (London: Routledge, 1997), 2.
[607] Jeaneane Fowler, *Humanism: Beliefs and Practices*, (Brighton: Sussex Academic Press, 1999), 6-7.
[608] Pellegrino, *The Philosophy of Medicine Reborn*, 88.
[609] Ibid,

illness imposes additional obligations of greater sensitivity-precisely those found wanting by the critics of medicine today."[610] When the mechanistic practice of medicine has threatened human values, we see Pellegrino promoting a humanistic medical ethics by insisting that the premium of humanizing medical care should be prioritized at the highest level. He calls for a practice of medicine with a human face that is compassionate. His view expresses that we need more humanity than machinery and technicality in medical practice despite their significance.

Further still, Pellegrino broadly views medical humanism as integral and all-encompassing, composed of both the physician's cognitive and compassionate response to the patient's person.[611] This notion embraces humanism as a set of mental skills derived mainly from the humanities, and these are integral to the conception of medicine as science, art, and virtue. Humane medicine, indeed moral medicine, requires that the physician understands the distinctions between these intellectual and practical activities, the kinds of reasons each may adduce, their limitations when applied to each other's realms, the different sources of their methodology and the different subject matter appropriate to each.[612] Through his doctrine of medical humanism, Pellegrino seeks to demonstrate the collaborative and interconnected nature of the particular methods of medical activities and their efficacy in medical practice as a whole. For this reason, Pellegrino believes that medical professional education should be humanistic in approach in such a manner that the skills necessary and required for sound dialectical, ethical and rhetorical reasoning modes, which are useful for clinical activities, must be more explicitly incorporated into professional education, especially in the clinical contexts within which decisions for patients are being made.[613] Humanistic ethics gives more attention to the particularities of the clinical encounter than the traditional ethics that seems rigid and one-sided, centered on the physician's power to decide at all, times what he defines as the good of the patient.

In a more specific dimension, Pellegrino reflects his doctrine of humanism by focusing on the humane aspects of what it is to be ill and what it is to be healed. Pellegrino defines its

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[610] Ibid, 88-89.

[611] The human aspect has been considered as timeless and unchanging at a time of great changes in modern technology and delivery of medical care, Savett states: "what is timeless and unchanging for patients and physicians is the human side of medicine, the non-technical part. Many feel that unless one is by nature a compassionate and understanding person, that dimension of medicine is hard to teach and hard to learn" Laurence Savett A., *The Human Side of Medicine: Learning What It's Like to Be a Patient and What It's Like to Be a Physician* (London: Auburn House, 2002), xxv.

[612] Edmund D. Pellegrino "The Anatomy of Clinical Judgments: Some Notes on Right Reason and Right Action," in Clinical *Judgment: a Critical Appraisal* ed. H. Tristram Engelhardt, Jr. and F. Spicker (Holland: Reidel Publishing Company, 1979), 191.

[613] Pellegrino, *The Anatomy of Clinical Judgements*, 191.

concrete features from this state of being ill and then delineates the ethical imperatives that stem from it. According to him: "These ethical imperative cannot constitute anything else but humanistic ethics because they are tied to a specific human experience and, not to a social or historical for the profession."[614] Humanistic ethics is not without an essence. According to Pellegrino:

> The essence of humanistic ethics is this: particular features of illness diminish and obstruct a patient's capacity to live a specifically human existence to its fullest. These features create a relationship of inherent inequality between two human beings: one a physician, the other a patient. This inequality must be removed as fully as possible before the humanity of the patient can be restored. The obligation to restore the patient's humanity is intrinsic in the relationship physicians assume why they "profess" medicine. Specific obligations are derived from the "profession"-an active assumption by the physician as a free person entering a relationship with another person. These obligations transcend any responsibilities, rights, or privileges physicians may feel were conferred upon them by the degrees they possess.[615]

Pellegrino employs the use of two essential concepts of curing and caring to make clear in concrete terms his theory of humanism in medical practice. He makes a distinction between curing and caring for the notion of the physician-patient relationship. In doing this, he concentrates more on the caring than on the curing aspect of the healing relationship as a dominant trait of medicine, and on the moral obligations subsumed in the notion of caring.[616] While acknowledging that curing and caring have the same function, goal and are of the same Latin root: *curo, curare*- 'to cure,' 'to take care of,' 'to take the trouble,' and later 'to treat' medically and surgically, to 'heal' or 'restore' to health.[617] However, Pellegrino argues that curing and caring differ in the senses of their usage. He explains that while the word cure is used by many health professionals in a radical sense, technical and scientific, to refer to the eradication of the cause of an illness or disease as the radical interruption, and reversal, of the natural history of a disorder, care largely refers to the body's self-healing powers through the physician's compassion, caring, encouragement, and emotional support.[618] Pellegrino laments that the dilemma of modern medical ethics derives from the fact that the practice of modern medicine tends to neglect the caring aspect without which, effective curing cannot take place. In an atmosphere of technological and scientific development, many professions tend to lose sight of the significance of the human aspect of their professional roles. Professional roles have become mechanized, and technicality seems to overshadow and take precedence over human touch, care, compassion, and support.

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[614] Pellegrino, *The Philosophy of Medicine Reborn*, 93.
[615] Ibid, 93-94.
[616] Edmund Pellegrino, "The Caring Ethic: The Relation of Physician to Patient" in *Coping, Curing, Caring: Patient, Physician, Nurse Relationships* eds., Anne H. Bishop and John R. Scudder (United States of America: The University of Alabama Press, 1985), 8.
[617] Ibid, 9.
[618] Cf., Pellegrino and Thomasma, *The Christian Virtues*, 92.

In his attempt to assess what should be the best foundation for the healing practice between the curing and caring models of medical practice, Pellegrino argues that the three elements of the physician-patient relationship of the clinical encounter "make it clear that although curing and caring are essential parts of medical practice, caring 'founds' that practice."[619] It is based on these tripartite elements of the clinical that Pellegrino builds his claim of caring as a moral obligation and defines the end of medicine, in the philosophical sense, as a right and good healing decision for a particular human being.[620] He argues that the combination of the curing and caring models is both necessary and indispensable for sound medical practice and an influential healing profession. Pellegrino avers, "To care for a patient in the full and integral sense I have outlined it requires a reconstruction of medical ethics, one that attends to the concept of care in its broadest sense and, indeed, makes caring a moral obligation."[621] Pellegrino's proposal for a humanistic approach to the practice serves to correct the danger of only seeking for excellence or healing and forgetting to be human while in essence without the breath in the human there cannot be any excellence to pursue.

Similarly, Alastair Campbell proposes and builds his theory of ethics of care around this humanistic dimension of medical ethics. His ethics of care derives its sources from the *Hippocratean* emphasis on goodwill. Campbell's ethics also finds its root from the feminist critiques of the paternalistic and over-rationalist character of much contemporary medical ethics, which argue for a distinctively feminine approach to ethics, in which intuition and relationships played by a dominant part rather than reason and the search for universalization of principles.[622] In this context, caring becomes a core element and an inevitable principle of the healing process.

Similarly, Savett Lawrence submits that the human side of medicine keeps the practice of medicine stimulating; not fascinating cases, but engaging people is the best reason to enter medicine. He adds that paying utmost attention to the human side of medicine is the physician's best protection against professional disenchantment.[623] It is possible to imagine a life without medicine and social institutions, but difficult to imagine a life devoid of human affection. The phenomenon of caring is so fundamental to humanity to the extent that one is tempted to say society cannot exist without religion, culture, tribe, race, and other humans institutions, but

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[619] Pellegrino, *The Caring Ethic*, 13.
[620] Ibid, 16.
[621] Ibid, 17.
[622] Alastair Campbell, "The Ethics of Care as Virtue Ethics," in *Advances in Bioethics: Critical Reflection on Medical Ethics* ed. Martyn Evans (London: Jai Press Inc., 1998), 297-298.
[623] Laurence Savett, *The Human Side of Medicine: Learning What It's Like to Be a Patient and What It's Like to Be a Physician* (London: Auburn House, 2002), xxvi.

humanity can't exist without the experience of care which proceeds from the attribute of society as coexistence. This shows the significant role that care plays in human relationships, in particular, physician-patient relationships.

The desire for affection or care is innate in every human being. Pierre Mallia argues that besides the internal and external goals of medicine, the doctor enters the relationship out of concern, thus caring for the patient, doing the job of their profession, and providing health care.[624] Humanistic ethics, therefore, integrates science and technology with the human side as it declares that scientific knowledge is not enough if one is to be a good physician indeed. However, Savett warns that the human side of medicine is not simply and myopically conceived as "being nice to patients; but a combination of many dimensions of care, a deliberate, focused, reproducible process."[625]

4.2 The Place of Conscience in Medical Practice

The phenomenon of conscience is as universal as the human experience itself. It is so central to morality that no culture can suppress the fact of its existence. The idea of conscience is the main to ethics. Karol Wojtyla argues that conscience "is a fundamental fact of the experience of morality, a fact which tells us to see in normativity and essential and constitutive feature of ethics, and which connects the normativity of ethics with the responsibility of the person."[626] Conscience arguably remains one of the most reliable and widely used moral concepts and a cornerstone of ordinary ethical thinking. From the parameters of moral thought, conscience obliges man to seek truth. Dr. Martin Luther King, Jr, was obliged by his conscience to bring into moral vision and take a public stand for civil rights in America. In his famous 'I Have a Dream' speech, he spoke of his hope that in the future that people of color and all people will be judged not by the color of their skin but by the content of their character. Conscience is widely viewed and discussed from wider and diverse perspectives like the religious, secular, psychological, philosophical and many other viewpoints but without losing its common denominator that characterizes it.

From a phenomenological perspective, Jason Howard avers that conscience is indispensable for understanding moral experience since it serves as a battlefield for all kinds of moral wars. In his view, phrases such as having a guilty conscience, experiencing a fit of conscience, or acting in good conscience are common descriptions of moral experience. For

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[624] Pierre Mallia, *The Nature of the Doctor-Patient Relationship Health Care Principles Through the Phenomenology of Relationships with Patients* (New York: Springer, 2013), 32.
[625] Savett, *The Human Side of Medicine*, xxvi.
[626] Karol Wojtyla, *Man in the Field of Responsibility* trans. Kenneth W. Kemp and Zuzanna Maslanka Kieron (Indiana: St. Augustine's Press, 2011), 46.

him, "conscience is best seen in terms of its function in moderating the moral emotions."[627] The indispensability of conscience in ethics reflects in the fact that it helps determine whether these emotions of self-assessment are integrated into a coherent sense of moral accountability, one that makes more explicit how our understanding of dignity is rooted in our dependency on others. Without this integration, the senses of right and wrong or shame, guilt, and pride remain largely social in orientation rather than moral. Their value as sources of constructive motivation is inexplicit, and their rationale is confused and lacking more considerable justification.[628]

Conscience serves as that natural and objective human capacity to sense or to be aware of moral truth, which enables the moral agent to choose and do evil and avoid by judging particular choices, approving those that they are good, and denouncing the bad ones.[629] It means that conscience that conscience is a judge within us, which helps us to discern between what is right and good. Henry Newman describes conscience as a personal guide, which is nearer to a person than any other means of knowledge.[630] For Karol Wojtyla: "It is our judge and prosecutor."[631] Wojtyla sees conscience as a principle or moral norm, which defines what, is good and bad, describes the objects of action, and experiences the objects of morality, then conscience acts a witness to this moral norm. It is our experience in our experience of guilt that this principle of morality which resides within our conscience that our own "I" now stands against us compelling us to make the right choice.[632] In a similar manner

The roles of virtue and conscience in the moral palace are correlative. The distinction between them is fragile and sometimes unnoticeable. We have repeatedly seen that the clinical encounter is phenomenological and relational, involving a rational relationship between the profession and the patient. Anthony Akinwale argues that "conscience is the application of the achievements of rationality in ordering society. It is the deployment of our rational capacity in the act of making a judgment of values, that is, the judgment of rightness and wrongness of a line of action in the numerous tasks we must assume if our society is too intelligently ordered; to the attainment of our common good."[633]

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[627] Jason J..Howard, *Conscience in Moral Life Rethinking: How Our Convictions Structure Self and Society* (London: Rowman & Little field International Ltd, 2014), 69.
[628] Howard, *Conscience in Moral Life*, 69.
[629] Catholic Bishop's Conference of Nigeria, *Handbook for Catholic Medical Practitioners of Nigeria* (Abuja: Printed by Fab Anieh Nigeria Limited, 2021), 33.
[630] John Henry Newman, *An Essay in Aid of Grammar of Assent*, ed. Ian Ker (England: Oxford University Press, 1985), 251.
[631] Karol Wojtyla, *The Polish Christian Philosophy in the 20th Century* eds., Grzegorz Holub, Tadeusz Biesaga and Jaroslaw Merecki (Krakow: Ignatium University Press, 2019), 38.
[632] Ibid., 38.
[633] Anthony Akinwale, "Religion and Societal Conscience Formation," in *The Role of Religion in the Conscience Formation of Society* ed. Victor Usman Jamahh (Kaduna: De Crown Printing Press, 2019), 8.

Akinwale's analysis shows how conscience, just like virtue, facilitates human judgment and decision-making. Thus, conscience, being furnished by the law, judges and applies the knowledge in a given situation to do good and avoid evil in that situation. [634] The relation between virtue and conscience, especially prudence, lies in their function to seek practical truth. In the journey to practical reality, as Reginald Doherty writes: "It is the precise function of prudence to assure practical truth and produce the actual exercise of operation."[635] In this sense, conscience is connected to the virtue of prudence since prudence complements conscience's defect to attain practical truth (operative truth) and the actual production of operation.[636]

The understanding of conscience from the Catholic moral tradition gives conscience a *theonomous* character. That is, it subjects conscience to God's laws and compels it to accept the teachings of Christ as normative, making it to evaluate human conduct from the perspective of the law of Christ, which is the objective norm for every Christian. The teaching on moral conscience is clearly stated in the Church's teaching. In the Second Vatican Council, the church defines conscience as the human faculty (capacity) that enjoins the acting person at the appropriate time to choose good and reject to do evil, without an external legislator or authority imposing their decision or will on the person acting. It states:

> Deep within his conscience, man discovers a law which he has not upon himself but which he must obey. Its voice ever calling him to love and to do what is good and to avoid evil, sounds in his heart at the right moment. …His conscience is man's most secret core and his sanctuary. There he is alone with God whose voice echoes in his depths.[637]

While this traditional definition of conscience provides a solid understanding of the concept and working of moral conscience, our approach here is more philosophical than theological. We give prominence more to human rationality and practical reasoning in which the acting person responds rationally to the command of the natural law in making moral judgments. Nevertheless, conscience serves as congruence point between reason and faith or between Christians and non-Christians. However, we do not intend to give a detailed account of the concept of conscience in this this work; we are employing it here only to make a quick reference of its role in moral judgement by using Pellegrino's analysis of its relevance to physician's ethical judgements in medical practice. Pellegrino promotes virtue in medical practice by demonstrating that a virtuous physician is likely to always act in accordance with the goals and ends of the medical profession, namely, the good or health of the patient. He also

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[634] Anthony Akinwale, *Religion and Societal Conscience,* 10.
[635] Reginald Doherty, *The Judgements of Conscience and Prudence in the Doctrine of St. Thomas Aquinas* (Illinois: The Aquinas Library, 1961), 101.
[636] Cf. Ibid., 101.
[637] Cf. *Gaudium es spes,* no. 16.

demonstrates the role of conscience in medical practice by arguing, "Conscientious persons strive to preserve moral integrity."[638] While Pellegrino insists that physicians must respect the autonomy of the patient and work towards the good of the patient, he equally states: "Integrity of conscience and professional judgment are moral rights of physicians. Society and patients have an obligation to respect them".[639]

Pellegrino views conscientious persons as those capable of merging their external behavior to be congruent with their conscience's internal dictates about what they take to be morally right and feel compelled to do not mind the conflict, clash, or values that may arise to the diverse moral nature of the world. On the indispensability and inevitability of the conscientious physicians as preservers of moral integrity in medical practice, Pellegrino affirms: "Convictions about the right and wrong conduct, both as professional and as a person, form the physician's conscience. Conscientious physicians have always had to protect each domain from the demands of tyrants, law, custom, and professional colleagues."[640]

With this motivation in mind, Pellegrino proceeds from a Catholic moral perspective to promote the significance of conscience formation for professionals with particular reference to medical professionals. He argues further: "Any society purporting to serve the good of its members is therefore obliged to protect the exercise of conscience and conscientious objection."[641] Pellegrino acknowledges that the task of conscience in our pluralistic society involves that of countering those dilemmas, which arise from the different fount of ideologies around the modern world such as the pluralists, democratic, liberal, the constitutional state, religious diversity, and freedom of individual choice, social entitlements and the moral beliefs of others. This is also applicable in societies where both the physician-patient relationship and society's construction of the ends of medicine, as well as the secularization of the society, conspire to the physician's claim to freedom of choice.

Medical professionals are bound to face these challenges in carrying out their professional roles amidst the people of different religious beliefs and ideologies. Pellegrino points out that this challenge is most acute to medical professionals who hold so tenaciously to their strong religious beliefs and tenets, some of which cannot be compromised in a good conscience.[642] Pellegrino, however, limits the context of his debate on the role of conscience in the medical profession to the scope of the Roman Catholic physicians whose religious beliefs

[638] Pellegrino, *The Philosophy of Medicine Reborn*, 281.
[639] Ibid, 225.
[640] Ibid, 283.
[641] Ibid, 281.
[642] Ibid, 282.

are becoming progressively counter-cultural on human life, especially end of life issues at the bedside.[643] The function and role of the conscientious physician appear here to be the same as the role of the virtuous physician, whom Pellegrino refers to as the moral beacon of morality. Thus, conscience and virtue correlatively move the health professional toward the proper action or the patient's good.

According to Pellegrino, virtuous and conscientious Catholic physicians are meant to be icons of morality in a society where profoundly religious issues such as the morality of abortion, euthanasia, human cloning, and stem cell research are determined on the grounds of utility, consensus, or freedom of choice.[644] He adds that such physicians should serve as poles of morality in the societal contexts that pose serious conflicts of conscience for all physicians and their moral integrity, to physicians of Jewish, Protestant, and Moslem religious backgrounds, but especially of the Roman Catholic physicians who live by the Catholic teachings and traditions on medical morals and human life issues that go back to half a millennium.[645]

Pellegrino's doctrine of conscience in medical practice aligns with the Catholic traditional teaching on conscience. He holds that freedom of conscience is a moral phenomenon that reflects the first principle or axiom of a moral life, namely, to do good and avoid evil. This first principle of morality has remained the true guide to every moral theory of right and wrong or good and bad, whether a moral absolutist, a deontologist, utilitarian, or a communitarian or social constructionist. This inner conviction or voice should always be good unless impaired by some erroneous misappropriation in judgment. According to Pellegrino, any attempt "to ignore this 'inner voice' is to induce quilt, remorse, and shame. Only the moral sociopath escapes the grip of conscience."[646] Hence, to ignore or "act against the dictate of the conscience is to act against natural law –that portion of divine law accessible to human reason."[647] Health practitioners have the moral responsibility to follow their consciences' dictates and grasp the moral truth about each particular case.

Still within the context of the Catholic tradition, Pellegrino argues strongly that for any physician, "to then ignore, repress, or act against conscience for any reason is a violation of

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[643] Ibid.
[644] Ibid, 84.
[645] The context referred to here by the by Pellegrino is within the background of the changes which occurred in the climate of American medicine and its practice that conscience clauses made their appearances. For instance in 1973 when the United States Supreme Court removed the prohibition against abortion and legalized a medical procedure and this was morally repugnant to many physicians of different religious backgrounds. See Pellegrino, The *Philosophy of Medicine Reborn*, 284.
[646] Ibid, 286.
[647] Ibid.

philosophical as well as theological ethics, an error. In moral agency and a sin against God."[648] This re-echoes that it is a violation of the first moral principle or the theological and philosophical ethics and a violation of the Hippocratic Oath, which gives a solid foundation for medical proactivity as a unique human activity. As we can see, the violation of the voice of conscience is both a violation of the personal moral integrity of the physician of his professional integrity.

It is in the light of this double-barreled effect of the violation of conscience that Pellegrino proposes:

> Physicians, in the course of their work as healers, must form their consciences in two inseparable dimensions of their lives- the professional and the personal. Professional conscience concerns itself with two facets of the physician's daily work. First is the ethical propriety of her conduct qua physician with reference to the moral duties of physician-patient relationship. Second is the moral obligation to practice "good" contemporary medicine, i.e., medicine that is scientifically competent and humane. Personal conscience deals with the physician's moral beliefs of a spiritual, philosophical, and cultural, and ethnic nature. Both professional and personal conscience are owed protection.[649]

The subtle combination of personal and professional morality in medicine points to an almost universally accepted claim that there is more to medical practice or to being a competent medical professional than just the possession of clinical skills. Medical practice as both an art and science and a special kind of human activity requires technical skill, moral competence, knowledge, wisdom, and experience to heal. This is so because medicine consists of ethical values as well.

4.3 Virtue Theory for Medicine

Pellegrino's capacity as a physician, scholar, and as a renowned bioethicist recognized and espoused the humanities as integral to medicine. He is a leading figure in advocating the virtues in and for medical practice.[650] He is remembered by many today as one of the major advocates of medical practice as a moral enterprise, for virtuous practitioners, with the patients' good being at the center of care. From the outset, Pellegrino forms his moral theory for medicine on a very strong pillar by arguing that character is the foundation of the moral life and that an ethic of virtue must complement the existing ethic of principles if we are to have a comprehensive perspective on the ethical behavior of the scientist.[651]

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[648] Ibid.
[649] Ibid, 287.
[650] Luchuo Engelbert Bain, "Revisiting the Need for Virtue in Medical Practice: A Reflection upon the Teaching of Edmund Pellegrino's Philosophy," *Ethics, and Humanities in Medicine* 13, no 4 (2018) :2.
[651] Pellegrino and Thomasma, *The Virtues,* 133.

Pellegrino's motivation for advocating for virtues in medical practice is reflected in his lament that society has lost consensus on a definition of virtue. Without a moral agreement, there is no vantage point from which to judge what is right. In search for complementary alternatives to the inadequacies of the principle-based ethical frame in medical ethics and in response to both the problem of the erosion of virtue ethics and over the urgency of the need for a new ethic that will address the new ethical issues arising from scientific advancement and socio-political changes, Pellegrino proposes a philosophical basis for the restoration of virtues in medical practice. He holds so firmly to his thesis that medical practice requires virtue in the caregiver.[652] Similarly, Thomasma avers: "Virtue is tied directly to the goals of the practice. In other words, the moral basis for the practice is derived not from the moral theory itself, but the predetermined moral force of the goals of the practice".[653] Thus, the goals of the practice of medicine determine the morality and ethics of the medical profession.

Pellegrino basis his claim on the view that given the realities of professional relationships, the character of the professional cannot be eliminated from its central position and that is why virtue ethics must be restored as the keystone of the ethics of the professions.[654] In this regard, he promotes virtue or character as the foundation of the moral life. He argues that an ethic of virtue must complement the existing ethics of principles if we are to have a comprehensive perspective on the ethical behavior of the scientist.[655]

In his virtue-based normative ethics for the medical profession, Pellegrino deliberately confines his discourse on the virtues to only one of the two aspects touched upon by Aristotle, that is, virtues make us do our work of medicine well. Virtues are also states of character that make a person good as a person as well.[656] Adopting the Aristotelian concept of virtue to medicine, Pellegrino defines medical virtues as character traits, which dispose the physician habitually to act reasonably and wisely concerning the work of medicine, its ends, and purposes. A physician who exhibits these character traits is a good physician and a good person.[657]

Like Pellegrino, Thomasma, states that ethics has traditionally been concerned with the agent, the motive of the agent, the action itself, and the goal or end of the action.[658] For him,

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[652] Pellegrino, *The Philosophy of Medicine Reborn*, 231.
[653] Thomasma, *Virtue Theory*, 333.
[654] Pellegrino, *Character, Virture and Self-Interest*, 66.
[655] Pellegrino and Thomasma, *The Virtues*, 133.
[656] Pellegrino, *The Philosophy of Medicine Reborn*, 64.
[657] Edmund Pellegrino, "Professing Medicine, A virtue Based Ethics, and the Retrieval of Professionalism" in *Working Virtue: Virtue Ethics and Contemporary Moral Problems* eds., Rebecca Walker and Philip Ivanhoe (New York: Oxford University Press Inc., 2007), 64.
[658] Thomasma, *Virtue theory in Medical Practice*, 100.

virtue is important in medical ethics because it helps to resist the erosion in modern practice of medicine. He sees virtues as very important in this questioning environment where the cultural expectations of the role of caregivers and patients are high because many are strangers to one another. Virtue is to enable one to trust that a person in a white coat, in the role of nurse or physician, has certain precast standards that can be relied upon within the variabilities of social standing, culture, cities and rural areas, even countries.[659]

Similarly, Justin Oakley and Dean Cocking provide an outline of a virtue-based approach to professional roles, which they apply to medical practice by claiming that a theoretically advanced virtue ethics offers a plausible and distinctive alternative to utilitarian and Kantian approaches to understanding and evaluating professional roles, in particular, the role morality of medical practice. They argue for the merits of virtue ethics over these other approaches on both theoretical and practical grounds.[660]

The keynote sound in Pellegrino's virtue theory in medicine states that "intelligence is not enough. Character and virtue must precede it in human affairs."[661] The truth of this statement in medical practice rests on the ineradicable fact that in the clinical encounter of the physician-patient relationship at the bedside when no one is watching, the physician's character determines the moral quality of his action and decision concerning the vulnerable patient. If integrity in the medical practice is problematic, we must start and end with the principal actor, the physician. According to Pellegrino: "The goods internal to a practice are recognizable in terms of the aims of that practice and the understandings of its practitioner. For example, the good internal to medicine is healing or health, and the virtues of the physician are those traits we need to attain those goods or to overcome the obstacles that frustrate them."[662]

The prescriptions and proscriptions of virtue proponents in medical practice look to the character of the physician as the final guarantee of the patient's well-being and as the basis of medical professional standards and practices. Montgomery argues that medicine's success relies on the physicians' capacity for clinical judgment. It is neither a science nor a technical skill, although it puts both to use, but the ability to work out how general rules of scientific principles, clinical guidelines apply to one particular patient.

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[659] Thomasma, *Virtue theory in medical practice*, 99.
[660] Justin Oakley and Dean Cocking, Virtue *Ethics and Professional Roles* (New York: Cambridge University Press, 2003), 1-2.
[661] Pellegrino and Thomasma, *The Virtues*, 133.
[662] Ibid, 134.

This is, to use Aristotle's word, *phronesis*, or practical reasoning.[663] In this regard, it goes to show that medical professionals should be trained to demonstrate a high standard of moral integrity as well as the skill, so as to execute sound moral judgment that is based on the virtues.

Many contemporary ethicists now resort to the significant renaissance and resurgence of interest in virtue ethics, specifically as it applies to the character a professional medical needs to develop to withstand those professional pressures and achieve medical excellence. To practice medicine and ethics, physicians need wisdom and integrity. These characteristics allow physicians to integrate the wide range of information and values that arise from scientific knowledge, patient preferences, moral commitments, and society's expectations. Learning to bring these domains together is an essential part of becoming a physician, and it determines the ethics that guide the care of patients.[664]

Despite the criticisms leveled against virtue ethics for its inability to provide sufficiently clear action guides as too private, too prone to individual definitions of virtues, or the virtuous person, and too independent on culturally-based notions of virtue.[665] Pellegrino persistently and consistently argues: "A teleological-based ethic of medicine is the only one tenable basis for an ethics of the healing profession as a whole in an era of widespread moral and social pluralism like ours. It is also the only basis for moral authority. The authority derives from an understanding of the ends and purposes for which health professions are established."[666]

Pellegrino was convinced that no matter the evolutions in the concept of virtue by philosophical systems, the idea of virtue and the virtuous person can never be erased. Ethicists and philosophical systems will continue to confront the question of the character of the moral agent.[667] Pellegrino's unshaken goal was not to defend virtue as a thing in itself but to justify the role of virtue in the medical profession. He does not dare to go into the metaphysical analysis of what constitutes virtue as a thing in itself, "to defend virtue in itself is a dangerous thing to do."[668]

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[663] *Montgomery, How Doctors Think*, 5.
[664] Lauris Kaldjian, Practicing *medicine and ethics: Integrating Wisdom, Conscience and Goals of Care* (Cambridge: Cambridge University Press, 2014), viii.
[665] David Thomasma, *Virtue Theory,* 332.
[666] Pellegrino, *The Philosophy of Medicine Reborn,* 53.
[667] Ibid, 263.
[668] Hauerwas and Pinches, *Christians Among the Virtues*, 55.

4.4 The Virtuous Physician as a Moral Beacon

Pellegrino merges and integrates the qualities of the acting physician with the quality of his acts in the clinical encounter to determine whether he is virtuous or not. Here we see Pellegrino as arguing for the existence of the connection that exists between character and conduct. Pellegrino's conviction that virtues can make a difference in medical practice is expressed and demonstrated in his theory of the concept of the virtuous physician as the icon of morality in the health care profession. Pellegrino explains how virtues in medicine would make a tremendous difference in moral analysis and the kinds of ethical choices physicians make in concrete cases.[669] The virtuous physician in Pellegrino's thought relates to the Aristotelean sense in which a physician's trait or character orients him to act according to the best technical knowledge and skill to achieve an end. These habitual character dispositions described as discernible properties of reliable, consistent, and non-transient enable physicians to go beyond obligation, even to the point of self-sacrifice.[670]

The physician's act of going beyond his duty to attain the *telos* of medicine is what leads Pellegrino to describe the virtuous physician as a person who practices an integrated ethic of medicine in his moral responsiveness when he fuses both the principle and virtue-based ethics and supererogatory acts to bring about the good of the patient. Pellegrino does not see any distinction in moral responsiveness but an integration. He avers: "We do not see duty, nonduty, and beyond duty as three sharply demarcated regions of moral worth. Rather, they are points on a continuum, with an ideal of perfection at one end-the saint, perhaps-and the idea of the amoral sociopath at the other".[671]

Pellegrino's confidence in the capacity of the virtuous physician cannot be overstressed. He so believes in the moral accurateness of the virtuous physician to act rightly at all times and in all clinical circumstances for the good of the patient. He expounds the thesis on the physician's habitual disposition to rightness and to choose the good. One remarkable and arguably, the most consistent idea throughout Pellegrino's writings is: "The character of the moral agent, the physician in medical ethics, is a fundamental fact, regardless of the model of ethical reasoning one elects—a principle or rule-based, duty-based, casuistic, situational, emotivist, egoistic, intuitionist, and so on. In every ethical theory there comes a moment of opportunity, the use of the theory by a particular person in a particular circumstance".[672]

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[669] Pellegrino and Thomasma, *The Virtues*, 165.
[670] Saunders, *The Good Doctor*, 283.
[671] Pellegrino and Thomasma, *The virtues*, 166.
[672] Ibid, 29.

One distinguishing character of the virtuous physician in Pellegrino's argument is his position of the virtue of prudence. Prudence remains the touchstone on Pellegrino's view that a virtuous physician is one who can be trusted to act rightly in whatever circumstance he encounters. For him, "if the physician has the master virtue of prudence, they can more rightly adjust the deeper and genuine meaning of the principles to the particularities, of the case in question by seeing more clearly what compassion, wisdom, courage, and justice require in this case and these circumstances."[673] It implies that applying the virtue of prudence, which possesses the capacity to harmoniously coordinate and order the rest of the virtues into a single purpose, provides the ground for the certainty that a virtuous and prudent physician will always act rightly in every circumstance. Pellegrino adds: "The virtuous person, in possession of *phronesis,* has the necessary intellectual capacity to discern what is right and good in a particular case. His actions grow out of practical wisdom and are generalizable".[674] Pellegrino believes that physicians are the eyes of medicine and the custodians of the ends of medicine. In his theory of medicine, Pellegrino channeled his energy in ensuring that the physician is well trained in both character and skill.

Virtue distinguishes virtuous persons from others. For Pellegrino: "virtuous persons are distinguished as agents, and their acts as well, by a capacity to be disposed of habitually not only to do what is required as duty but to seek the perfection—the excellence, the *arete* of a particular virtue."[675] Consequently, he argues that as good persons see themselves as bound to act well as a person habitually, physicians too are bound to act as excellently as possible in achieving their ends, namely, the patient's healing. As good, distinct, and virtuous physicians, they accept as a duty what others do not require of themselves, thereby redefining the threshold between duty and supererogation.[676] The virtuous physician goes beyond those duties, which are merely specific statements of what is needed or morally obliged, by some principle or role, in contrast to what we might wish to do.[677]

The above argument makes supererogation a prominent characteristic of the virtuous person or physician in Pellegrino's account. The virtuous physician goes the extra mile even to the point of achieving what mere duty cannot attain. This gives the virtuous physician in Pellegrino's analysis heroic canonization. This is implied in his further description of the virtuous physician as a person who:

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[673] Ibid, 26.
[674] Ibid, 22.
[675] Ibid, 166.
[676] Ibid.
[677] Ibid.

> Is impelled by his virtues to strive for perfection—not because it is a duty, but because he seeks perfection in pursuit of the *telos* of whatever it is, he is engaged in. He cannot act otherwise. It is part of his character. He is disposed habitually to fill out the potential for moral perfection inherent in his actions because he wishes to be as close to perfection as possible, to approach it asymptotically, realizing all the while that he cannot get there and, in that realization, being prevented from the vices of self-righteousness and hubris.[678]

The virtuous physician is unique in another sense as "one who places the point of separation between moral acceptability and moral unacceptability of a decision to act at a different place than would one who acts solely from principle, role, or duty. The virtuous person will interpret the span of duty, principle, or role more inclusively and more in the direction of perfection of the good end to which the action is naturally oriented".[679]

In another place, Pellegrino demonstrates the exemplary role of virtuous physicians as persons whose lives serve as moral poles or ladders and sign guides to moral credibility. He also describes them as beacons of ethical sensitivity in society. He writes: "No matter to what depths a society may fall, virtuous persons will always be beacons that light the way back to moral sensitivity; virtuous physicians are the beacons that show the way back to moral credibility for the whole profession."[680] He goes further to say: "Certainly, the person of character is still the indispensable unit of a morally good society"[681] Pellegrino's argument about the significant difference of virtue ethics in medical practice and moral analysis of the concrete moral choices revolves around his conviction that the virtuous physician can never act or choose only in any situation. They are capable of pursuing what is morally good in every particular context.

4.5 On Cultivating Virtues

According to Daniel Russel, many philosophers who talk about virtues rarely talk about how the virtues are cultivated.[682] The need to address how virtue is developed flows from the fact that most philosophical discussions on the nature of virtue an advance that virtue is dynamic. This section responds to the need for moral education for medical professionals and it responds to the question about whether virtues can be taught and acquired. More so, if at all, virtues can be taught. How can we teach medical students and anyone else in the healthcare

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[678] Ibid.
[679] Ibid.
[680] Edmund *Pellegrino, "The Virtuous Physician, and the Ethics of Medicine," in Virtue and Medicine Explorations in the Character of Medicine* ed. Earl E. Shelp *(Dordrecht :* D. Reidel Publishing Company, *1985), 237.*
[681] Pellegrino and Thomasma, *The virtues, 45*.
[682] Daniel Russell C., "Aristotle on Cultivating Virtues" in *Cultivating Virtue Perspectives from Philosophy, Theology, and Psychology* ed. Nancy Snow E., (New York: Oxford University Press, 2015), 17.

profession to acquire humane qualities necessary for excellence in the practice of disciplines, particularly medicine? Simply put, our attempt here is to seek answers to the question, "why to teach medical ethics to medical practitioners?"[683]

Virtues are either innate, infused or acquired.[684] In the sense of being invested or innate, we appeal first to that innate capacity of the human rationality of possessing reason and the soul, the structure upon which these virtues reside and to the theological dimension in which theological virtues are said to be divinely or illuminatingly infused into us. In the sense of being acquired, virtues are learned through practice or habituation through a process of constant and persistent practice. It is believed that virtues or humane qualities for medical practice can be learned through the senior professionals' exemplary moral acts and behavior. For example, during clinical teaching, the idea is that medical students grasp or learn ethical and virtuous actions from observing an experienced virtuous medical professional. Just as the novice surgeon or the nursing student picks up knowledge and techniques from watching an experienced practitioner, ethics was expected to be absorbed.[685] It means, therefore, that virtues can be said to be both acquired and infused based on the context within which we view them.

On whether virtue can be acquired, Pellegrino responds: "I believe it can."[686] Pellegrino upholds that virtues can be inculcated by cultivating them through habitual good acts. For this reason, he takes the formation of integrity and character to be the principal foci of ethics. He writes: "The aim of ethics from its beginnings has been twofold: to teach how to form good character and how to make morally good decisions."[687] This reiterates the fact that the medical profession and its ethics require both skill and virtue competence. According to Pellegrino, "the formation of character is as important in the education of professionals as their technical education."[688] It is important to educate physicians on moral virtues to recognize the medical profession's sound good or healthy good and always choose it. Aristotelian and Thomistic virtue theory underlines the necessity for virtue formation by arguing in connection with the moral law theory that all human beings have an inborn nature that tends to the good in moral actions, but needs molding and direction, and most especially repeated habitual action, to refine that nature away from vices and towards the good.[689]

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[683] Martyn Evans, "Learning to See" in *Medical Ethics Education, in Advances in Bioethics: Critical Reflection on Medical Ethics,* ed. Martyn Evans (London: Jai Press Inc., 1998), 99.
[684] Joseph Alvin Burroughs, *Prudence Integrating the Moral Virtues According to Saint Thomas Aquinas* (Washington D.C: The Catholic University of America, 1995), 3.
[685] Downie and McNaughton, *Can We Teach People to be Morally Good Doctors*?, 88.
[686] Pellegrino, *The Philosophy of Medicine Reborn*, 250.
[687] Pellegrino and Thomasma, *The Virtues*, 134.
[688] Ibid, 157.
[689] Thomasma, *Virtue theory in philosophy of medicine*, 100.

Similarly, John Saunders argues that a good physician or medical practitioner must possess both virtue and skill for effective functioning as a health care giver. Saunders wrote, "The good doctor requires scientific knowledge, practical clinical skills, and an attitude of commitment to the patient. These are interrelated to such an extent that the skills and attitude effectively constitute a form of 'tacit,' practical knowledge. But teaching skills and knowledge can be straightforward; attitude must be taught and learned in the light of taking medicine's goal of relieving suffering seriously".[690] Thus, a good medical professional in Saunders' thought should know and possess what he describes as the 'three right things'. He states: "A good doctor knows the right things; a good doctor possesses the right skills; a good doctor displays the right attitudes. Knowledge, skills, and attitudes: these three appear together, a mantra of medical teachers. A good doctor should aim for excellence in all three."[691] The qualities are necessary for meeting the three demands for proposed by Pellegrino for a sound medical practice, namely, knowledge of what medicine is and its purpose, skills and attitude for its practice.

The physician as a moral agent should be excellently formed in both skill and ethical competence. As one of the practical implications of virtue ethics, Pellegrino argues that the formation of the character is as important as in the education of professionals as their technical education.[692] Pellegrino suggests that the project of teaching virtues or the building of character should not be left to the professional schools alone. Families, churches, and schools should serve as matrixes for shaping students' character before entering professional schools. The most effective instruments of character formation are the professional schools that teach in medical, law, and seminaries. These professional schools must be able to demonstrate that "competence and character are inseparable and that fidelity to trust and self-effacement can be, and must be, indispensable traits of the authentic profession."[693] Thus, their goal is to teach what it means to be an excellent professional- what a good physician, lawyer, or clergyman ought to be. The long process and dimension of virtue formation rely on the fact that virtues are not acquired automatically; they are nourished and grow.

On the significance of moral, medical education, what it is, and what it is not, reasons for its inevitability in the training of modern health care professionals, Martyn Evans writes:

> It can hardly be in order to explain fundamental moral concepts, or to *train* doctors in morally good practice. It might more plausible be in order to explore the special situations, contexts and challenges which modern medical practice generates. Exploring and understanding these

[690] John Saunders, *The Good Doctor and Aristotle's Good man*, 279.
[691] Ibid, 280.
[692] Pellegrino, *The Philosophy of Medicine Reborn*, 250.
[693] Ibid.

> challenges is not the same as being instructed in how should act in response to them. However, the teaching of medical ethics can aim to develop habits of consistent moral reasoning, and the avoidance of wholly unexamined moral reactions. The aim is to encourage medical practitioners to develop and articulate their own coherent point of view and to apply this to the challenges of clinical practice. For medical practitioners this inevitably involves the conceptual or philosophical exploration of deep questions about the nature of human beings arising characteristically or even uniquely in medicine-questions such as those concerning the beginnings and endings of human and (if this be different), personal, life. However, the end result of even a formalized analysis of these questions and situations is not that all see them in the same way. Moral situations are complex patterns of what we can call 'moral particulars'- their morally relevant components. People legitimately disagree on the importance, and sometimes even the relevance of the different items and aspects of the situations. The aim of medical ethics education should be to foster medical practitioners' ability to develop and articulate their own moral perspectives, and so bring these to bear upon their practice consistently and thoughtfully.[694]

Evans believed that the role of medical ethics education is to provide opportunities for sustained exploration of a wide range of moral particulars, with richer detail than is possible in the regular, causal inspection of the issues, for example, the one that comes from reading the newspaper. Medical ethics education provides the practitioners with the habit of rational inquiry in carrying out their explorations. More so, it enriches them with the potentials of recognizing and applying different moral patterns to familiar situations.[695]

Pellegrino's unique vision was to preserve the integrity of medicine, the physician, and the patient. His desire was to ensure the stability of a universally binding medical ethics, not an ethic of political expediency or societal convention. His goal is for a concrete and good moral guide on which physicians must base their moral conduct and justifications in their duties as physicians. He sought teleological medical ethics, which does not require any negotiations between the physician and the patient on what constitutes the good of medicine. He envisioned medical ethics that is unchangeable, and one that is not a socially constructed contract varying from society to society, era to era, and patient to patient.

Pellegrino argued that medicine and its ethics must not be whatever is politically negotiated between the profession and government or other socially and politically constructed forms of ethical justifications of modern times. In his vision, Pellegrino was already convinced of proffering and offering a solution to the ethical challenges, crisis, and dilemmas in modern medicine: ranging from the problems of medicine's abuses, its commercialization and commodification; crisis concerning its ends, its philosophical, anthropological deficiencies and a big chunk of other medical problems.

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[694] Martyn Evans, *Learning to See*, 99-100
[695] Ibid, 109.

4.6 Possible Virtues for medical practice

Pellegrino presents a list of virtues that he describes as essential for defining a good physician, nurse, or other health care professionals. He sees these virtues as entailed by the phenomena of the relationship and the telos of medicine. Most importantly, "They are virtues essential to achieving the ends of medicine optimally and without which those ends would be frustrated or attained in less than optimal fashion."[696] Thus, these virtues are essential to medical professional roles and indispensable for effective medical practice.

Pellegrino admits that it is notoriously difficult to compose the list of the virtues essential to medical practice. This difficulty lies in the dilemma of restricting the virtues to the content of the list by ignoring other vital virtues that might be relevant for medical training. To solve this dilemma, Pellegrino underlines that the list of the virtues he presents for medical practice is not meant to include all the virtues necessary to healing. Rather, the virtues included are those he considers as most essential to the healing purposes of the clinical encounter.[697] He does not list these virtues in an order of preference but as reinforcing each other so closely, for to compromise one is to compromise others. He finds it difficult to put this virtues in a lexical order. He says: "A lexical order among them would be difficult to defend". [698] Worthy of note is Pellegrino's assertion that medical virtues are both to be developed by the patient and the physician as part of the process of healing. But Pellegrino's selection of the virtues gives prominence to the virtues of the physician since his vision was to reconstruct a virtue-based approach to professional ethics for medicine.

4.6.1 Fidelity to Trust

The virtue of trust is the foundation on which almost all forms of human relationships are based. Trust is ineradicable in all human relationships because it radiates a sincere commitment to each other. Pellegrino underlines trust's importance and necessity in human society by claiming that without it, we could not live in society or attain even the rudiments of a fulfilling life.[699] Francis Fukuyama describes trust as social virtue and as indispensable in social relations. Trust is a social virtue because of its immense contribution to social capital

[696] Pellegrino, *The Philosophy of Medicine Reborn,* 271.
[697] Ibid.
[698] Ibid.
[699] Pellegrino and Thomasma, *The virtues*, 65.

and the impossibility of its exercise in isolation except only in a social context.[700] The phenomenon of social trust manifests in our relationship with professionals like doctors, lawyers, ministers, rabbis, priests, chaplains, and others, especially when we need their help. People commit their life, wealth, health, and bodies into the hands of professionals with the assurance or certainty of the trust that such professionals will always act well for the good of those come to them for help. We trust someone if we judge the person to be responsible.

Similarly, Terrence Kelly argues that trust is essential and indispensable for professional practice precisely because it is the attitude in which one is willing to make oneself vulnerable to the discretionary choices of another person. For Kelly, the cultivation and development of trust in professionals practice is a functional imperative. The necessity of trust in the professional role is based on instrumental, ethical, and moral reasons that invite and develop the trust of those that professionals intend to serve.[701]

We tend to trust that a medical doctor will not give us a prescription that will harm us, so we take his medical prescriptions very seriously and act in accordance with his instructions believing to attain healing. With the same trust, we jump into a commercial vehicle with the moral certainty that every commercial driver owes their passengers the moral obligation of safely taking them to their destinations. Even when it is evident that the driver is drunk, people still believe that he will never run the risk of deliberately running into the river to ruin his own life and the lives of others. Trust creates an unbreakable bond among people, especially between professionals and their clients. Sometimes, a trust may appear as if it makes people blind to the practical implications and consequences of certain things that they commit themselves to in the name of the trust.

Pellegrino echoes the centrality of trust as an ineradicable phenomenon that has been a generative force in professional ethics for a long time. Trust is fundamental to clinical encounters[702] as it is a feature in friendship and other human interactions. Trust can enhance medical practice when doctors treat their patients like intimate friends, their patients will be

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[700] Francis Fukuyama, *Trust: The Social Virtues and the Creation of Prosperity* (New York: A Free Press Paperbacks Book published by Simon and Schuster Inc., 1995), 43.

[701] Terrence Kelly M., *Professional Ethics: A Trust Based Approach* (Lanham: Lexington Books, 2018), 21.

[702] Trust is not only fundamental to medical practice but it gives it a special identity, which is characterized by a fiduciary model. Eugenijus Gefenas identifies two diametrically models of clinical relationships, namely, the contractual, which leaves nothing to trust and the fiduciary model model which leaves everything to trust. He identifies another higher model which he calls the encounter model. The encounter model is a sophisticated version of the fiduciary model which is capable of integrating trust a nd understanding in medical relationship which is most often conceived as an unequal relationship between the physician and the patient. See. Eugenijus Gefenas , "Medical Ethics Education" in *Advances in Bioethics: Critical Reflection on Medical Ethics*, vol.4 ed. Martyn Evans (London: Jai Press Inc., 1998),307-308.

moved to share their most personal problems, which will promote the patient's autonomously expressed interests. According to Saunders: "This strong personal bond emphasizes the doctor's virtues".[703] Thus, reliability and trustworthiness constitute essential qualities of an excellent medical practitioner. In our age where it is challenging to trust, Pellegrino argues that the virtue of trust is an ineradicable element defining the morality of the healing relationship. The whole of the medical profession is built on trust. It is an essential disposition of good medical practitioners or health care givers. Its very ineradicability dictates that the violation of trust automatically vitiates healing in any genuine sense.[704]

For Pellegrino, "trust has special moral dimensions that form the foundation for professional ethics."[705] For example, in the medical relationship, people seek physicians when some adverse sign or symptom threatens the conception of their health sufficiently to impel them to seek expert advice and help. This act of seeking help from professionals is based on trust that physicians possess the capacity to help and heal. It is out of the same trust that patients open the most private domains of their bodies, minds, and social and family relationships the physician's probing.[706] Pellegrino's argument is that the physician's character and fidelity to trust contribute to building an atmosphere of healing in clinical encounters. It gives hope to the patient because he sees the physician as his final advocate.

The central point made by Pellegrino is that trust is indispensable to the *telos* of medicine as well as other professions. It is difficult for a sick person to be healed or made whole again if they are suspicious of the motives and methods of the physician. A sick person heals himself if he is empowered to do so. One of the best ways to assign an ill person for self-healing, as we see in Pellegrino's proposal, is through the virtue of trust. As we have said, this is applicable to every profession. In another example, a parishioner (penitent) will be quickly served or reconciled with God if she sees the priest confessor as a reliable avenue of access to spiritual healing. Pellegrino avers that trust must act as a fundamental foundation for constructing modern professional ethics, considering the importance and indispensability of trust in human relationships and professions. He argues:

> Since trust is a permanent feature of human relating, fidelity to trust is an indispensable virtue of the good professional—lawyer, doctor, chaplain, or teacher. Without this virtue, the relationship with a professional cannot attain its end. It becomes a lie and a means of exploitation of vulnerability rather than a means of helping and healing. If there is any meaning to professional ethics, it must revolve around the obligation of fidelity to trust.[707]

[703] Saunder, '*The Good Doctor and Aristotle's Good Man,* 283.
[704] Pellegrino and Thomasma, *The Virtues*, 88.
[705] Ibid, 67.
[706] Ibid, 68.
[707] Ibid, 75.

However, the concept of trust envisaged by Pellegrino is neither a blind nor a passive kind of trust but an active trust that takes due diligence into cognizance. Pellegrino openly acknowledges that an ethic of trust does not ignore the sad professional facts of incompetence, quackery, fraud, inadequate self-regulation, and peer review of the addicted or alcoholic professional. Again, he warns that recognizing trust's ineradicability is not, therefore, to argue against regulation of the professional by licensure, educational and certification procedures, quality controls, periodic re-licensure, and liability laws. He also admits that Professionals are ordinary humans called by the nature of the activities they engage to extraordinary degrees of obligation and trust.[708]

In his final analysis on the virtue of trust, Pellegrino observes that an ethic of trust must go beyond the level of principle-and duty-based ethics to and ethics of virtue and character. The virtuous physician stands as icon or model of trust in medical practice. Trust as conceived by Pellegrino, is not a privilege to a professional but it is something that should be earned and merited by his or her performance and fidelity to its obligations and implications. He argues:

> Professionals cannot expect to be trusted simply because they are professionals. The ineradicability of trust is a source of obligations, not of privilege. Professionals who resent the queries and the skepticism of their patients or clients are insensitive to the changed climate of professional relationships. They fail to sense the predicament of vulnerability in which those who seek their help must find themselves.[709]

4.6.2 Compassion

Pellegrino proposes compassion as an essential and indispensable virtue in medical practice.[710] Similarly, Robin Downie and Jane Macnaughton maintain that the virtue of compassion is medicine's characteristic moral imperative.[711] Compassion has been described as a fundamental human quality and as a universal human phenomenon. It is thus described as a universal quality in the sense that the ability to perceive the pain of another person and the inclination to act to alleviate that pain is naturally imbued and inherent in all human beings in their nature as social creatures.[712] Compassion thrives beyond the boundaries of age, race, and religion since it is a feeling or a natural human emotion that appears in all human history and cultures.

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[708] Ibid, 76.
[709] Ibid, 77.
[710] Ibid, 79.
[711] Downie and Macnaughton, *Can We Teach People to be Morally Good Doctors?*, 83.
[712] Khen Lampert, *Traditions of Compassion from Religious Duty to Social Activism* (New York: Palgrave Macmillan, 2005), vii.

For this reason, compassion becomes a tool for alleviating sufferings of all kinds in the world whether they are pains caused by diseases, natural calamities, political oppressions or injustices. Lampert argues that the erosion of compassion and lack of its practice in a society brings about a lack of social justice, distress, poverty, wants, severe hardship and suffering.[713] A virtuous or good life is summarized in compassionate relationships with others since character and virtues of good require a stable and enduring relationship with those who share with us what we consider important about life.[714] This is deeper and something profoundly more powerful in its meaning. The physician's heart breaks because the patient's heart is broken as a result of the pains that he or she is going through. Thus, the physician's heart breaks because the patient's issue is an issue.

Pellegrino laments of the perceived deficiency of the virtue of compassion as one of the most widespread criticisms against medicine and its practitioners. He defines compassion in medicine as "the capacity of physicians to feel something of the unique predicament of the patient, to enter into the patient's experience of illness and, as a result, to suffer vicariously the patient's anxiety, pain, fear and so on."[715] Pellegrino employs compassion in the clinical encounter to mean a habitual disposition of the health care giver, to act in a certain way, a way that facilitates and enriches the *telos* or purpose of medicine. The act in question is the act of healing, helping, and caring for someone who is ill. Acting compassionately is therefore the character trait that shapes the cognitive aspect of healing to fit the unique predicament of the patient.[716]

Like Pellegrino, Lawrence Blum employs the use of the virtue of compassion to demonstrate his argument that despite the fact a virtue is dispositions to a certain emotional state, they are not just "irrational" emotions of psychological equivalence to the emotions of hunger pangs, orgasms, or the passing of gas. Instead, internal emotions (virtues) such as compassion can be a full participant in the moral life because it is internally connected in specific, definite ways with such things as recognizing and caring about another person's suffering, the conceptualization of the person as a member of the humanity.[717] He describes compassion as selfless in that it involves regard for the good of other persons.[718]

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[713] Lampert, *Traditions of Compassion*, 150.
[714] Richarch Gula M., *The Good Life, Where Morality and Spirituality Converge* (New York: Paulist Press, 1999), 122.
[715] Pellegrino and Thomasma, *The virtues*, 25.
[716] Ibid, 79.
[717] Lawrence Blum, "Compassion," in *The Virtues: Contemporary Essays on Moral Character* eds., Robert B. Kruschwitz and Robert C. Roberts (California: Wadsworth Publishing Company, 1987), 229, pp. 229-237.
[718] Blum, *compassion*, 229.

Furthermore, Pellegrino vehemently argues that without compassion, only the medical good, which is the lowest of the higher interest in medicine, is attainable. The highest good of medicine, obtained through the objective assessment of the medical good is modulated by compassion. He says: "By necessity, in achieving, the ends of medicine, compassion must be a virtue of the good physician. Although it is an internal disposition, compassion is also manifest in the physician's behavior".[719] Thus, if the patient is to be healed in a total sense, the physician must possess the virtue of compassion. The health caregiver must empathize or feel something of the patient's experience of the predicament of illness. Pellegrino describes this feeling as essential in adjusting the treatment to the particularities of this patient's life story, time in life, and so forth.[720] Therefore, compassion enables the health professional to feel and understand each patient's condition according to his pains and the situation surrounding his illness. It moves the physician into more profound concern, care, and attention to the patient's plight.

4.6.3 Prudence

The virtue of prudence is often described as an indispensable and necessary for other virtues to be truly virtues. Although as we have seen in Pellegrino's analysis, all virtues work together in harmony but guided by prudence. In its true sense, prudence is the virtue of practical reasoning. It is a moral virtue par excellence since a bad man cannot be prudent. It is the right reason for that which is to be done (*recta ratio agibilium*). A good person is not only someone who knows what is good to do in general, but who knows what to do here and now, and who not only knows it, but effectively performs it as well.[721] Prudence "guides man in judging what must be done in a singular, contingent act."[722] For Thomas Aquinas, prudence is the perfection of reason and is necessary for all moral virtues, since moral virtue is a habit of choosing, bringing about good choice.[723] It means that prudence establishes in us the good and is for the rational part of the soul.[724] In most of his discussion in the *Nichomachean Ethics,* Aristotle stresses the need, the importance, and the indispensability of using practical reason instead of its contemplative counterparts since ethics is a practical discipline.[725]

[719] Pellegrino and Thomasma, *The virtues*, 25.
[720] Pellegrino, *The Philosophy of Medicine Reborn*, 272.
[721] Rhonheimer, *The Perspective of Morality*, 191-192.
[722] Doherty, *The Judgement of Conscience and Prudence*, 64.
[723] Smith, *Virtue Ethics and Moral,* 21.
[724] Ibid, 20.
[725]Ibid, 14.

Pellegrino argues that prudence is essential in ethics because it serves as a guide to the right way of acting with respect to all the virtues. It provides the capacity or disposition to select the suitable means and the right balance between standards and good ends. It orients us to moral truth, to the moral quality of particular acts and their relationship to the ends of human nature. Prudence itself is shaped by the universal moral guideline that we must seek good and avoid evil. Prudence helps us to discern, at this moment, in this situation, what action, given the uncertainties of human cognition, will most closely approximate the right and the good.[726]A prudent person in this context is one who makes good beautiful choices. An attractive choice here refers to the right to make correct decisions that conform to moral principles. Thus, a prudent person knows the principles and norms of the right and healthy good, and acts according to them in every concrete circumstance. In this understanding, prudence serves the purpose for achievable, actionable, and productive goals.

For Pellegrino, prudence is at the heart of the medical enterprise precisely because it strengthens clinical and ethical judgment.[727] He avers that it is an "indispensable virtue of the medical life, essential to the *telos* of medicine, a right and good healing action for a particular patient, and essential as well to the *telos* of the physician qua human being, the life of fulfillment and flourishing."[728] Pellegrino describes practical wisdom as a virtue of deliberation and discernment and as central to any theory of virtue in the health professions. The clinical judgments and notes of note require prudent weighing of the alternatives in situations of dilemmas and uncertainty. Prudence helps health practitioners know how to unscramble conflicts among the virtues and integrate them more closely according to their relationships to one another to enable them to attain the *telos* of health professions.[729]

In this way, the virtue of prudence plays the unique role of guiding and harmonizing the other virtues of medical practice to function cordially and harmoniously without conflict among themselves. As Pellegrino underlines: "Thus, in medical as in moral choice, prudence is the capstone or guiding virtue that influences the way the other virtues are exhibited in any given clinical situation. Therefore, Prudence is both an intellectual and a moral virtue in medicine, as it is generally in moral encounters".[730] The mark of the wise physician, as captured by Pellegrino, is that who knows what and when to act in each given situation or context as it

[726] Pellegrino and Thomasma, *The Virtues*, 85.
[727] Ibid, 113.
[728] Ibid, 84.
[729] Pellegrino, *The Philosophy of Medicine Reborn*, 273.
[730] Pellegrino and Thomasma, *The Virtues*, 86-87.

is the mark of a wise driver knows the right time to march the breaks when driving. Prudence involves knowing what to do and doing it rightly and moderately well.

For Saunders, practical wisdom is the only tool certainly available for decision-making for physicians in a clinical setting. It guides and regulates the physician when he is faced by the uncertainty of knowledge in the clinical encounter where many patients are either unwilling or unable to make decisions. This leaves the doctor with the anticipation of desire, and he is left to make decisions amid these uncertainties. He affirms: "The only sure guide is the practical reason."[731] Pellegrino's doctrine of the virtuous physician as a moral beacon is powerfully demonstrated in his expectations of the prudent physician. Pellegrino avers: "The prudent physician is the one we expect to make these difficult distinctions based on a character fixed in its disposition to act well, to keep the end of healing in its totality in view, and to modulate the application of means to foster but not frustrate that end".[732] To this end, we can buttress the claim that prudence is the 'mother' of all virtues since it integrates the moral virtues for a single and unified purpose.

4.6.4 Justice

The concept of justice is vast. It occupies an enormous scope of issues in human society. It is one of the most complex of all the virtues because of the complexity of the mean and the relationships involved in achieving it. Aristotle wrestled with the problem of what sort of mean justice is, and what the extremes are between which justice lies. His discourse on the virtue of justice lies on the general basis that "it is a strict habit of rendering what is due to others."[733] He described it as that kind of character that disposes people" to perform just acts, and behave in a just manner and wish for what is just; and in the same way they mean by injustice the state that makes them act unjustly and wish for unjust things.[734] The problem of just and equality lies in the fact all states are never the same and all human persons are supposedly said to possess fundamental dignity. The problem of justice, especially commutative or distributive justice revolves around this lack of a mean or scale of determining equality. This lack of mean of the proper balance due to individuals and groups, as Pellegrino argues, results in political disputes

[731] Saunders, *The Good Doctor and Aristotle's Good Man*, 286.
[732] Pellegrino and Thomasma, *The Virtues*, 88.
[733] Ibid, 92.
[734] Aristotle, *Nicomachean Ethics,* 1129a5-9.

about the common good and affects the health sector concerning significant issues of access to and rationing of health care common public goods.[735]

Pellegrino employs commutative justice as a paradigm to demonstrate the role of the virtue of justice in healing relationships. He begins by affirming that the root of justice lies in the individual's good, not only in the common good.[736] Pellegrino's philosophy of medicine conflates commutative justice in the one-on-one situation with both the principle of beneficence and the virtue of benevolence since he argues that in the doctor-patient relationship, the patient is due respect as a person, such that the professional must always act based on that person's good. According to him, "it cannot make sense in medicine to cure if one does not aim to heal the patient."[737]

As we have seen earlier, the good of the patient involves judgment and discernment since it is attained in different degrees and hierarchies. Thus, the effort to discern the good of the individual in the clinical encounter of the physician-patient relationship and to do justice to the individual requires both intelligence and struggle. "It requires intelligence to adjust continually to situations and to keep the other's needs and goods in view."[738] This implies that acting justly demands the knowledge of what is just and the disposition and the willingness to act toward its efficacy. As Pellegrino says: "Beyond intelligence, the virtue of justice involves a struggle. It is often a painful task to constantly adjust and balance conflicting needs and goods, especially under our voluntary care. The task of equalizing or of being fair requires constant vigilance and monitoring".[739]This clearly brings out the fact that only the virtuous physician can go beyond the level of intelligence to ensure that justice is served for the good of the patient because he possesses the character trait, a habitual disposition to always render to each person what is due. In this context, the good of the patient, which is health, is what the just physician strives to cause to each patient according to the patient's condition and demand. Virtue keeps the will from being hindered from following reason's judgments, as it enables the acting person to persevere in the face of an oppressive difficulty. It helps the person to be well balanced in regards to feeling overly confident or fearful.[740] A virtue enables the will to follow reason when it is pulled away from its good by an object of pleasure.[741]

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[735] Pellegrino and Thomasma, *The Virtues,* 92.
[736] Ibid, 93.
[737] Ibid, 94.
[738] Ibid.
[739] Ibid.
[740] Smith, *Virtue Ethics and Moral*, 20.
[741] Aquinas, *Summa Theologiae*, 2a2ae, cited in Smith , *The virtues and Moral*, 20.

4.6.5 Fortitude

The virtue of fortitude is another particular virtue that Pellegrino describes as enabling the virtuous physician to make a difference. It gives strength and courage to the physician to always go for the good of the patient. Pellegrino conceives medical fortitude as a virtue that inspires confidence in physicians so as to resist the temptation to diminish the patient's good through their own fears or through social and bureaucratic pressure, and it enables them to use their time and training resourcefully to accomplish good in society.[742] This virtue also takes us to the supererogatory dimension of the virtues in medical practice, where the virtuous physician takes risks and transcends beyond the scope of duty and principles to achieve the goal of the medical profession.

Furthermore, fortitude opens the physician's mind to the patient's plight. It develops in the physician a sensibility that moves him to advocate, promote and do everything within his reach to help the patient. Fortitude spurs him on to act for the patient's good without minding the dreadful circumstances or risks involved in achieving such an end. To this end, the virtue of fortitude encompasses the physician's resistance to retreat from the right thing to do in the face of corporate, collegial, or public adversity. In Pellegrino's words:

> Fortitude is the kind of tenacity that helps physicians move the powers that be to get their patients into an appropriate clinic for tests. Or it is the tenacity to continue to accept Medicaid payments when they only remotely approximate the costs of caring for the poor. Or it is the courage to speak out strongly in favor of care for all the sick, the poor, the needy; to expose fraud and incompetence; to acknowledge the failings of the current health care system when needed; and to contribute to the public debate about the distribution, availability, and access to health care for all.[743]

Through the moderation and guidance of prudence, the virtue of moral courage or fortitude enables the physician to act on principle in the face of potential harmful consequences without either retreating too from that principle or remaining steadfast to the point of absurdity. According to Pellegrino: "Physicians need fortitude to do the right thing when it is required and expected of them, given their role in life. In the ordinary practice of medicine, it is moral courage or fortitude in the face of consensus, rather than physical courage, which is depreciated by our society".[744]

We must point out here that Pellegrino acknowledges that the virtue of fortitude involves both the physical and the moral aspects of courage. The physical part of the virtue of fortitude renders the subject able to resist flight in the face of physical danger or moderates

[742] Pellegrino and Thomasma, *The Virtues,* 114.
[743] Ibid, 113.
[744] Ibid, 111-112.

impulsive behavior under the same circumstances.[745] Some examples of the physical aspect of fortitude are the courageous fireman entering a burning building or a physician treating a patient with a contagious disease. Some examples of the moral aspects of the virtue of fortitude are a person who finds a large amount of money and returns it to the rightful owner rather than keeping it for themselves or the priest who refuses to reveal what a person may have said in confession. The willingness of the physician to suffer personal harm for the sake of a moral good (the good of the patient), the spy who does not reveal potentially destructive secrets to an enemy, or the hostage who faces the daily terror of loneliness and isolation or a priest who refuses to reveal a confessional secret of a penitent for the sake of the penitent's good and of the integrity of his priestly confidentiality.

In the end, Pellegrino's interest lies more in emphasizing that while physical courage is essential and needed for medical practice as a quality of the medical practitioners, he also argues for the indispensability of moral courage for professional roles by stating: "It takes physical and moral courage to run even a very small risk with an invariably terminal future disease. It takes even more fortitude to disclose to patients the fact that one has AIDS".[746]

4.6.6 Temperance

According to Smith, "Temperance implies a sense of being well balanced in one's appreciation of life's pleasures."[747] Smith's definition captures very well the traditional concept of the virtue of temperance as the virtue that controls one's appetite for food, drink, and sex very well. Thus, to be virtuous in abstinence is to be habituated in proper pleasures and to lack this is to be vicious in temperance. It plays a central role in all moral activities because it brings the acting moral person in direct contact with concrete truth of the moral reality. Pellegrino expands this traditional notion in relation to some of the temptations usual to modern professionalism in medicine. He argues that in a society that legitimates conspicuous self-indulgence, the exercise of the virtue of temperance becomes difficult. These temptations range from the abuse of substances by professionals, to the inappropriate use of modern medical technology.[748] While exposing the factors militating against the practice of the virtue of temperance in professional roles, Pellegrino attempts to examine the value and the implications for cultivating this virtue in medicine and in the life of the physician today.

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[745] Ibid, 111.
[746] Ibid, 112-113.
[747] Smith, *Virtue Ethics and Moral*, 20.
[748] Pellegrino and Thomasma, *The Virtues*, 117.

Pellegrino laments that contemporary society is more pruned to hedonistic goals than it was in the classical-medieval ages because of "the power we have to control our environment, to provide readily for food and drink, fashion, and sexual fulfillment. Today, it seems more an explicit goal to indulge oneself than to try to live a perfect life."[749] He further argues that the abuse of technology and science in our age is a big problem since it leads in the opposite direction by altering the natural order and expanding our control over it. [750] Any principle or method that goes against the natural order heads to dilemmas and self-contradiction.

The need to maintain balance in clinical doctor-patient relationships requires that a physician possesses the virtue of temperance which equips him with the habitual capacity to make judgments correctly, and with the constant disposition toward responsible use of medicine for the good of the patient, avoiding over use of technology and other interventions. Temperance is also required to assess the interventions properly to be given to the sick.[751] The function and role of the virtue of temperance in medical practice, as Pellegrino argues, is to ensure that technology and other interventions are properly used for the good of the patients to check professional abuses in medicine.

4.6.7. Integrity

Integrity is a mighty medical virtue. According to Saunders: "A doctor without integrity is a doctor without moral character."[752] The problem of integrity is at the heart of Pellegrino's moral preoccupations in medical practice. The virtue of professional integrity differs in some sense from ordinary morality. Professional integrity involves having and acting with a commitment to serve the proper goals of one's profession. We take as an example of the virtue of medical integrity when doctors cite professional integrity as a reason for refusing to provide a futile intervention for a dying patient because such an intervention would be contrary to their overarching professional goal of acting in their patients' best interests. A doctor in this situation could legitimately tell the patient, "I cannot with my doctor's hat on do this for you." This clearly differs from cases where doctors reject such interventions by appealing to ordinary morality, such as the idea that futile interventions are contrary to human rights or human dignity

[749] Ibid, 119.
[750] Ibid.
[751] Ibid, 123.
[752] Saunders, *The Good Doctor and Aristotle's Good Man*, 285.

and from cases where doctors reject an ineffective intervention because they have a personal, conscientious objection to using it, for example, on religious grounds.[753]

Pellegrino envisages that a physician who possesses the virtue of integrity is habitually disposed to work toward restoring the integrity of medicine itself and the sick person since this is the moral basis of genuinely holistic medicine.[754] For Pellegrino, "the ultimate safeguard of the integrity of the patient's person is the fidelity of the physician to the fiduciary nature of the healing relationship."[755] Thus, this requires that a physician be a person who is habitually disposed to exhibit the virtue of integrity, a person who interprets the application of principles in a most sensitive manner. For Pellegrino, the doctor-patient relationship so relies on integrity and trust especially in situations where the freedom to be creative in clinical healings, as well as scientific research, are often abused. More so, in a complicated milieu of industrialization, commercialization or commodification, and corporatization of biomedical research, the final determinant of the quality of medical practice and research remains the character and conscience of physicians and scientists.[756]

4.6.8 Effacement of Self-Interest

Pellegrino employs the virtue of self-effacement as a measure against the forces of modern exploitation in the medical profession characterized by the traits of commercialization, competition, government regulation, malpractice, advertising, public and media hostility, and a host of other inimical socio-economic forces.[757] He believes that these ills bring about the exploitation of patients and places them in a vulnerable state.

The virtue of self-effacement, according to Pellegrino, is, therefore, an indispensable tool for an effective and sustainable medical practice "since, without it, the patient can become merely a means to advance the physician's power, prestige, profit or pleasure."[758] He argues further: "In these days of managed and for-profit care, the need for the effacement of self-interest is urgent if the patient is to be protected against exploitation."[759] The practical implication of the virtue of self-effacement is that it calls the physician to refrain from exonerating themselves from morally dubious practices

[753] Justine Oakley, "Virtue ethics and Bioethics" in *The Cambridge Companion to Virtue Ethics* ed. Russell Daniel C. (New York: Cambridge University Press, 2013), 207.
[754] Pellegrino and Thomasma, *The Virtues,* 130
[755] Ibid, 132.
[756] Ibid, 141.
[757] Ibid, 144.
[758] Pellegrino, *The Philosophy of Medicine Reborn*, 172.
[759] Ibid.

based on survival since this corruption and exploitation in medical roles suffocates professional ethics as a result of the moral compromises among medical practitioners.

4.7 Religious Virtues

Drane has described human beings as structurally religious just as they are structurally needy, ethical, spiritual, and effective. He argues that even atheists are religious on grounds that all human beings form their lives on the basis of a vision of what life is all about, and this vision is always supported by faith and not by science. At the point of illness and death, doctors are often drawn into religious concerns as they contemplate the meaning and value of life.[760] Unfortunately, the doctor's medical expertise does not give him authority over these unavoidable phenomena of the clinical encounter in the physician-patient relationship.

For this reason, Pellegrino proposes from a Catholic perspective on moral or medical ethics that a coherent moral view that transcends purely philosophical ethics in some distinctive ways should be integrated with the philosophical dimension of medical ethics.[761] His aim for proposing the catholic perspective on medical morals reads: "My principal aim is to examine the way in which the central virtue of the Christian life - the virtue of Charity - shapes the whole of medical morals".[762] It is quite clear that Pellegrino does not in any way propose this catholic perspective to be an ethic whose methodology and content are distinct and closed to philosophical reasoning. He does not intend an uncritical fideism but reasoned ethics that is reconcilable with the moral imperatives of the Gospels or their authoritative interpretation by the church.[763] Consequently, this calls for a conceptual examination of the relationship between faith and reason, which explicitly leads Pellegrino to reflect, from a Catholic perspective, on the relationship between reason and theological virtues. He does this with a motivation that in Christian ethics, being moral is explicitly different from what it is in a naturalistic ethic. For instance, the Christian knows that doing the right thing and the good is a means of growing closer into a deeper relationship with God, the creator, and redeemer.[764]

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[760] Drane, *Becoming a Good Doctor*, 28.
[761] Pellegrino, *The Philosophy of Medicine Reborn,* 349.
[762] Edmund Pellegrino, Agape and Ethics: Some Reflections on Medical Morals from a Catholic Perspective," in *Catholic Perspectives on Medical Morals:Foundational Issues,* eds. Edmund Pellegrino, John Langan John and Collins Harvey (Dordrecht, Kluwer Academic Publishers, 1989), 277.
[763] Pellegrino, *The Philosophy of Medicine Reborn*, 349.
[764] Pellegrino and Thomasma, *The Christian Virtues*, 72.

Like Drane,[765] Pellegrino considers the role of religion in his profession-centered virtue ethics. He examines how the central virtue of the Christian life and charity shape the whole of medical morals.[766] Pellegrino examines the interrelated roles of these coordinated religious virtues in enabling the Christian physician to make right and good medical moral decision. The three supernatural virtues are never in conflict with each other but work harmoniously. Faith shows the physician the path, hope leads him to persevere on the way, and charity orders and motivates him such that he is not willing to let go of the goal of the medical profession which he seeks to achieve above any other goal, even in the face of an impending danger or threat.[767]

In their famous book, *The Christian Virtues in Medical Practice,* Pellegrino and Thomasma attempt to respond to the timely question about the identity and behavior of the Christian physician and what difference it makes to be a Christian physician. This question specifically seeks for an investigation as to whether Christian physicians can separate their religious beliefs from their professional commitments, or whether there is anything special required over and above what is required philosophically to be a physician, if one professes to be a Christian as well as a physician.[768] Bishop Apochi Michael expresses the significant role expected of Catholic medical practitioners and other professionals in the secular world. He argues that the church relies heavily on Catholic medical practitioners working in the secular field to bring the light of faith to bear in their different professions since faith has a contribution to make in promoting human dignity in all kinds of legitimate human engagements.[769] The bishop's admonition is specifically directed to Nigerian Catholic Medical practitioners whom he calls to be apostles of faith in their engagements by reflexively living out their faith in their medical practice. Catholic medical practitioners are true to their identity when, in their relationships with their patients, they choose to imitate the Church as the Church imitates Christ.[770]

Coming from a Catholic background, Pellegrino reflects on medical morals from a Catholic perspective by focusing on the kind of person the Catholic physician or health professional should be. He addresses the question whether it is possible in pluralistic society

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[765] Religion is the last of the six virtues in Drane's classification list of medical virtues. For him, religion as a virtue, is the personal quality which makes it possible for the doctor to be adequate to in responding to the religious needs of the patient especially when the patient needs help with issues of ultimate of meaning or struggles to hope when all human possibilities seem exhausted. See, Drane, *Becoming a Good Doctor*, 29.
[766] Pellegrino, *The Philosophy of Medicine Reborn*, 349.
[767] Pellegrino and Thomasma, *The Christian Virtues*, 42.
[768] Ibid, 1.
[769] Michael Apochi, foreword to *Handbook for Catholic Medical Practitioners of Nigeria* by Catholic Bishop's Conference of Nigeria (Abuja: Printed by Fab Anieh Nigeria Limited, 2021),v.
[770] Catholic Bishop's Conference of Nigeria, *Handbook for Catholic Medical Practitioners of Nigeria* (Abuja: Printed by Fab Anieh Nigeria Limited, 2021), 28.

for a Christian (Catholic) physician to inseparably remain both Christian and a physician, acting charitably towards those who do not share his or her view since a "Christian physician is not just a physician who happens to be a Christian. He is, at once, a Christian and a physician, one who is competent, but one whose competence is practiced within the constraints of Christian ethics."[771]

In their attempt to reconcile profession and faith in a secular or pluralistic society, Pellegrino and Thomasma proceed to propose a Christian approach to medical morals characterized by a coherent view of the moral life that transcends purely philosophical ethics in distinctive ways. They advocate a virtue-based teleological approach to medicine by integrating the three theological virtues of faith, hope, and charity into medical ethics, which promote the kind of person the Christian physician, ought to be and the kind of decisions he or she ought to make. This theological approach provides a holistic guide to medical practice by at least assisting the doctor to respond to some faith related issues that surface in medical practice. One could describe this proposal as a complex amalgam or congruence of faith, religion, and reason. In other words, to reconcile ethics based on reason, principles, and precepts with the fact that the fullness of the Christian ethos is unselfish love.[772]

Christian health professionals are expected to be custodians of the dignity of the human person as created in the image and likeness of God. Thus, at the heart of health care this respect for the inherent dignity of the human person. It means that health care professionals are called to be guardians of human dignity, servants of human dignity, and witnesses to human dignity. All health care professionals are called to be guardians of human life and, therefore, guardians of human dignity. As guardians of human dignity, health care professionals are called to be vigilant advocates for those persons whose dignity is threatened, compromised, or violated because of factors including, but not limited to, weakness, disability, illness, age, economic status, culture, ethnicity or perceived lack of quality of life. Health care professionals are also called to advocate for those who are at risk for dehumanizing procedures and technologies that are performed under the guise of health care (e.g. abortion, non-therapeutic embryonic research, assisted suicide, voluntary active euthanasia).[773]

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[771] Pellegrino and Thomasma, *The Christian Virtues*, 2.
[772] Pellegrino, *The Philosophy of Medicine Reborn*, 354.
[773] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services,* 5th edition; (Washington, D.C.: USCCB Publishing, 2009),2.

4.7.1 Faith

According to Pellegrino, faith "is the virtue of entry into the Christian life and which assures us of a personal relationship of love with God."[774] In another place, he describes faith as the inaugural virtue that opens the way to the truth and points to the path that leads to salvation.[775] For him, "faith is our spiritual compass,"[776] and it is also essential and an indispensable background to an agapeistic ethic because without faith in God's existence, we could not derive the command to love God, and the virtue of charity is grounded in God's love for us and his revelation of that love.[777]

The role of the virtue of faith in medical practice resembles that of trust in the philosophical virtues of medical practice. It functions like the virtue of confidence because there could be no healing relationship without it since without it we could not believe in each other. Pellegrino argues that the virtue of faith is complex because it touches both the mind and the will of the believer, requiring a change in life and a difference in conduct.[778] Faith initiates the virtue of love of others, hope for the eventual good, prudence about applying fundamental moral principles to new situations, compassion for the sick and the vulnerable, generosity of time and effort for others, and a host of other virtues.[779]

The virtue of faith in the clinical encounter reveals itself in the physician or the patient's humility, which enables them to realize and acknowledge their dependence upon God, even while they can never penetrate the mystery of the challenge to their hope and love in the events of their daily lives. Thus, despite the challenge of this mystery to his scientific training, the Christian physician nonetheless accepts the mystery.[780] Christian physicians and health care professionals believe that there is more to healing than a mere scientific cure. They strive to care for the sick and alleviate their suffering while believing that God cares and heals through his divine love.

There is no doubt that the virtue of faith has an enormous influence on medical practice and ethics. Pellegrino argues that faith makes a difference in the Christian physician's approach to the practice of medicine and how they interpret a physician's moral obligations. This is obvious in concrete clinical situations where the Christian physician is called upon to be both

[774] Pellegrino, *The Philosophy of Medicine Reborn*, 353.
[775] Pellegrino and Thomasma, *The Christian Virtues*, 42.
[776] Ibid.
[777] Pellegrino, *The Philosophy of Medicine Reborn*, 353.
[778] Pellegrino and Thomasma, *The Christian Virtues*, 43.
[779] Ibid.
[780] Ibid, 45.

a healer and a Christian healer.[781] Pellegrino outlines more instances in which faith influences how the Christian physician practices his profession in conformity with his faith. He writes:

> Faith orients the healer to the way in which the practice of healing becomes charitable healing, i.e., an act of love performed in the manner of Christ's healing. Faith keeps before the healer his or her ultimate end and that of the patient. Faith restrains the hubris technology so easily engenders in today's physician or nurse. When hope flags, faith calls to mind that the purpose of human existence is union with God, not immortality or freedom from pain and suffering. Faith restores hope, even in the face of an incurable illness, not because cure of the illness is less a good but because faith promises more than cure. It invites belief in a good even higher than cure because God has promised that higher good to those who suffer.[782]

The theological or supernatural virtues are not seen to be in conflict with the natural or philosophical virtues. Instead, they enrich them for higher efficacy. Pellegrino underlines this point in relation to the virtue of faith. He insists that the Christian physician must exhibit these philosophical virtues of medicine as a healing art because these virtues are good in themselves. They are necessary dispositions to good healing. They should not be erased by faith or replaced by supernatural virtues. They should rather receive added meaning because they are good in the order of nature created by God. Through faith, all the virtues of the good physician are prefigured by the healing example of Christ himself.[783]

In Pellegrino's thought, faith becomes a powerful catalyst and tool for the reformation of the modern health care system. It must always be guided by the goal of improving the healing relationship with fellow creatures of God. In Pellegrino's words: "Faith, in short, is a lantern that illuminates the way Christian physicians should live all the natural medical virtues. Faith is also the spiritual compass we need in the face of modern medical practice's moral and ethical dilemmas. Faith entails a commitment to a source of morality beyond humankind, a source in Sacred Scripture, tradition, the teachings of the Church and of its official magisterium."[784] Therefore, one could be correct to say that medicine as perceived by Pellegrino is a fertile ground for bearing witness to faith and for making Christ's love present to those in need and in painful suffering as a result of the vulnerable state of their sickness. In this way, a physician whose practice of medicine is guided by the virtue of faith sees his work a special kind of devotion and as a missionary enterprise for bringing the salvific work of Christ to the wounded humanity.

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[781] Ibid, 51-52.
[782] Ibid, 52.
[783] Ibid.
[784] Ibid, 52-53.

4.7.2 Hope

We have seen Pellegrino's argument on how the virtue of faith points and illuminates the way to the goal of healing in medical practice. This is followed by virtue of hope, which sustains the medical practitioners on that way. Pellegrino argues on this ground for the inevitability and indispensability of the virtue of hope in medicine. According to him: "Every physician and nurse, indeed every observant person, knows that hope is essential to healing. When either the physician or the patient loses hope, the will to be healed is eroded".[785] Hope enables the parties involved in the clinical encounter to persevere in the face of the predicaments of illness, despair, disability, depression, or death.

For Pellegrino, the virtue of hope is a motivating force essential to any human endeavor and it is inextricably tied to the spiritual virtues of charity and faith, which characterize the religious perspective on the experience and ethics of healing.[786] The Christian spiritual virtues of medicine are essential and relevant for holistic healing of the human person since healing involves both body and mind. It follows that for healing to take place, healing of the body, mind and the soul, hope in God's design for us, in his mercy, and in his promise of an afterlife whose glories we cannot even conceive motivates to sustain and relieve our suffering even when death is inevitable. The Christian virtue of hope is essential for the doctor as well as the patient. They and all who look after the sick must possess the virtue of hope to promote healing. Pellegrino clarifies that hope does not dispute the reality of the existence of sickness, pain, and human suffering, nor does it replace the benefits of medical care. Instead, "it confronts the realities of the patient's predicament, but it directs the mind and heart to something much larger, the reality of God's presence in history, his promises to humanity, and his unfailing love for every one of his creatures". [787] Through his doctrine of the supernatural virtues, particularly the virtue of hope in medicine, Pellegrino profoundly establishes the metaphysical aspect of healing; the inevitability of religion and the fact of miracles in human affairs that indicate God's intervention in nature and human activities. However, Pellegrino does not relegate medical healing, which is God's knowledge shared with man, must always be our first port of call.

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[785]Ibid, 56.
[786] Ibid, 57.
[787] Ibid, 68.

4.7.3 Charity

Pellegrino has examined some of the conceptual relationships between reason and charity in traditional and contemporary discourse. He grounds his charity-based medical ethics not solely on the principle of beneficence but on the Christian obligation to fulfill the commandment of love, the principle of the love of God through a neighbor. Pellegrino describes this principle as charitable beneficence, grounded in God's love for us and His revelation of that love.[788] Pellegrino describes charity to be the ordering of the virtue of Christian ethics, medical and otherwise. It is distinguished for shaping the whole of the healing relationship.[789] Pellegrino describes charity as the central virtue of the Christian life. This centrality reflects in its role as shaping the whole of Christian medical morals, as it does every other aspect of the moral life.[790]

In medical practice, the virtue of charity from a Christian perspective disposes the Christian physician to choose or select among the many particulars of a concrete moral choice, those that must conform to the virtue of charity. In this context, the virtue of charity serves as practical wisdom that motivates and orients the charitable physician to act in a way pleasing to God in any particular situation.[791] Pellegrino addresses the thorny problem of how virtue relates to rules, duties, and principles in making moral medical decisions by arguing that rules, duties, and principles are part of the reality of moral life as love is. They cannot be disengaged from each other. In his agapeistic ethic, he argues that principles, rules, and duties are chosen or shaped by charity. More substantially, he states that the primary principles of medical ethics are ascertainable by human reason. Still, the virtue of charity provides a unique way in which these principles are to be lived and applied in concrete situations in the spirit of the Gospel teaching, as against pure human reasoning.[792]

At this point, we see a harmonious integration between the Christian virtue of charity and medical practice. More so, charity acts as practical wisdom in a Christian, sorts out and resolves any conflicts that may arise between these principles in the face of a medical moral decision. It does this as already observed by resorting to revelation or sacred scripture, a tradition in which charity is considered an obligation. Pellegrino describes charity in medical practice, as we have already seen, to be the form of virtues because it acts as a practical

[788] Cf. Pellegrino, *The Philosophy of Medicine Reborn*, 353.
[789] Pellegrino and Thomasma, *The Christian Virtues*, 4.
[790] Ibid, 29.
[791] Pellegrino, *The Philosophy of Medicine Reborn*, 362.
[792] Ibid, 362-3.

principle of discernment and a benchmark against which the Christian physician measures concretely, here and now, the moral worth of their sensible medical ethical decisions.[793] Thus, charity plays the role of an interior principle that encompasses the philosophically derivable internal morality of medicine and, without abrogating, transmute healing into an act of grace.[794] According to Pellegrino, "compassion is the concrete evidence that the virtue of charity is at work in the healer."[795] Pellegrino argues further that the virtue of charity disposes moral judgments to their proper end. "It fuses the qualities of both mind and heart, reason and faith-a fusion without meaning a non-agapeistic ethics."[796] This fusion is only tenable in a charity-based model of medical ethics.

The unique thing about Pellegrino's agapeistic ethic is that it does not accept easy justification for reducing beneficence to mere non-maleficence which demands nothing of the physician. Instead, his agapeistic ethics calls the Christian physician and other health professionals to strive for perfection in charity even though they may fail, given the ineffability they must emulate. But they should know when they have fallen and strive to come closer always as an act of obedient response to a loving God.[797] The charitable beneficence which Pellegrino advocates for medical practice is grounded in God's love for us and in his revelation of that love. It follows from the virtue of faith which ushers into the Christian life and which assures us of a personal relationship of love with God.[798]

Pellegrino laments the unfortunate situation where many Christian medical professionals today try to justify their compromising the virtue of charity on the grounds of necessity and survival. As a remedy to this ugly situation of comprise in medical professional roles, Pellegrino advocates strict adherence to a Christian and charity-based ethics model as an ideal approach to the physician-patient relationship in the clinical encounter. In this sense, Pellegrino argues:

> A genuine Christian ethic would be incompatible with health care as a commercial activity. The idea of the physician as primarily a businessman is inconsistent with the Christian ethic of medicine. Likewise, such an ethic would reject the healing relationship as primarily an exercise in applied biology or as a legal contract for services. No could the relationship be construed as paternalistic, or as primarily a means of livelihood, personal profit, or prestige for the physician. Equally incompatible are models which make the physician primarily a government bureaucrat, a proletarian employee of a corporation, or an agent of the state as in totalitarian regimes.[799]

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[793] Cf. Ibid, 370.
[794] Ibid, 371.
[795] Pellegrino and Thomasma, *The Christian Virtues*, 86.
[796] Pellegrino, *The Philosophy of Medicine Reborn*, 361.
[797] Ibid, 364-5.
[798] Pellegrino and Thomasma, *The Christian Virtues*, 33.
[799] Pellegrino, *The Philosophy of Medicine Reborn*, 369-370.

Pellegrino quickly remarks that he does not by his theory of the Christian virtue of charity absolutely deny the fact that medicine in some measure is simultaneously a business, a craft, a science, and a technology. Instead, the agapeistic ethic places these differing facets of medical practice into a morally defensible order, recognizing when and to what degree they must yield to the ordering principle of charity.[800] In his doctrine of the virtue of charity in medical practice, Pellegrino underlines the mutuality of respect by physician and patient for the virtue of charity. The physician-patient model advocated in Pellegrino's agapeistic ethic is a covenantal relationship as it imposes an obligation not only on the physician but on the patient as well. He imposes on the patient the obligation of honesty, compliance with the physician's regimen, refraining from frivolous, frankly unjust, or injurious legal action, and respect for the human and moral values of the physician that are logical corollaries of a covenantal relationship.[801]

Pellegrino's view provides an excellent thought on the relationship between the faith and reason relationship in professional ethics. It is an interesting effort to reconcile one's faith and work. A Christian vocation to medicine is a call for an integration of what it means be a Christian physician in conformity with what it means to be a Christian. In this sense, profession and faith, though two distinct phenomena, become inseparably united in a single purpose. By linking charity with principles and rules in moral decision making, Pellegrino renders a religious contribution for solving the prickly problem of the virtue between virtue and principles in every moral thought. His theory on the foundation of God's love and his revelation is a unique attempt to demonstrate the practicality of Christian faith in charitable acts in medical professional roles.

4.8 Similar Approaches to Edmund Pellegrino's Medical Ethics: James Drane

There is no doubt that Pellegrino has remained quite uniquely outstanding in his attempt to integrate virtue into health care ethics. There are equally other scholars, who like Pellegrino have made frantic efforts to integrate virtues into health care ethics. These similar efforts, as we have already seen, range from their theory and doctrine of the identity of medicine, its ends, and the ethics that guides its practice. While we admit and acknowledge the existence of other attempts to build a virtue-based medical ethics aside Pellegrino's, any attempt to review such works will only lead us into repeating Pellegrino's arguments since most of them gained

[800] Ibid, 370.
[801] Ibid.

their inspiration from him. We cannot but here mention and briefly review James F. Drane's approach, which is worth considering because it is in-depth and most similar to Pellegrino's approach.

Drane is a good example of a similar approach to Pellegrino because he believed in the inevitability and indispensability of virtue or the good character of the agent for a sound medical practice in the doctor-patient relationship. Like Pellegrino, Drane conceives virtues to be sources of higher ideals in medical practice. He proposes that virtue and character must have a place in medical ethics because of the size of today's health care institutions. He says: "Virtue is not dissociated from objective moral standards of conduct, but higher standards of professional conduct require higher virtue and greater personal effort in character formation".[802] This view is found in Pellegrino's theory of the virtuous physician as the beacon of moral ideals, who goes beyond the general or objective standard of conduct to a supererogatory level to attain a certain moral ideal, irrespective of the threatening conditions. The point is that being ethical is not enough. Ethics must be appropriated in good behavior through right choices and conduct. In Drane's argument: "Each patient and every medical situation provides an opportunity for a number of possible goods or values to be accomplished. As doctors go through life making value choices and appropriating them into conduct, they constitute themselves as certain types of persons. Certain ethical habits are developed and character is created."[803]

Drane's definition of virtue and its operation in medical practice is identical to that of Pellegrino. Drane describes virtues as possessing enduring qualities of healing relationships which enable health providers to make right choices according to the use of proper reason. Thus, virtue for Drane "is the personal appropriation of values made with the help of reason. Practical reason, in the sense of deliberation and prudential choice, belongs to the very definition of virtue and is crucial for the practice of good medicine".[804] The practice of virtue is not visionless or without a goal. As Drane notes, virtue is targeted at some good: "Virtue practice without a vision of the good, or disconnected from belief about the meaning of life, becomes virtue for its own sake; moral gymnastic or ethical masochism."[805]

Like Pellegrino, he does not make a case for the destruction of principle-based ethics in favor of virtue and character. Still, he calls for an inclusive ethic in which both principles

[802] Drane, *Beconing a Good Doctor*, 18.
[803] Ibid, 164.
[804] Ibid.
[805] Ibid, 165.

and virtues are necessary to help make concrete ethical decisions in health care relations.[806] Furthermore, he argues that to be a good doctor, one must satisfy the demands of technical competence and be a type of person to whom sick people can relate. To be a good doctor is to develop those traits and habits that correspond to the patients' specific needs.[807] Drane beautifully outlines six dimensions of the patient's needs in the physician-patient relationship: medical, spiritual, volitional, affective, social, and religious.[808] He describes six corresponding medical virtues as those character traits that would enable the doctor to attend better to the patient's needs. These virtues include benevolence, truthfulness, respect, friendliness, justice, and religion.[809] A slight discrepancy exists in the list of his selection of medical virtues. While Pellegrino selects and lists certain correlated virtues for medical practice, Drane limits each selected virtue to a particular patient's need in a more rigid manner. He does not create a harmonious relationship between the virtues as it is in Pellegrino's account of virtues.

Pellegrino and Drane both proposed a virtue theory in which the virtues are grounded in the doctor-patient relationship. Like Pellegrino, Drane believes that the doctor-patient relationship is an inescapable structure for healing activities. It brings into a unique relationship one who is ill and one who heals, and it becomes the basis of medicine as a moral enterprise. It is the source in which medical virtues are rooted. He describes this relationship as more than just a little professional concern by emphasizing the humanistic element and that human beings are disadvantaged by nature.[810] Pellegrino and Drane's use of the term physician-patient relationship is quite distinct from the term's general use, which is sometimes explained in terms of contract, duties or rights. They have in mind a moral personal relationship between two persons, as we have seen in their description of medicine as a moral enterprise, and this is the context in which healing is to take place. From their arguments on the inevitability and indispensability of the doctor-patient relationship and encounter in medical practice, it follows that ideal healing should take place within this context. They both emphasize and acknowledge that this relationship is often characterized by the encounter between two unequal persons, the physician as superior to the vulnerable patient. They do not, however, deny that there exist other contexts or avenues of healing.

Despite his unquenchable enthusiasm to establish the place of virtue in practice, Pellegrino does not consider ethics as ultimately redeeming the flaws of principle-based ethics. He admits

[806] Ibid, 19.
[807] Ibid, 20.
[808] Ibid, 23.
[809] See Ibid, 23-29.
[810] Ibid, 21.

that virtue ethics is not a salvation theme for the difficulties of principle-based ethics since it also has its limitations.[811]

Owing to the professional dimension of Pellegrino, Thomasma and Drane's approach to virtue ethics, they seemed to have paid much attention to the virtues of healthcare providers but laid little emphasis on those of the virtues of the patient. Pellegrino and Thomasma for instance advance that some virtues such as benevolence, humility, and courage apply to practitioners as well as patients and dispose both parties to act well in relation to the ends of medicine.[812] Their theory of medicine gave prominence to the patient since medicine has the good of the patient as its telos. That they gave precedence to the virtues of the physician does not mean imply that patients are not expected to cultivate some virtues that enable them to act in relation to the ends of medicine. If patients are expected to develop some virtues to enhance healing process, it therefore means that being sick and vulnerable is a fertile ground to cultivating medical virtues. Nancy Snow subscribes to the view that pain, sickness or meaningful suffering could serve as a necessary medium for a patient to develop and express the virtuous traits that constitute strength of character fortitude, perseverance, courage, resilience, and patience.[813]

4.9 Chapter Summary

This chapter captures the role and necessity of virtuous character traits in medical practice. It centers on the very heart of Pellegrino's virtue-based humanistic approach to medical ethics. He proposes a humanistic approach to medicine, which considers human care as a foundation for curing diseases. It puts Pellegrino's essentialist virtue theory as indispensable for medical practice and a valuable tool for confronting the challenges in the physician-patient relationship. The primary narrative of this chapter is that virtuous physicians are more likely to make correct and good decisions in every situation in the clinical encounter. The chapter demonstrates the virtuous physician as the beacon of morality in society.

In this chapter, we have seen how Pellegrino painstakingly demonstrates how particular medical virtues enable the physician to be more effective in his professional roles. These medical virtues, both philosophical and theological, provide the physician with the rational and religious capacities to discerning the patient's good. This captures the inseparable relationship

[811] Pellegrino and Thomasma, *The Christian Virtues*, 24.
[812] Pellegrino and Thomasma, *The Virtues*, 194.
[813] Nancy Snow E., "How Good is Suffering? Commentary on Michael S. Brady, Suffering and Virtue," *J Value Inquiry* 55, (2021), 572.

between faith and reason in understanding reality. These virtues work harmoniously toward realizing the good of medical practice. On the relationship between faith and reason in the morality of medical practice, Pellegrino offers a Catholic perspective on the morality of medical practice in which conscience plays a central role.

Chapter Five: The Relevance of Pellegrino's Theory of Medicine in the Contemporary Debates on the Philosophy of Medicine

5.1 Critical Reflections

This chapter seeks to consider and situate the outcome and the relevance of our investigation on Pellegrino's proposals for modern medicine. It brings to light the significance, consequences and implications of the philosophical and theological groundings and contributions of Pellegrino's moral discourse on contemporary medical ethics. In other words, we intend to demonstrate that Pellegrino's views and proposals respond adequately and proffer solutions to the philosophical problems and medical dilemmas in contemporary society. Our work has both theoretical and practical relevance. The attempt here is to consider the various aspects in which the knowledge gathered from this investigation may be made available to discover and develop those valuable moral skills and virtues necessary for the effective practice of modern medicine.

This work has demonstrated that the strengths of Pellegrino's thought are found of his contribution to the theory of health care and in his insistence on a philosophical basis for modem medicine. He argued strongly that contemporary challenges in medicine and technology are in danger of outstripping current health care theories, endangering traditional commitments to the patient's good. For proper appreciation of Pellegrino's philosophy of medicine and its application to the present-day situation, we must take a critical look at some of the essential elements or themes that frequently demonstrate this relevance. This summation is not meant to multiply analysis or to go into more complexities about these themes that we have already explored in the body of this work. Instead, the aim is to provide a practical, precise perspective from which the relevance of this dissertation can be viewed. Our purpose, therefore, is to relate the relevance of Pellegrino's contribution to the contemporary discourse on medicine by reflecting on some of these selected keys and significant themes that appear most often in medical discussions.

There is no doubt that Pellegrino's thought serves a manual or a guide to the value and use of medicine. His proposals are meant to promote reliability and scientific practice quality of medical practice. Pellegrino relied heavily on Aristotelian teleology and virtue theory. He is famous as an erudite scholar and a compassionate physician. He played a significant role in

changing the common biomedical identity of medicine from being a mere body of valuable knowledge for treating illness to a more metaphysical dimension. He is reckoned as one of the great minds of the contemporary age in both the philosophical and medical worlds. He gave medicine a unique philosophical definition. He viewed medicine as possessing intrinsic goals that determine the type of knowledge medicine needs to achieve these ends. He also played a significant role in the development of bioethics and the philosophy of medicine. Pellegrino's doubling figure and his unique experience as a philosopher and a physician enabled him to present remarkable medical ethics that has stood the test of time. His scholarly contributions, both philosophical and theological, brought about medical and professional education. They created much awareness about the significant role of medicine in the human community and of the excellent image of the health care profession. Despite its lacuna, weaknesses, and loopholes, Pellegrino's work remains a vital tool and guide for the medical profession as it plays an incredible role in shaping the practice of modern medicine.

We have critically examined and analyzed Pellegrino's works on medicine's identity, structure, meaning, and essence and its practice as a moral enterprise. We have seen his numerous contributions to the nature of medicine and how it should be practiced. We have also seen how Pellegrino's interests extend far beyond the field of medical practice. His research works cover various topics such as the philosophy of medicine, the history of medicine, professional ethics, the Hippocratic Oath, and the physician-patient relationship in the clinical encounter.[814] Pellegrino's philosophy of medicine provides a rich analysis of the phenomenological and existential contexts of illness, finitude, and disease. His account is rich, timely, and of enormous contemporary relevance to physicians and other health care professionals who must be familiar with the shifts in modern moral philosophy if they are to maintain a hand in the restructuring of the ethics of the medical profession. It will guide them to provide a reality check on the nihilism and skepticism of contemporary philosophy.[815] His philosophy of medicine provides the health care practitioners with a proper guide that helps them apply theories into practical situations of healing relationships and to develop virtue for medical practice.

[814] Pellegrino, *The Philosophy of Medicine Reborn*, 441.
[815] Thomasma, *Virtue Theory in Medicine*, 95.

5.1.1 The Practicality of Philosophy

One of the major outcomes and the relevance of Pellegrino's philosophy of medicine, as discovered in this investigation, is that it reaffirms and demonstrates that philosophy plays a practical role in medicine and human society. This project expresses how philosophy is a tool for solving both philosophical and clinical challenges and problems in medicine. Pellegrino's virtue theory for medical practice revolves around his claim that virtue will always assist the physician in making morally good choices and decisions in every practical situation of the clinical encounter. This work also demonstrates that every problem in life has a philosophical character. It is for this reason that philosophy permeates and shapes every facet of the individual and communal life. Philosophy penetrates the personal, moral, social, political, religious, and cultural aspects of human experience. The Lublin school of philosophy claims that philosophy is practical and that everyone philosophizes. The Lublin school's philosophical program tried to put philosophy on the foundation of experience as perceived broadly, consisting of sensory-intellectual conception and intellectual intuition, that is, the inclination and the wonder to know the truth and the practical consequences or ends follow from the fact.[816] This dissertation significantly demonstrates the functional relevance of philosophy in human relationships and interactions and on choices and decision-making. That philosophy plays both practical and theoretical roles in human activities cannot be doubted. It helps in the formulation of theories and guides in their applications to particular existential phenomena, for the benefit of men and their society.

Pellegrino's doctrine on the indispensability of philosophy in medical practice is a significant demonstration of the relevance and necessity of philosophy in understanding the ultimate value of the phenomena of medicine, human existence, and reality as a whole. It emphasizes that philosophy exists as a guide to the understanding of the ultimate meaning of everything. Like every other branch of philosophy, ethics focuses on those seemingly simple questions that revolve around the ultimate meaning of the phenomena of human actions and the phenomenal universe. Ethics seeks to answer fundamental ethical questions: What makes direct medical activities suitable and dishonest ones wrong? Why do we need to always act morally right in medical practice? Why is death a bad thing for the person who dies? Is there anything more to happiness than pleasure and freedom from pain? These are some of the

[816]Cf.,Krąpiec Abert M., and Maryniarczyk, Andrej, *The Lublin Philosophical School* [Unpubl.], translated by Hugh
McDonald. Lublin: Polskie Towarzystwo Tomasza z Akwinu, 2010), 21-22.

intriguing, pressing, and ultimately perplexing questions that naturally occur in the course of our daily lives, just as they naturally happened in the lives of people who lived before us and in the lives of those that will come after us. These same perplexing questions occurred in other societies whose cultures and technologies differ from ours. Every attempt to answer these questions from the scientific or sensible approach will always prove unsatisfactory. This inability and dissatisfaction mark the beginning of philosophy. All questions about the ultimate meaning of existence and the quest for meaning and purpose of life are philosophically oriented. Particular sciences cannot provide any satisfactory answers to these questions, but philosophy does.

We have already established that philosophy influences and shapes the concept of medicine and guides its professional application in particular cases to promote health and life. The subject matter of philosophy goes beyond the confines of just the acquisition of knowledge. Instead, it consists of the quest for knowledge and the determination of the kind of knowledge, its goals, the nature of acquiring it, the method of receiving it, its validity and reliability, and its truth and value. Philosophy provides various tools such as logic and epistemology, which are employed to investigate the validity and reliability of knowledge claims: metaphysics, axiology, ethics, and aesthetics, which verify their essences, values, moral claims, and their beauty, respectively. It also employs the use of the tool of philosophical anthropology to unify several empirical investigations of human nature and the entire person in an attempt to understand persons as both creatures of their environment and creators of their values.

One of the outstanding discoveries in this work is that it brings the role of philosophy in shaping scientific disciplines. Although philosophy is a distinct discipline of its own, it is often applied to particular disciplines and professions to help them solve their specific problems and challenges. For instance, when we use philosophical theories and findings to the concept of law, we have a philosophy of law, philosophical jurisprudence, or legal reasoning, as the case may be. In other instances, when we apply philosophy to science, we have a philosophy of science. When used in politics, we have a political philosophy. If philosophical principles were applied to the basic concepts of education, we would then have a philosophy of education. Philosophy helps in the understanding of the concepts of disciplines and professions. As in education, philosophy helps form educational goals and the principles of their application to particular existential situations. We cannot think of quality education without any guiding philosophy behind its functionality. Philosophy is a guiding principle for every form of education in society.

The point is that particular sciences, in their search for knowledge and in their struggle to promote the good of human society, cannot flourish efficiently without the influence of philosophy. This point was seen repeatedly in our research. We analyzed how philosophy, the search for wisdom, enables the scientist or the physician to go beyond the level of just knowledge of empirical facts and data to discover the ultimate values of the acquired empirical facts and data and guides him to apply this knowledge for practical use. We found that practical wisdom or prudence is the indispensable virtue of medical practice. A wise and knowledgeable physician is better than just a brilliant physician who lacks wisdom. Philosophical background and influence in scientific enterprises are inevitable. Philosophy plays an incredible role in the promotion of the good of the human person. It aids the human person and empowers them to conquer the problems of their environment.

More than the particular science as we have already observed, philosophy discovers what is valuable and worthwhile in life. It presupposes the methods of achieving that which is helpful and at the same time provides the right attitudes towards being active in the application of the discovered values for the common good. It helps professionals confront the most perplexing and pressing questions of life that puzzle them in their professional roles. The basic idea is that philosophy is harmoniously related to a precise science, as demonstrated in its relationship with medicine. This is what we find in Pellegrino's contribution: an attempt to unite philosophy and sciences and science with wisdom.

There is no doubt that academic philosophy does not seem to produce practical solutions, theories, accumulated knowledge or scientific results, or commercial goods in the way we would expect other applied disciplines to do. Nevertheless, one of its functions is the heavy responsibility of showing people how to live and function rationally by offering a rationale for the diverse moral convictions which people learn at different stages of life.[817] No doubt, ethics, in general, is a practical discipline. However, we intend to say here that Pellegrino's moral ethics demonstrates uniquely that ethics is a practical discipline and that it applies to every human condition and the values of everyday life choices.

Pellegrino’s virtue-based medical ethics shows how ethics can be helpful in dealing with practical and peculiar problems in medical practice. Pellegrino’s demonstration of the practicality of ethics reflects the general views of many contemporary ethicists who advance that ethics from its original understanding finds its

[817] Cf. Martyn Evans, introduction to *Advances in Bioethics: Critical Reflection on Medical Ethics* (London: Jai Press Inc., 1998), 14-15.

roots in the structures of human nature and persons in their day-to-day struggle for self-actualization through free acts daily choice making. For Drane, ethics is a practical discipline and part of everyday human life; it is not far removed from human life and choice making; it is problem solving.[818] Similarly, Alfred Wierzbicki argues: "The most important problems of life are practical problems, where practical is understood as that which is connected with practice, with human decisions."[819] This point is highly demonstrated in Pellegrino's approach to ethics, which focuses more on the practical problems, the medical treatment of humans and on the here and now healing relationship between the doctor and the patient found in the practice of the medical profession. In Pellegrino's approach, we emphasize that ethical problems and dilemmas arise more from the particularities than from the theoretical aspects of professional roles.

It was in response to the practical medical problems found within the context of the cultural challenges of his time and environment that Pellegrino proposed his theory. While he set out to tender a solution to the medical challenges of his time, his contributions still play a significant role in today's discourse on medicine as a profession. Regarding this contextual, cultural background, Tadeusz Biesaga remarks: "Edmund Daniel Pellegrino developed his humanistic, philosophical and ethical thinking in the context of what was happening in Anglo-American culture at that time. Both the education he received, as well as what he studied and sought, reveal what trends of cultural, humanistic and philosophical thinking influenced him and how he processed them in building his philosophy of medicine and medical ethics."[820] Therefore, we state clearly that Pellegrino's vision, as we have demonstrated in the entire work, was to restore and preserve the lost professional dignity and integrity of medicine, of the physician, and the patient. His desire was to ensure the stability of an intrinsic and a universally binding medical ethic and not an ethic of political expediency or societal convention. He clamored for a concrete and sufficient moral guide on which physicians must base their ethical conducts and justifications in their duties as physicians. He sought a medical ethic that does not require any negotiations between the physician and the patient on what constitutes the good of medicine. Any medical ethics that does consider this background is liable to be shallow and myopic.

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[818] Drane, *Becoming a Good Doctor*, 175.
[819] Alfred Marek Wierzbicki, *The Ethics of Struggle for Liberation: Towards a Personalistic Interpretation of the Principle of Non-Violence* (Frankfurt: Peter Lang, 1992), 1.
[820] Biesaga, *Spór o Podstawy Etyki Medycznej Teleologizm*, 11.

We see much relevance in Pellegrino's proposal that medical ethics should not be a socially constructed contract varying from society to society, era to era, and patient to patient. This is a unique way to demonstrate his position that medical ethics must not be whatever is politically negotiated between the profession and the government or other socially and politically constructed forms of ethical justifications of modern times. Pellegrino argued for an internal morality of medicine, which provides a universal medical identity for all times and seasons. Commenting on Pellegrino's essential concept of the identity of medicine, Hoa Trung Dinh writes: "Most remarkable is Pellegrino's claim that the internal morality of medicine has universal significance."[821] Pellegrino was against a medical moral climate that seemed like the present politicization of medicine's identity in the face of medical challenges such as the present drama of the Covid 19 global pandemic and other medical-related crisis in which contemporary medicine has allowed itself to be cajoled and controlled by socially, and politically constructed motives. The politics and circumstances surrounding the COVID-19 pandemic and the harmful effects on humanity is a good example of the politicization of medical practice that Pellegrino set out to correct at his time. Nancy Snow argues that during the pandemic, many "mistakes were made by many governments at many levels that allowed the virus to extend around the globe, resulting in countless deaths and needless suffering, some of it leaving sufferers permanently impaired."[822]

More relevance is seen in Pellegrino's vision to offer a solution to the problems of ethical challenges and dilemmas in medicine, and of other problems ranging from medicine's abuses, its politicization, industrialization, commercialization, and commodification caused by medical practitioners and academicians alike. Sulmasy affirms that many of Pellegrino's ideas and insights in the philosophy of medicine are not only relevant for contemporary discussions but that they also remain illuminating and very useful. While some of the thoughts remain incompletely formed and invite further scholarly inquiry and development, others just seem timeless and correct.[823]

The contemporary debate on the philosophy and ethics of medicine employs and relies so much on Pellegrino' s philosophy in resolving most of the tormenting modern clinical challenges and dilemmas in medical practice. His attempt to restore sanity and dignity to the eroded medical profession has remained beneficial and inspirational to modern medical practitioners. One could be right to describe Pellegrino as an advocate of profession-centered virtue ethics in modem medical ethics where the language of rights and principles is more

[821] Hoa Trung Dinh, *Theological Medical Ethics: A Virtue-based Approach* (Boston: Boston College Electronic Dissertation on eScholarship@BC, 2013), 84.
[822] Snow, *How Good is Suffering?,* 574.
[823] Sulmasy, *Engaging Pellegrino's Philosophy of Medicine*, 169.

familiar to the public. This claim finds justification in his theory of virtues in medical practice, which has been explored in the body of this work.

5.1.2 Sickness and Healing

Pellegrino's work reflects on different aspects of sickness and the meaning of the reality of sickness for humanity as a sign of human weakness, futility, and frailty. The reality of the tradition of sickness and disease and of the care for the sick in both pagan and Judeo-Christian tradition, which was highlighted by the biblical history of Jesus caring for the sick. Pellegrino's emphasis that medicine deals with the problems of clinical, public health, and human encounters with health, illness, and death has remained a special point of reference for contemporary debates on medicine. The phenomena of sickness and health as we have seen in this investigation remain the core toward which all medical activities are directed. Pellegrino's concentration on these phenomena gives his work a universal quality since it reflects on the phenomena that affect all human beings regardless of race, place and time. The concepts of sickness and health are as universal as the concept of humanity itself.

It was demonstrated in this research that the phenomena of sickness and health cannot be fully understood in a profound sense without the aid of philosophical interventions. The superficial understanding of these phenomena given by science and technology fails to satisfy man's curiosity about the concepts of sickness and health and the existential challenges surrounding the reality of the phenomenon of sickness in human life. He chose to demonstrate that medicine rests solely not on the realms of physical, chemical, and biological phenomena observable by the methods of the sciences studying the organism. He argues that medicine is more than just the search for visible truth about the functioning and malfunctioning of the human body. Instead, medicine is a search for truth determined by this observable truth, which serves to heal human beings. Pellegrino's approach provides both the ontological, phenomenological, and even religious explications about the reality of sickness and health beyond the one given by biomedical definitions. His philosophical and theological approach to medical ethics is of great relevance to the contemporary world, where everything seems to be limited to scientific explanation.

The central relevance of Pellegrino's extension of the notion of illness from the physical realm to the ontological dimension provides a framework that enables physicians and other health care providers to better understand how medicine should be conceived ontologically and morally. This enhances the efficacy of the role of the clinical encounter in which professionals

seek to help the sick by caring. Thus, Pellegrino's model of the concept of the phenomena of illness and health continues to provide guidance and direction for contemporary medical practice.

5.1.3 The Virtue

Pellegrino is uniquely distinguished among medical philosophers for his virtue-based approach to medical ethics. He tirelessly advocated for the formation and utilization of medical virtues in a complex and technologically sophisticated healthcare system. He considers the training of physicians, which mostly focuses on the objective, and quantifiable science of clinical practice as insufficient and as at times crippling the values of the patient-physician relationship in the clinical encounter. Pellegrino provides an excellent vision of virtue by tracing the history of virtue in moral thought and within the current debate about virtue ethic's place in contemporary bioethics. His virtue model underscores the relevance of virtue and moral values in promoting and protecting medical professional goals. It demonstrates that moral values and good character traits such as justice, compassion, and trust are indispensable in medical practice and that they are meant to promote professional efficacy and objectivity. The virtues discussed in his work indicate that virtuous acts are universal and point to the good of the medical practice. Pellegrino's virtue theory demonstrates how empty professional roles and their ethics are without virtue. Without virtue, knowledge will be fruitless because it lacks character and science without humanity.

One essential feature in Pellegrino's theory of medicine is his ability to distinguish between the values of care and cure in healing process. He identifies care as the core of the goal of healing without which, cure is impossible. In his philosophical analysis of virtue in medical practice, Pellegrino attempts to draw a thin distinction between being good in the various arts and being good as a human being. He however, closes this gap by emphasizing how both forms of virtues harmonious complement each other in both dimensions. He demonstrated how being a good person influences the physician's virtue in medical practice. Similarly, David Resnik and Kevin Elliott argue that ethical norms, standards, and values play a fundamental role in promoting professional efficacy and objectivity. This argument is based on the value-laden nature of professional enterprises. Thus, "values can and should influence scientific judgment and decision making."[824] The theory of virtue helps professionals to bring virtues to life application in their professional roles.

[824] David B.Resnik and Kevin C Elliott, "The Ethical Challenges of Socially Responsible Science," *Accountability in Research* 23, no. 1 (2016), 35 http://dx.doi.org/10.1080/08989621.2014.1002608

The particular relevance of Pellegrino's virtue theory lies in his ability to deal with the resurgent interest in virtue ethics as it relates specifically to medical ethics. This relevance is found in his persistence and proposal that virtue is an irreducible element in medical ethics and that the characteristic of a good physician must be traced in the fusion of general ethics and special virtue ethics which is peculiar to the nature of medicine as a special human activity that is characterized by intrinsic goals that are unique to it. His redefinition of ethics in medical practice guides contemporary physicians on medical ethics, on the healing relationship, and on the phenomenology of this healing relationship that exists between the physician and the patient. More so, his work is beneficial and relevant to health policymakers, the educated public concerned with the state of professional ethics, practitioners of the various branches of medicine, medical researchers, physicians, philosophers, and ethicists who devote some interest in virtue theories.

Furthermore, through his virtue ethics, Pellegrino presents a beautiful and unique image of the physician who is not just a skilled or technically competent person but a morally competent medical caregiver who is compassionate, loving, and treats the patient not just as an object of cure but as a fellow human being who needs care and healing. In this cordial and purposeful image of the physician-patient relationship promoted by Pellegrino, we see the human face in medical practice in which the virtuous physician strives for the interests. The profession of healing as perceived in Pellegrino is a delicate one because it deals with the vulnerable or the dying person. Therefore, the need for the formed in virtue is to enable them to tread carefully, discreetly, and compassionately.

5.1.4 The good

The centrality of the notion of good in Pellegrino's philosophy of medicine and its relevance and contributions to the contemporary debates in medical ethics cannot be overstressed. He argues that the notion of good is intrinsic to ethics because all ethical systems, medical ethics included, must begin with the first principle of all ethics, which states that one must do good and avoid evil. This dictum means that the good must be the focal point and end of any theory or professional action claiming to be morally justifiable.[825] This implies that the good must be counted as the only yardstick for moral judgment and guidance. The good of the patient in Pellegrino's medical ethics is found in his quadripartite good, as we saw earlier in

[825] Pellegrino, *The Philosophy of Medicine Reborn*, 81.

chapter four. This theory of the good of the patient generates the physician's duties and obligations; it also has applicability for the ethics of the other healing and helping professions and the virtues and principles pertinent to their practitioners.[826] I am tempted to say that Pellegrino was too generous in using the good as it applies to the healing profession. The good of the patient appears to be the most used word in Pellegrino's works. This underlines the importance and the centrality of the phenomenon of good in all human endeavors.

Pellegrino was convinced that a clear concept of what constitutes good in general and in medical ethics would help counter contemporary moral pluralism and relativism as to why we must be moral and what we define as the moral life. In virtue ethics, he proposes the good person as the normative standard, upon whom one can rely habitually to be good and to do the good in and under all circumstances.[827] For Pellegrino, the concept of the good, or the good, virtuous person, is a universal concept celebrated in every Western and non-western. The good serves a paradigm person, real or idealized, who sets standards of noble conduct for culture and whose character traits help as a model person that others in that culture aspire to be or ought to emulate.[828] In this context, he stresses the natural in every man to pursue good as a movement to perfection.

While Pellegrino proposes virtue theory as a reliable and tenable ethical framework to solve the current moral crisis in medicine, he suggests that ethics should be connected to a coherent notion of the good and the human person. He states: "We need to reconnect ethics to some notion of the good and a coherent philosophical anthropology."[829] The best way to reconnect is by re-examining the classical, medieval synthesis, which was in existence before ethics was torn from its roots in moral philosophy. Suppose we critically amplify the medieval synthesis, using our newer knowledge of human nature, derived from the biological and social sciences and reflected upon theologically. In that case, this might consequently provide the further resuscitation that a practical virtue ethics demands.[830] The emphasis on the good about the human person and of his nature is paramount to virtue ethics since it claims that one cannot completely separate the character of a moral agent from his or her acts, the nature of those acts, the circumstances under which they are performed, or their consequences.[831] No ethical theory can ignore these elements of moral life. Any attempt to ignore them fails to encompass the fullness and complexity of the challenge and struggle to be good human beings.[832]

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[826]Ibid., 81-82.
[827] Ibid., 256.
[828] Ibid., 257.
[829] Ibid, 251.
[830] Ibid.
[831] Ibid, 256.
[832]Ibid.

Pellegrino provides a clear and specific notion of good for the professions of helping and healing through his perception of the patient's good as the typical end of medical professional activity. Pellegrino presented the virtue in medicine in which good character traits make a good physician and dispose him to identify the good of medical practice and works toward attaining it. His analysis of the good is relevant because it presents the good of the patient in concrete terms related to the phenomenology of the clinical encounter.

The central attention on the dignity of the human person as the subject of medical decisions as an individual in a state of vulnerability, anxiety, pain, and dependence, marks Pellegrino's contribution to the development of the medical anthropology that is built on personalistic norms. He repeatedly claims that medicine exists for the good of the patient as a human person. This personalistic feature conforms to the cherished personalistic standards of Lublin philosophical school, which places the good of the person as the focal point and concern of all scientific endeavors. Every knowledge aims toward the good and wellbeing of man and his society. Investigations in Lublin's philosophical anthropology were concentrated on a search for the foundations of the transcendence of the human person and human amative moral action.[833] The value of the human person is discovered for this reason is an absolute value of the highest dignity, and the truth about the human person becomes the center for philosophical enterprises—the good of the human person as remains the keyword in Pellegrino's philosophy of medicine.

5.1.5 Faith and Reason

This sub-title presents the relevance of Pellegrino's thought on the marriage between theology and philosophy, or faith and reason, as key for comprehending the phenomenon of medical practice. Pellegrino's analysis of the role of faith and reason in medical practice relies on the Catholic perspective that builds on the special fusion of theology and philosophy that is the distinctive mark of the Catholic intellectual tradition. In this aspect, Pellegrino brings to light the fact that there are two wings to understand reality and demonstrates a meeting point between human understanding and divine understanding. Pellegrino structures medical morality based on a Catholic perspective, which is framed by belief in an objective order of morality and in a specific philosophical and theological anthropology, which takes into account the spiritual as well as the material destinies of human life. This runs counter to the historicist bias in much of ethics today.

[833] Krąpiec and Maryniarczyk, *The Lublin Philosophical School*, 62.

Today more than ever, there is a need for dialogue between science and religion to enhance their collaborative coexistence and avoid the clash that sometimes emerges between them. Scientists and theologians must dialogue with one another to scholarly achieve unity and professional integrity. Pellegrino attempts this dialogue between rationality and faith in his theory of medicine. The themes of faith and reason are of particular interest in the works of Pellegrino. He distinguished himself as a Christian philosopher and physician by critically analyzing the dialogue between faith and reason in medical practice. He sees philosophy as the basis for understanding the nature of medicine and a solid foundation that provides a good background for religious, medical morality.

Through his examination of the philosophical virtues alongside the religious virtues, Pellegrino's work offers a professional guide to Christian health care professionals who are often confronted with uncertainty about the place of faith in their professional roles in our secular and pluralistic society. The medical ethics proposed by Pellegrino helps Christian health care providers to reconcile faith with reason, and professional duty. Using Christian bioethical moral principles, he addresses today's divisive challenges and issues in medicine. Pellegrino focuses on the Catholic perspective of medical morality for Catholic physicians. Through the themes of faith and reason, Pellegrino brings to dialogue the relationship between the basis of the natural sciences and the sense of the Christian religion. For him, there is no overlapping between science and religion; they both require rationality. He further demonstrates that the Christian religion explicitly involves rationality. Our analysis of the role of faith and reason in medical practice requires that we refer to the medieval age and St. Thomas Aquinas, who is said to be the excellent synthesizer and advocate of the relationship between reason and faith, which the western world has known.[834]

Bringing faith together with the existential phenomena of life is an exciting enterprise. It demonstrates the beauty in the inseparable unity of faith and reason in understanding reality. St. Pope John II in the encyclical, *Fides et Ratio*, primarily addressed the relationship between religion and reason and urged Christian philosophers and theologians to enter into a severe dialogue asserting that "faith and reason are like two wings on which the human spirit rises to the contemplation of truth."[835] Through his doctrine of the harmony of faith and reason in medical practice, Pellegrino establishes a special kind of relationship between the patient and physician not just on the level of professional background but also on the level of religious

[834] Parker, *The Aquinas Lecture*, 1.
[835] John Paul II, encyclical letter *Fides et Ratio* (Roma: Libreria Editrice Vaticana, 1998). no.1.

belief. This enables the physician to penetrate the patient's history beyond the professional level to the deeper level of the patient's life and religion. Pellegrino shows how faith and reason can combine to create the best possible healing relationship between the health caregiver and the vulnerable patient. His theory of on integrality of faith and reason in medical morality will have some remarkable significance if incorporated into the many pastoral works on medicine and church's pastoral care for the sick. It also has relevance for Catholic moral theologians and ethicists who have special interests in medical matters

Conclusion

It is clear in the investigation that Pellegrino was interested in establishing a peculiar identity and essence of medicine which he describes a unique and intrinsic to the nature of medicine itself. This investigation was guided by three fundamental questions about the identity and structure of medicine. It sought to understand the profound meaning of medicine and to answer the question about its purpose and the kind of knowledge, skills and ethics necessary for its effective practice. It sought to demonstrate that medicine should be essentially construed by its interior morality and goal and that it should be practiced with moral decorum since it is a moral enterprise.

The first chapter provided a philosophical background and foundation for our understanding of the identity of medicine and the need for a philosophy of medicine. It traces the ethical foundation of medicine. It focused on the intimate relationship, the inevitable dialogue, and the inseparable connection between philosophy and medicine. In it, we saw the way Pellegrino argued that although philosophy and medicine are distinct disciplines and have different outstanding goals and methods of operating, they both strive in a complementary manner to ensure the welfare of man and society. Through his philosophical and critical reflection of the content, method, concepts, and presuppositions peculiar to medicine as medicine, we arrive at the identity and structure of medicine, as that which is intrinsic to the nature of medicine itself. In this sense, medicine is purpose-oriented and value-laden and a moral enterprise whose ethics is determined by the internal morality intrinsic to the goals of the medical profession. These traits of medicine identified in the first chapter paved a way for the subsequent chapters to discuss the good or the goal of medicine and the knowledge and ethics required for its practice. This chapter ascertains that the many problems and challenges of modern medicine can be resolved through philosophical interventions and guide.

The second chapter of the dissertation presented the true face and identity of medicine as found in the physician-patient relationship and responded to the fundamental question about why medicine exists and the kind of knowledge that is needed for its practice. It affirmed that medicine exists for the good of the patient, which is good health. Since the phenomena of illness and health that characterize the nature of the phenomenology of the clinical encounter make medicine a value-laden enterprise, therefore, it implies that the practice of the medical profession requires both scientific and moral competency. It serves to demonstrate Pellegrino's proposal that both scientific and ethical knowledge and formation are prerequisites for an effective medical profession. Both the moral and technical competencies enable the medical

practitioner to discover and persistently, pursue or attain the intrinsic goals of medicine and to respond effectively to the problems and complexities of the physician-patient relationship, introduced by the capabilities of medicine and the pluralism of values in a democratic society, which are accentuated by the depersonalization inherent in the growing institutionalization, and bureaucratization of the medical encounter. Pellegrino identifies in this chapter the types of good sought in medical practice by demonstrating the hierarchy of the patient's good. He highlighted also the role of clinical judgement in medical practice.

The third and the fourth chapter presented a virtue-based or humanistic approach to medical profession and adopts it as an indispensable tool for effective medical practice and for curbing the medical challenges and dilemmas in modern medicine. The virtue ethics as adopted in this thesis is integral as Pellegrino attempts to bring to harmony both the principle and virtue-based approaches in medical morality. It incorporates the different ethical theories into one to form a formidable ethic for medical practice. The medical virtues work harmoniously and enable the virtuous physician to always act rightly for the patient's good. Certain virtues are discussed as possible virtues for medical practice and the virtuous physician is featured as a moral beacon in medical practice. The role of conscience and its indispensability in moral judgement is also featured in this chapter in relation to medical ethics.

Every knowledge is meant to impact positively on the society in which it is used. The findings and results of this investigation have both theoretical and practical relevance. The piece of knowledge gathered from the dissertation will be useful in many ways for equipping healthcare students with the intellectual skills to reflect upon the values, challenges, and expectations of medicine which they hope to practice someday. It will also help physicians and other healthcare professionals who cannot practice effectively without falling back to the philosophy of medicine as a crucial subject. This work seeks to help physicians navigate the plurality of models available for medical knowledge and practice with philosophical analysis.

More so, the study is essential to both bioethicists, philosophers, and public health policy-making organizations and agencies in their respective domains. Thus, it is believed that the study will be a resource on which to draw a framework of thinking, especially for potential and professional medical workers, the government, and the public in the current debates on medical matters. The interchange of views between physicians, philosophers, nurses, and psychologists recorded in this work about the subject matter provides a broader approach and knowledge to interdisciplinary medical issues. We hope that this study affords the reader, whether nonprofessional, physician, or philosopher, a helpful perspective on the process of knowing what occurs in medical practice at a more profound and critical level.

We have noted earlier that academic philosophy does not seem to produce practical solutions, theories, or accumulated knowledge in the way we would expect other applied disciplines to do. Instead, it guides and shows people how to live and function rationally. Our aim at this concluding stage is to state the ways in which the results of this research offer solutions to both the theoretical and practical problems, challenges and dilemmas in medicine, and to other problems ranging from medicine's abuses, its politicization, industrialization, commercialization, and commodification caused by medical practitioners and academicians alike.

The significance of this work, which has both theoretical and practical dimensions, is connected with some basic conclusions and discoveries that are very fundamental to the practice of medicine. The researcher reaffirms Pellegrino's claim that philosophy is at the heart of the medical practice. Pellegrino characterizes the philosophy of medicine as inseparable, inevitable and indispensable for understanding the profound meaning of medicine and for its effective practice. He sees philosophy as providing an adequate explanation to those philosophical concepts and terms in medicine that practical sciences cannot explain. This re-echoes that philosophy studies reality in its most profound and most radical aspect and seeks its ultimate causes, while particular sciences study specific aspects of reality and seek more immediate and proximate causes.

Another result in this research establishes the character of knowledge for problem solving. The purpose of responding to the three philosophical questions of the dilemmas of modern medicine, namely: What is it? What is it for? What knowledge does it need, is to help to solve the numerous professional, moral, scientific, technological problems and many other vexing issues in modern medicine. Pellegrino believed strongly that a teleological-based ethic of the healing profession could serve as a basis of moral authority to solve professional problems in an era of widespread moral and social pluralism like ours.

More so, a strong point that appears in this research maintains that the ends of medicine are intrinsically defined from the nature of medicine itself. These ends derive from that which is more fundamental than medicine itself, namely, the universal human experience of illness. These ends make medicine what it is. The universality of this experience, its existence beyond time, place, history or culture- and the need of the sick person for care, cure, help and healing that- gives medicine its essential character. This notion stands the test of time where medicine and health care have been commodified, commercialized and politicized by social constructs. Clinical medicine represents the ideal identity and structure of medicine. For Pellegrino, clinical medicine is the face -to-face interaction between the physician and the patient in the

clinical encounter is the true face of medicine. It is also the foundation, the starting, melting or mega point for a philosophy of medicine, and it is the root of medical morality. When the knowledge and skills of any of the other branches of medicine are used to heal a particular person, then the ends of that branch fuse with the ends of clinical medicine. Clinical encounter gives medicine its true definition and it also both the patient and physicians a sense of identity to their professional roles. It sets physicians apart from others by publicly declaring them as devoted to healing the sick. It as well sets the patient apart from the healthy people as one who is vulnerable and in special need. In addition, personhood takes a special place in clinical medicine since every constitution and endeavor aims at the realization and good of the human person.

This investigation reveals that medicine is a moral enterprise because it deals with moral agents who go into a relationship that goes with moral responsibility. It also deals with the sensitive themes of human life, health and diseases and other bioethical issues. Thus, moral and technical competencies are indispensable to medical practice, though they serve from different perspectives but aim at the patient's good. This fusion between moral and skill demonstrates the integrality of Pellegrino's theory of medicine. Pellegrino amalgamates the technical and moral competencies into an integral basis for a holistic understanding of medicine by insisting that the practice of medicine does not consist primarily in the application of science, nor in a philosophical account of central concepts such as disease or the social and political understanding of what it means to be ill.

Virtues are indispensable and inevitable in medical practice**.** The dissertation submits to Edmund Pellegrino's proposal that virtues are necessary for solving the problems of modern medicine. Pellegrino persistently and consistently adhered to the view that a teleological-based ethic of medicine is the only tenable basis for the ethics of the healing profession as a whole. Pellegrino held that virtues are necessary for effective professional roles discharge and went further to define the virtuous physician as a paragon of morality in the society since virtue distinguishes virtuous persons from others.

Faith and Reason are inseparable. One final but exciting result of this research is the marriage of the theological and philosophical dimension of viewing reality and for practicing medicine effectively. He uses this same methodology to marry the theological and philosophical conceptions of the human person. He fuses the philosophical anthropology's definition of the dignity of the human person as a rational being with theological anthropology on the person as created in the likeness and image of God. He places the human person at the center of every medical activity and considers human nature as the norm in medical ethics. He does this in

order to promote and give a profound understanding of the dignity of the human person in medical practice. By fusing faith and reason, Pellegrino brings to light the fact that there are two wings to understand reality and demonstrates a meeting point between human understanding and divine understanding. Today more than ever, there is a need for dialogue between science and religion to enhance their collaborative coexistence and avoid the clash that sometimes emerges between them. Scientists and theologians must dialogue with one another to scholarly achieve unity and professional integrity.

Pellegrino's approach to the problem of clinical medicine, as examined in this work, is open to several other possible solutions and systems. He is open-minded to the views of other scholars and considers their views as equally important for building a comprehensive philosophy of medicine. Pellegrino's works point to new domains of inquiry that can become the object of further investigation within the school of the philosophy of medicine. I mentioned at the beginning that this investigation is neither an attempt to provide a final word concerning the various debates surrounding the problem of the meaning and practice of modern medicine nor an attempt to prove that Pellegrino's model of medicine is complete in itself. This investigation does not claim to offer a final solution to the problems in medical practice. It stimulates the need to promote a socially responsible science in an era in which the practice of scientific medicine is ethically challenged by numerous dilemmas that confront professionals and scientists on their way to delivering socially accountable scientific projects. These dilemmas continue to multiply on the basis that science, in particular medicine, is a value-laden enterprise. This value-laden nature of professional activities continues to increase the demand for philosophical interventions in professional roles.

Having examined the results of my research, it becomes evident that these results invite further scholarly inquiry and development of the subject matter. The researcher is keen on adding further input to the already existing scholarly contributions and steps on the status of modern medicine and to open new horizons to which further research on this theme can be directed. The investigation aims to sting to consciousness, stimulate, and provoke further research on the need to apply philosophical theories and findings into other forms of healthcare professional roles in medicine, such as nursing, pharmacology, and a host of others.

This approach can, in the broader sense be extended to other investigations on the identity and structure of other professional enterprises such as engineering, business, architecture, priesthood, law, and politics. It opens boundaries for further investigations in other fields of study. The role of philosophy as studied in this research can be applied to other professions in such a manner that it suits their goals and practices. Medicine itself is a broad

field. This investigation only adopted a philosophical approach to clinical medicine and on the physician-patient relationship issues, which culminates in the clinical encounter. This was described in this investigation as the center and summit of medical activities.

Further study and research in this field could be centered on the role of particular sciences in aiding philosophical investigations. It is possible to study the position and the necessity of specific sciences in promoting philosophical studies. For instance, we have in this dissertation examined how philosophy shapes and purifies the profession of health. It is possible also to undertake a survey of how medical facts serve as a tool for philosophical investigation and enterprise. This dissertation is just a tiny window that opens to further research possibilities.

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