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# The end of medicine. Part 2. The doctor-patient teleology

## *El fin de la medicina. Parte 2. La teleología médico-paciente*

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**ABSTRACT**

This work discusses the end of medicine from the doctor-patient relationship. It addresses the notion of medicine as art in the classical era and the current epistemological differences between art and science, the disagreements between the end or ends of medicine, both social and personal, the confusion between applications as means or ends, the complications arising from opposing perspectives and the difficulties the physician faces opposite the patient's desires and demands.

***RESUMEN***

*En este trabajo se discute el fin de la medicina desde la relación médico-paciente. Trata la noción de medicina como arte en la época clásica y las diferencias epistemológicas actuales entre arte y ciencia, los desacuerdos entre el fin o los fines de la medicina, tanto sociales como personales, la confusión entre las aplicaciones médicas como medios o fines, las complicaciones que surgen de perspectivas opuestas y las dificultades que el médico enfrenta ante los deseos y exigencias del paciente.*

## INTRODUCTION

In response to (not so) recent transformations in medical practice resulting from technological changes, but also social changes and a not at all "new paradigm" between service providers and users, a relevant question is whether the end or ends of medicine have changed as well. In this paradigm, the physician's functions have diluted from the traditional doctor-patient relationship to being at the service of different enterprises (state institutions, private hospitals, consortiums) as an official in a position or as an employee. The purposes of medicine evolve, following social processes in which the practice is immersed, as a result of increased medical knowledge, improved technologies, and changes in cultural and moral expectations. But purposes and ends are not exactly synonymous. Different purposes serve as means to different ends.

This calls for scrutiny of the factors that have confronted 'traditional' medical ethics, internal to medicine, with contemporary ethics, external to it, of the perspectives of the patient in the face of the promises that they believe medicine offers, of the challenge of physicians in the face of the demands of the patients and of conflicts of interest these factors represent.

I will address first the old discussion about whether medicine is an art or a science, then, given the difficulty of delimiting its boundaries, its end or ends, as well as the confusion between applications, means, and ends. I will then deal with some of the complications that arise from opposing perspectives on the good of the patient, to conclude with a reflection on the situation of the physician in the face of the demands of the patient and the alternatives they can adopt.

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## ART OR SCIENCE

To be able to speak of an end we must first define what we want to elucidate, the commonplace that refers to medicine as a science and as an art, often taken for granted. This preliminary reflection will bring us closer to understanding the role of the physician in practice. In the classical, Hippocratic version, the art refers to the practice of medicine as a whole, all the knowledge, all the skills personally taught from mentor to student. In contemporary medicine, it is possible to reflect on two lines of thought.

As a science, medicine tends to the general, to the explanation of phenomena and causal processes of diseases. Its theoretical and practical aspects aim to increase knowledge of the functions and dysfunctions of the organism in the light of different theories and to design diagnostic and therapeutic technologies. In this sense, clinical physicians —although not researchers— consider medicine a transfer of scientific knowledge to practice. They are instructed in the biomedical paradigm and do what in everyday language is called "scientific medicine". However, the justifications for this paradigm, from the end of the 19th century until its zenith in the mid-20th, have been challenged, among other reasons because human interaction and interpretation during the clinical encounter cannot be validated by a biomedical method.[1-3]

Not only is the golden age over,[4] but the reputation of the physician, particularly the surgeon, has been undermined. This in part because of failures of their own, depersonalization, incompetence, recklessness, negligence, and overcharging. But also by alternative medicines, "natural" therapies, and unsupported miracles that patients seek as a counterweight to the biomedical perspective.

There is then a hiatus of information between scientific research, evidence (considered in different ways) and medical practice, where the physician must interpret the uncertainty, the biological variability of each patient, who also brings their own "theoretical load". It is here that the art of medicine comes in. It is in the tension between these two ways of assuming that end or ends of medicine can be thought. But let us first look at the second one, the art of medicine in its contemporary version.

The art of medicine is more complicated than the word suggests when associated with the literary, plastic, and performing arts, among others. It also has a negative connotation, since doctors themselves have included in this category everything that is not science in the strict sense. The biomedical paradigm excludes values, affections, advice, comfort, and the placebo effect of the physician's behavior. It favors rationality and scientific knowledge, diagnosis through technology, hard facts, and objective coldness as a sign of efficiency and situational control. These characteristics contributed to the golden age of medicine in the first half of the 20th century and up to, say, the 1970s. Art, on the other hand, emerges from human interaction, includes tacit knowledge based on experience, different heuristics, and practical reasoning, which combine the medical and non-medical knowledge of clinical care.[2,3,5]

Art is the application of that knowledge to the particular, not to the general; it is the ability to establish diagnosis, treatment, and prognosis in the specific context of each patient.[6] It is clinical judgment, the process of deciphering and deciding; it is not theoretical but practical, it can be taught and learned through experience. The art of medicine is an aesthetic activity, that is, based on perceptions and interpretations of those perceptions. It requires a different kind of rationality from the biomedical perspective. It requires medical and non-medical knowledge. It is not experimental but empirical, without the negative charge the term 'empirical' has accumulated. Art develops during the clinical encounter and, very importantly, it does not include only successes. Like science, art is fallible.

## TELOS, END OR ENDS OF MEDICINE

Medicine has no clearly defined boundaries and it is impossible to isolate it from practices and goals shared by other related disciplines. Other activities and practices are also elements of medicine. Given they aim at the population's welfare, talking about medicine can be as broad as the health sciences, different kinds of knowledge, and techniques for the prevention

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and eradication of diseases and the well-being of populations. These interdisciplinary sciences include, for example, epidemiology and public health. Several practices aim at health and disease prevention that cannot be considered medicine in a strict sense. Similarly, health and disease prevention are not restricted to medicine alone.

The term 'teleology', since Aristotle, implies the idea of a process (efficient cause) that is directed to its end, until it is finished (final cause). In the sense of intention, the end is its fulfillment, its purpose, and objective, but also its limit.[7] Already in the classical period, during the fifth and fourth centuries B.C., Greek medicine had an internal teleology. An example of this is the text *Epidemics I*, in which the so-called Hippocratic triangle is mentioned; "[t]he art has three factors, the disease, the patient, the physician. In the same text, immediately afterward, the role of the physician is established "[t]he physician is the servant of the art. So internal was the teleology, that the last line of that paragraph even establishes the duty of the patient; "[t]he patient must co-operate with the physician in combating the disease".[8]

In the contemporary context, teleology is internal when it refers to intentional individual behavior. According to Edmund Pellegrino the intrinsic purpose of medicine is personal, derived from the clinical encounter between physician and patient, "whose lived worlds intersect at the moment of clinical truth, [...] in which the actions of individual physicians and the health system converge, the moment when an afflicted human being seeks the help of a physician".[9-12] Following his argument, teleology is external when it refers to a more or less consensual functional organization, which aims at goals identified through deliberative processes, as happens in an institution.[13] In this way, the institutional goals of medicine change socially and historically.

Despite the above dissection, it is obvious that any human being, as a patient, is an individual. They see themselves as unique; what happens to them happens only to them. However, although Pellegrino's notion is correct, it needs to be updated twenty or thirty years later. It is one thing for the intrinsic end of medicine to be given from the clinical encounter and quite another that the patient's perspective alone determines the end or ends. Pellegrino's "clinical truth" is not unique, it may be a different one for the physician. The encounter is between two. I will address this issue in the following sections.

## APPLICATIONS, MEANS OR ENDS?

Separating applications and practices from medical purposes is problematic, especially when they are used and carried out with lax, ill-considered criteria, in the form of habits or tacit knowledge (such as riding a bicycle) which, being automatic, do not require reflection. Cases that require the doctor to put purposes first and exclude available applications, sometimes because of novelty, or the practices of the majority of the profession, sometimes out of habit, are problematic. In such cases, decisions may be counter-intuitive.

It is often not possible to stipulate which data we can believe to be true, confirmed in our perception by what seems to be one same evidence, in the absence of other observable events during the process of a disease.[14] In the philosophy of science, this circumstance is known as underdetermination.[15] It is also possible when faced with a "medical" problem, not to have enough elements to determine the effect that our actions will have between the social (public and impersonal) and the individual (private and personal), between disease as a process and the person who suffers it as a person. The end of medicine is underdetermined by a limited understanding of some biological phenomena in a patient at a given time and —from a biotechnological point of view— by the scope and potentially harmful effects of available technologies and therapies, but socially and psychologically by the desires and hopes of the sick, by the efforts of doctors and by customary practices.

The problem can be even more difficult when we talk about means. The doctor may not be clear about the reasons for separating ends from means, especially in controversial cases where differences in values come into play. It may even be impossible for them to turn around the legal and regulatory debate on the

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appropriate use of medical means by appealing to their moral reasoning. Applications, means, practices, norms, and laws depend, in the end, on consensus between institutions and professional associations, on differences that always converge insufficiently despite the best efforts, which often adapt poorly to the situation of the individual patient.

Laws bind all physicians equally, moral standards do not; they are personal. Sometimes a physician cannot do what is required when the patient does not agree. Worse still, it is sometimes impossible to do what the patient rightly demands. It is then that one resorts to medical standards and discovers some things *should* but cannot be done, for legal, social, psychological, and moral reasons.[16] From the perspective of a patient's morality, internal teleology makes sense. However, from the norms of good practice, the physician reaches dead ends regarding the good and evil of a patient, because *their* personal beliefs, which are irreconcilable with those of that patient, are affected.

## SOME COMPLICATIONS

The physician is certainly responsible for the well-being of the patient, overall when in a vulnerable state. However, in contemporary societies –so pluralistic–, patients' preferences, worldviews, and religious practices collide with the physician's own beliefs about the best interests of a given patient. The so-called "supremacy of the good of the patient" undoubtedly includes a good judgment about what the physician considers to be good medicine and a good life. But the supremacy of the patient's good is not the same as the patient's *perception* of their good. Such confusion is a source of complications in the increasingly delicate and tenuous doctor-patient relationship, and it cannot simply be assumed that physicians are obliged to do whatever patients define as good.[17]

The questions arising from this situation are not simple either. Some are ambiguous, may have more than one answer or none at all, and some answers may contradict others. By way of example, why refuse the beliefs and wishes of patients? If the patient is the one who is sick, why not please them in everything they ask and believe is good for them? Because it is against the *end* of medicine? Is acting on a continuum from meeting the needs to please the wishes of a patient moral or immoral? According to whom, the patient or the physician? What is the place of the physician's moral system in the doctor-patient relationship? What is their alternative?

It is always possible that a patient will have preferences which are questionable for the physician, and that they may even violate the physician's moral principles. The good perceived by the patient cannot be taken as a moral law in itself, nor can it force a physician to be morally neutral or to abandon their beliefs and convictions. The physician cannot be used as a mere means to an end; they have their beliefs, autonomy, professional integrity, and decorum.

It is easy to dissolve the problem by saying that the doctor-patient relationship is, must, or should be a dialogue. That is a worn-out proverb. The real problem is that these dialogues often turn into disputes because no common minimum can be identified nor shared to overcome a disagreement. The dialogue between doctor and patient comes about less and less. Both see in this 'dialogue-dispute' the reflection of themselves, of the end of medicine as their wishes, expectations, and illusions. This dialogue, which is ideally said should exist, may be no more than a soliloquy that reveals the need to thoroughly review one's own beliefs before those of others, the need for careful self-analysis before condemnation. Worse still, such a thorough review of beliefs will not be done by the patient. The doctor is once again in that alley, from which they can only emerge by letting their patients "solve their dilemma", "choose according to their autonomy" and wander from colleague to colleague while their time runs out.

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## A FINAL, MORE REALISTIC REFLECTION

One of the great problems of contemporary medicine is that purposes, means, and ends collide or elude each other, there is no standard for their proper use, they rarely line

up and rarely coincide. Purposes and means are a curtain that makes it difficult to see the real scenario of the patient, their life, and biography put into play by the disease, what the patient considers, in a broad and strict sense, the end of their life. Controversies and disputes over normative (social) and moral (personal) purposes are unlikely to end. There is no general methodology that can resolve the moral dilemmas that result from such collisions.

In this not at all "new paradigm" of institutional care between service providers and users, flies the shadow of Contractualism. If the patient, making use of their autonomy, gives informed consent, almost everything can be done. Doctors and patients become diluted in a contractual and impersonal mass. Despite everything, the encounter between doctor and patient, the crux of the profession, remains one-to-one, and it is necessary to maintain the commitment to the patient opposite the massive, popular influences of post-modernity, however irrational they may be.

Ethics is not about doing good without looking to whom. The sacrifice of the benefactor up to professional suicide is a false notion of morality. There is something often discussed loudly in the guild, but rarely written. The doctor can find himself at a clear disadvantage when facing the demands of a patient and their context, the hospital, and the administrative apparatus in which they operate and carry out their profession. They can be manipulated or morally coerced by the vulnerability of the sick, consciously used *ad hoc*. Very importantly, the end of medicine and the ends of the patient may well not be the same. The patient may wish to make their own ends prevail over those of their doctor, overlooking the genuine interests of the doctor as a professional and a person. The physician may then decide not to become involved with that patient, and could not be blamed for exercising their autonomy. With one difference, while the patient may leave, without further ado, the physician is still obliged not to abandon the patient until they expressly so declare. The physician may then show the patient a way out, by recommending them to the attention of a colleague.

It is also worth reflecting on a matter not minor, medicine is not the same, nor is it practiced as it was in the 5th century B.C. Neither the Hippocratic precepts governed all of ancient Greece nor is it possible to take them by the book today, out of our historical context. It is true that in *Epidemics I,* it is declared that the doctor is the "servant of the art" and in good measure, they are at the service of the patients to alleviate their suffering. But in our contemporary context, physicians cannot simply be required to be the servants of the sick. To be a servant of the art means exercising it with mastery and prudence, but the *primum non nocere* can also be applied in the opposite sense "first, do no harm *to yourself*". The end of medicine resides in the clinical encounter, but this does not mean that it turns into the end of the doctor's career.

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