Comments on "Patient Morality"

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What is a good patient? William Ruddick finds the current models unsatisfactory. Each is based, he claims, on an imperfect analogy with a non-medical relationship. After exposing the inadequacies of the "child," "consumer," "client" and "soldier" models, Ruddick proposes the "coach and athlete" model and defends it by "elaborating and testing" its application to two cases. At the end of his paper, Ruddick acknowledges that his "metaphorical" methodology is neither conclusive in itself nor demonstratively superior to other methods. It offers, he says, an "escape" from "ruts of language and thought" into which medical ethics has fallen.

Ruddick seems to be right that in contemporary medical ethics the emphasis has been on the virtues of physicians and the rights of patients; there has been an unhealthy neglect of systematic treatment of the virtues of a good patient. Before scrutinizing Ruddick's analogies, it may be worthwhile to set out for comparison one of the "rutted" approaches, an approach that simply assigns duties to doctors and patients. Although most of the virtues of a person in general will also be virtues of a person as patient, there is a hierarchy of virtues that seems to follow from the very concept of a patient, or from what being a patient adds to the concept of being a person. Furthermore, even when the same word is used, the virtues of a person in general are somewhat different when the person is a patient. The essential hierarchy of virtues that follow from the concept of a patient may be outlined briefly.

Since patients are people, a good patient is a person acting well within regard to injury or disease. How ought one act with regard to injury or disease? Since injuries and diseases often have harmful consequences, one acts well in this regard if one acts so as to minimize the harmful consequences. But injuries and diseases can often have some beneficial consequences, so a good patient is a person who acts so as to maximize the good consequences of injury and disease.

Although there are important conceptual differences between injury and disease, what they have in common is that they are, or produce or might produce, a physical disability. A physical disability is an inability to act as one wills. For various reasons, historical, scientific and cultural, some episodes are classified as disease or injury even though they are not and do not have the potential to become disabilities. As long as a person is not disabled and is not threatened with disability there is no need for medical concern.
A person who cannot walk but has no desire or need to walk is no more disabled than a person who cannot fly but has no need or desire to fly or a person who cannot read minds but has no need or desire to read minds. Admittedly, there is a degree of stipulation in this account of disability. But if disability is not defined as “the absence of needed abilities,” then the account of what it is to be a good patient will be both more complex and more speculative.2

The first virtue of a patient, therefore, is self-knowledge. A person cannot know how to act as a patient unless he or she knows that there is something he or she needs or wants to do but cannot do for some physical reason.

What, in general, a person needs or what it is good to desire are questions for economics and general ethics, respectively, and go beyond the scope of these comments.

But the virtue of self-knowledge as applied to patients should not be confused with the virtue of self-knowledge in general. There are many aspects of one’s self of which it is not wrong to remain ignorant. Whatever the general virtue of self-knowledge amounts to, there is nothing wrong with forgetting the trivial details of what was done last week or being ignorant of whether with training and practice one has the ability to pass the CPA examination or to climb Mt. Everest. There is something wrong with ignoring physical disabilities that interfere with what one otherwise wants to do. The kind of self-knowledge demanded of patients is only vaguely related to the kind of self-knowledge required by Socrates.

Assuming that one has legitimate needs or desires that one cannot fulfill for some physical reason, the appropriate response is, of course, to seek help.

The physician, one who is expert in physic, is a person who is concerned about and has knowledge regarding physical disability. Once a person has determined that he or she has a physical disability, the next step is to seek help. Physicians or doctors are those who provide such help. If the first virtue of a patient is self-knowledge, the knowledge that one is disabled, the second virtue is willingness to seek and accept help. The physician or doctor is one whose job it is to provide help for the disabled; so the first virtue of a physician is to be a helper, to know how and when to help.

There are many ways to help the disabled. So many skills are involved in the general area of medicine that no one person can be expected to have more than a few of these skills. To avoid the terminological confusion that results from referring to doctors, physicians, nurses, medical technicians, aides, consultants, and so forth, it is convenient, in philosophical discourse, to have a generic term for all those who help the disabled. Fortunately, such a generic term already exists. A medic is one who makes it his or her business to help the disabled directly. A good medic is a person who knows how and when to help the disabled (directly) and who specializes in providing such help.
As is usually the case with personal deficiencies and forms of help, there is need for a broker, an intermediary, an agent or a match-maker whose job it is to match desires and needs with the supply of services. There is no reason in the nature of things why the patient and the medic cannot determine the appropriate match privately through a negotiation process. But since there is always the possibility that ignorance, greed, self-deception, conflict of interests, distraction or some other obstacle will inhibit such a pairing of medic and patient, a third party can often be of service. Such a third party is not strictly necessary and may only make matters worse. If a medic and a patient cannot find each other or cannot agree to co-operate then they need a third party; but both have to agree on the skill and trustworthiness of the third party. If an infinite regress is to be avoided, at some point medic and patient will have to agree on a mediator between them, or a mediator between their respective mediators. To raise the discussion to a philosophical level, reference may be made to a medical administrator. Depending on the circumstances, this administrator may be a single person, a group, an interlocking chain, an institution, or even merely hypothetical. Another virtue of both medic and patient, is obedience to the authority of an administrator or referee.

That it is a virtue to obey a "medical administrator" may seem to be a bizarre claim. What reason could there be to elevate a medical administrator to this status? The argument is that certainly a patient as a disabled person in need of help should surrender some autonomy. There is no reason to assume that the medic must be obeyed; medicas are not authorities in the political sense. So, it is argued, obedience is owed to that person or process that it rightly assumed to match patient and medic correctly. What is called an "administrator" here may actually be an administrator, but it could just as well be someone from another profession or just an administrative process between medic and patient. The essential point is that the patient does owe obedience to someone, but medical qualifications alone are insufficient in determining who should be obeyed. Hence, a non-medical (administrative) process should be used. A good patient does not treat himself nor does he manage his own treatment, but neither does a good patient simply obey any medic who happens along. A good patient obeys the medic assigned by an appropriate administrative process.

When there is complete trust and confidence between medic and patient, the medic and the patient can cooperatively manage their relationship and eliminate the middle man. But if the character or knowledge of either is insufficient, they need to find some third person to serve as a referee. Both the patient and the medic must obey the referee if the treatment is to be successful. Whatever the significance of the expression "doctor's orders" and apart from dramatic refusals to accept treatment, the basic point is that obedience to the medic is no
virtue in itself. The virtue is to obey whoever knows best. It is just as much a vice for patients to disregard or interfere with legitimate medical help as it is for them to credulously accept whatever is offered under the guise of medicine. To summarize, the virtues of a patient are self-knowledge, a willingness to seek and accept help, and obedience to whoever knows best regarding the help needed. The virtues of a medic are knowing how and when to help the disabled and obedience to whoever knows best, the referee.

In his paper, "Patient Morality: Compliance, Perseverance and Other Athletic Virtues," William Ruddick contributes to the discovery and elaboration of the virtues of a good patient. The main strategy of "Patient Morality" is to introduce and evaluate certain analogies between the medic/patient relationship and other human relationships. These analogies are the central concern of the paper, but more often than not the patient seems to get lost in the process. What, specifically, do analogies with business, with sport, with family life or with war tell us about medicine?

Analogies come in many forms and are used for many purposes: to illustrate, to persuade, to explain and to discover. No reason is given in the paper why the analogies suggested should help to illuminate the medic/patient relationship. Why, for example, shouldn't the medic/patient relation be used to illuminate other relations, rather than vice versa? Analogies can be discussed and elaborated with some profit even if for no particular purpose. It is impossible, however, to evaluate an analogy without determining what the analogy is for and what it is intended to show. Since an analogy is a comparison of two unlike things there will always be an enormous number of differences (dianalogies). But which of these differences makes a difference in rejecting the analogy as a poor one? Until we know the purpose of the analogy, there is no way to say.

Why, one might ask, is the analogy of friend/friend simply ignored, even though it is the most ancient and, some would claim, the most appropriate model for the medic/patient relationship.

The military analogy is only sketched and its terms are not clear. A military analogy that would seem least open to di-analogy is

\[
\begin{align*}
\text{medic} & : \text{patient} \quad : \text{death} \\
\text{soldier} & : \text{battlefield} \quad : \text{enemy}
\end{align*}
\]

but the analogy Ruddick seems to have in mind is

\[
\begin{align*}
\text{medic} & : \text{patient} \quad : \text{death} \\
\text{officer} & : \text{soldiers} \quad : \text{enemy}
\end{align*}
\]

Furthermore, the paper uncritically assumes that disease and injury can be grouped together with death as if there were
no important differences. The medic, it seems, leads or assists
the patient in fighting death, disease or injury. Is this an
analogy worth pursuing? Some would argue that the role of the
medic is to help the patient not fight but live with disability
and minimize its harm.

Putting aside questions about the exact nature of the
enemy, there seems no escaping the almost literal truth that in
much of medicine the patient's body is a battlefield. To carry
this analogy no further, however, leaves the patient with a
wholly passive role. The patient's body is a battlefield;
i.e., a war is being fought in his homeland, but the patient
(as person, not just body) is to some extent a participant in
the struggle. In these terms, the physician need not be as
Ruddick seems to assume, an officer. The medic might better be
conceived as an ally. Specifically, a foreign ally whose own
homeland is not now the scene of battle. This military analogy
is free of all the criticisms Ruddick has of the military
analogy.

The analogy with a coach is more difficult to evaluate
because there are no general rules for coaching. Certainly a
major disanalogy is that a coach cannot touch his athlete
during the contest (in most sports), but orthodox western
medicine has been strongly interventionist. In spite of all
that Ruddick says in its favor, the analogy between a physician
and a coach is open to at least as great an objection as
Ruddick is able to raise against the analogies that he rejects.
The consumer and client models, Ruddick says, ask too much of
the patient, while the child and soldier models ask too much of
the physician. Does the coach model really fare any better
than those based on clients and soldiers? After all, there are
times, and not just a few, when the patient has to play an
almost wholly passive role relative to the medic. Certainly
this is true when the patient is unconscious, but it is also
ture for a host of medical procedures performed on conscious
patients. The coach, on the other hand, no matter how active
he wants to be, has to work through the abilities, attitudes
and understanding of his athletes. Furthermore, in any organ­
ized sport the coach is necessarily in the role of an author­
ity, even if a less coercive one than that of a military
commander. The medic, by contrast, has, or should have,
authority not because of his position or role, but simply
because of technical competence. To what degree the medic
should take charge depends, or should depend, on who is best
able to do what needs to be done. There is nothing like this
kind of relationship in athletics. The coach is not free to do
for the less skilled or ambitious athletes what others do for
themselves. The coach gets them all into a condition where
they can play for themselves—or does not let them play.

The relationship just described seems very much like that
of military allies, especially when the resources available to
each differ greatly. Some allies, those with few resources may
have to play a largely passive or subservient role. How much
each ally should do depends much more on what they are actually able to do than what is spelled out in a treaty. Given a common goal, there is little choice but for those who are beat able to do something to take charge. Who takes charge of what will depend on the circumstances of each. That is not saying very much, but it may be about all we can say in general about the relative responsibilities of ally and ally or doctor and patient.

The virtues of a person and of a patient are sometimes used for determining who should get help. It is one thing to claim that patients have certain responsibilities; it is another to say that medical care will be provided only if those responsibilities are discharged satisfactorily.

What Ruddick calls (without endorsing) the "moral means" test for treatment or public funds, is open to a fundamental philosophical objection. It is hard to see how someone can be at fault in bringing on a condition that requires medical attention. The way people live certainly affects their health, but part of the medical job is to help people to overcome the ignorance and foolishness of unhealthy habits. To deny health care on the grounds that the illness or injury was in effect self-inflicted is to assume that in a cool hour people decided to harm themselves. Even when this certainly is the case, the usual inference would be that the patient needs psychiatric attention as well. The only clear case of a justified denial of medical treatment on moral grounds would seem to be when, contrary to the patient's claims, treatment is not medically indicated. Apart from issues of distributive justice, it seems wrong to seek unneeded medical care even though it is not necessarily wrong to seek and accept other unneeded personal services. For reasons that are not altogether clear, people who go to the barber every week because they enjoy the barber's company even though they do not need a haircut that often have not acted badly. But those who seek and accept medical treatment that they do not need have acted badly.

The other moral grounds for denying medical treatment assume a scarcity of medical resources. Under conditions of scarcity, someone will be denied needed treatment, the only question is who. Given that there is a shortage there is reason to deny treatment to those who because of their own lack of cooperation are unlikely to benefit from the treatment. But this is essentially a kind of triage and only incidentally involves a moral judgment.

It is also possible that in times of scarcity some people will be denied treatment on the grounds that they do not merit such care. Is there really no relevant difference between, say, a victim of a knife attack and his assailant? Suppose they both need immediate treatment and that a choice must be made. Surely those who are at fault cannot be allowed to preempt treatment for their victims. To accept this type of discrimination under conditions of scarcity is not at all to
endorse withholding medical treatment as a means of reforming another person's life or as a way of punishing them for bad behavior.\(^5\)

Both the athletic and the war analogies are especially appropriate when applied to the dying patient. Unlike disease and injury that can be avoided or cured, death is inevitable. Death can be accepted or delayed, but it cannot be fought with. Any injury or disease should be avoided or treated (if possible) but only a premature death is to be contested. Here sports are a real help. Once it is certain that an athletic contest will be lost what is important is “ending well”; finishing the contest in a sportsmanlike way and avoiding exhaustion or injury that might jeopardize a future performance. So too with war. Once defeat is certain, the virtues of a soldier change because the goal is now a negotiated surrender rather than victory. The advocates of hospice care for the dying are in accord with these analogies, but so are those who submit to non-therapeutic treatment in the interests of research that may benefit others.

Analogies are not necessarily intellectual playthings. When two cases of ethical concern are shown to be similar in some ways, the burden is on those who would judge them differently to point to some relevant difference. For this reason, Ruddick is perhaps overly modest about the import of his argument. If, on the other hand, there are enough relevant differences between the coach/athlete relationship and the doctor/patient relationship, then the analogy has no persuasive force and is at best merely suggestive.

NOTES


2. Von Wright discusses what counts as medical goodness for those who do not have normal wants and needs in *Varieties of Goodness*, pp. 58-59.

3. Indeed, “the conception of the good of man on the basis of medical analogies is characteristic of the ethics and
political philosophy of Plato. The idea is profound and, I think, basically sound." Von Wright, Varieties of Goodness, p. 61.


5. Jonathan Glover admits that it is "intuitively preposterous" never to discriminate between criminals and their victims, but he goes on to observe that "this is by no means the same as allowing general character evaluations by doctors treating natural disorders," Causing Death and Saving Lives (Harmondsworth: Penguin, 1977), p. 226.