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Culture, Sustainability, and Medicine in the Twenty-first Century. Re-grounding the Focus of Medicine Amidst the Current "Global Systemic Shift" and the Forces of the Market: Elements for a Contemporary Social Philosophy of Medicine

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Abstract This article analyzes the role and the status of medicine within the "post-modern" culture(s) of the West. As we know, culture is a major factor that influences the perception, the interpretation, and the expectations toward medicine, medical institutions, medical politics, and the persons involved with them. When culture changes, the social construct called "medicine" changes. Today, the Western condition of "post-modernity" finds itself in a process of rapid change due to the "global systemic shift" that is manifesting since a couple of years within all four main systemic logics and discoursive patterns of Western societies: in culture, religion, politics, and economics. In this situation, the article tries to elaborate on crucial questions about how a contemporary social philosophy of medicine can be delineated within the current "global systemic shift" and what some consequences and perspectives could be. It pleas for an integrative philosophy of medicine which has to strive to re-integrate the "(de) constructivist" patterns of "nominalistic" post-modern thought (dedicated primarily to freedom and equality) with the "idealistic" patterns of "realistic" neo-humanism (dedicated primarily to the "essence" of human dignity and the possibility of

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intersubjective morality). Only the institution of a balanced "subjective-objective" paradigm can ensure medicine its appropriate place, role, and status within our rapidly changing society.

Keywords Culture · Sustainability · Medicine · Global systemic shift · Market · Social philosophy of medicine

Worlds in Collision: Culture, the Current "Global Systemic Shift", and Medicine

As most social, cultural, economic, and political observers agree, Western culture is currently involved in a process of rapid development and change. An increasing number of structural transformations and crises, most of them related to a heightened degree of uncertainty and aperture, seem to be pushing forward the so far "post-modern" and "neo-liberalist" paradigm of Western culture in as much a dialectical as in an ambivalent manner. Given that most of these developments can be viewed as (perhaps equivalently) productive and destructive, they symptomatically shape an age of inter- and trans-disciplinary discourse that is frequently considered to represent "post-ethical" cultural growth (Benedikter 2005; Benedikter et al. 2008, 2009).

Part of this growth involves the evolution of "paradigmatic building stones" as ideological pillars of the post-September 11 epoch. This ideology challenges—and at times may integrate—one-sided "post-modern" nominalism with diverse forms of pre-modern "substantialism" and "realism".

We maintain that any critical analysis of the contemporary history of ideas must engage both sides of this paradigmatic tension when addressing the challenges of technological progress (i.e., the so-called "technological threshold"), population growth (the "demographic challenge(s)"), and progressive worldwide cultural interweavement (i.e., the "global cultural meltdown"). This analysis must acknowledge that society at-large is changing, as part of overall, somewhat *inbuilt* systemic developments within Western civilization, that are decisively related to, and may subserve what has been termed "global systemic shift".

This shift involves the four typological spheres of (1) economics, (2) politics, (3) culture, and (4) religion, in an increasingly interactive process of both dissonance and interdependency, and it is likely that this will create major changes in Western society, as components of what Max Weber (2001) regarded to be the re-formulation of "…(western) systemic identity with worldwide consequences".

To be sure, these effects will be instantiated throughout various domains of society, and we contend that this has—and likely will continue to—significantly impact the European-Western paradigm of medicine. Thus, the traditions of medicine that have been built upon more than 2,800 years of history will be increasingly subject to trends of commercialization within a market-model environment and the ethical, legal, and broadly social pressures, problems, and possibilities that these trends incur. Yet, if this socio-economic and political trajectory is inevitable, how could (or should) the humanitarian dimensions of medicine be preserved so as to sustain best use of new and novel technologies and maintain morally sound conduct as an individual and public good? The fundamental question seems to be: What is medicine in—and beyond—this post-September 11 epoch of global systemic shift? Is there a culturally sustainable vision for medicine, and if there is, what does such a vision concretely entail for the future paradigm of medicine in a potential age of "post-postmodernity"?

Medicine's "Character" in the Cultural Epoch of Post-September 11 Global Systemic Shift

Medicine, as classically defined, is the science and art of treating and healing those persons suffering disease, injury, and/or illness. As so defined, the focus of medicine is on the patient, literally as "…the one who suffers", but explicating what medicine is, and should be, and defining the articulation of this practice have become increasingly problematic as a consequence of changing socio-cultural interpretations and constructs in post-September 11 epoch.

In many ways, medicine reflects culture and thus can assume the *Zeitgeist* of the cultural milieu (Giordano et al. 2009). Over the past 100 years, the post-industrial rise in technology and the pervasiveness of the market model have become predominant socio-cultural forces. This has resulted in a value-ladenness which maintains the technological imperatives of objectivity, speed, and efficiency, as well as the market orientation toward profit. While technological developments in basic and clinical research as applied to medicine have resulted in enhanced diagnosis, eradication of particular diseases, and extension of the lifespan, technocentricism has also fostered a derision of subjectivity, and the growing market-model mentality has allowed the spread of a consumerist ethos and ethic to medicine. This combined technophilic/market agenda establishes medicine as a form of applied biotechnology, and as such manifests premises that advocate the need for certainty, compel the ever-increasing use of, and reliance upon technology as ends (unto themselves), while situating the provision and attainment of these ends within a commodified, profit-oriented economic model.

Equally influential upon medicine have been the effects of what has been called the post-modern agenda, involving both the de-construction of worldviews, narratives, and metaphysical orientations, and a general prevalence of moral skepticism. The positive attributes of post-modernism might include the development of a broader understanding of complex systems and the infusion of an information-age mindset that has allowed an expanded medical epistemology. However, post-modern skepticism denies any internal construct of medicine as moral enterprise, situating the role and meaning of medicine within contexts defined solely by society and culture, thus disavowing a philosophical worldview inherent to medicine, and the validity of any normative morality. Contemporary society tends to reject any possibility of overarching morality and norms and has placed an emphasis on an abjectly liberal pluralism and commodity values of time and cost. Taken together, these social forces threaten the traditional norms of the profession and practice of medicine. We argue that much is lost when medicine is wholly subordinated to socio-cultural influence: medicine becomes totemized, and its philosophical premises can be re-construed within purely social contexts and thus subject to capricious economic and political agendas.

We believe that we are poised at a philosophical and pragmatic crossroads between medicine's past, present, and future. Has medicine become applied biotechnology that exists as a commodity in a market-governed society? If this is the case, what of the humanitarian premises that established the ends of medicine as an interpersonal endeavor? Do such premises represent anachronisms or meaningless meta-narratives, and is the possibility of a telic, internal morality of medicine therefore unrealistic or invalid in a technocentric, market-driven world culture? In light of such questions, we posit that contemporary medicine is facing a crisis of identity and meaning. To be sure, we do not advocate a return to a pre-technologic mindset; to do so would be atavistic and would refute

the benefits of modern medicine. However, we must also recognize and retain the humanism of medicine so as to inform and respond to technological, epistemological, and social realities of a changing world.

Thus, we opine that it is important not just to examine what medicine is but to use this essential knowledge as a pedestal upon which to ground medicine as a intellectual and moral enterprise in society. To do this, we shall begin by examining the ends of medicine and the philosophical premises that both define and reflect such ends. If these ends reflect a philosophy of medicine, we must (1) determine if this philosophy is sound and valid; (2) address the epistemic, anthropologic, and ethical dimensions of this philosophy; (3) examine the applications of ethics that are instantiated upon this philosophy; and (4) address the realistic possibilities and limitations of such ethics in socio-cultural contexts.

What Medicine is: The Reality of a Teleological Definition

Before exploring the characteristics of the telos of medicine, it is worth noting that a number of authors offer static and objective philosophies of medicine that are not subject to the changes in scientific advance and yet are not based on the ends of the medical mission. Pellegrino (1983) provides a useful overview and critique of these attempts, and so here, it will suffice to mention only the pattern of deficiency from which he believes they tend to suffer. Somewhat reductionist theories, such as those of Donald Seldin and George Engel, while providing the frameworks in which medicine operates (e.g., the bio-psychosocial model) do not answer the question at hand, viz. "what is medicine?" Although they identify domains of knowledge that participate in medicine, they do not get at the heart of the nature of the clinical encounter. These theories provide (biological, psychological, and social) components of medicine without adequately characterizing medicine as a discipline unto itself. In contrast, phenomenological theories like that of Mark Siegler capture the spirit of the clinical encounter, but nonetheless rely too heavily on the patient's subjective understanding of her disease. Siegler's concept of the negotiation between the patient and the physician explicates the process involved in treatment of disease, but still tells us little about the nature of medicine.

In a departure from the foundations of these philosophies of medicine, the World Health Organization (WHO 1948) grounds its mission in a distinct telos: health. It is unclear whether the preamble to its constitution speaks only to the aim of the Organization or to the aim of the medical mission. Regardless of whether or not it represents a deliberate formulation of a philosophy of medicine, it is a proposal that we should take seriously. A philosophy of medicine based on the achievement of high levels of health by all people certainly helps us to better understand the aim of the medical mission, but we must also ask what is meant by "health". Leon Kass (1981) argues for one particular notion of health and includes in his definition the "…well-working of the organism as a whole" (p. 18). This stands in contrast to the conception of health of WHO, which speaks to total well-being and which includes calls for somewhat vaguely defined notions of justice, equality, informed opinion, and optimized childhood development (WHO 1948). Kass restricts the scope of health, thereby resulting in a more manageable concept for the purpose of the discipline of medicine rather than for all healing missions; however, the boundaries of wholeness are not distinct enough to know exactly when a patient's malady falls under the auspices of medicine rather than under other disciplines such as psychology, sociology, or spirituality (Pellegrino 1983).

What becomes more clearly evident is that any definition of health seeks to acknowledge the complex, integrative nature of persons and the need for multiple dimensions of

medicine to sustain such integrity. This fortifies the need for medicine to address both disease and illness through preventive, curative, and palliative/healing practices. However, unlike the more objective nature of disease, the facts and implications of illness tend to be more subjectively manifested and expressed in the person that is the patient. Interestingly, it may be that the very success of technological developments in medicine—namely decreased disease mortality, with a concomitant rise in illness morbidity as a result of chronic disease in an extended lifespan—has led to the contemporary conundrum in healthcare. The provision of a technologically based medicine within a market-driven system is poorly suited to address and provide the "health" needs of a longer-lived population with chronic disease and longitudinal illness.

Thus, although health seems to be a necessary element of a philosophy of medicine, it alone does not suffice for discernment of the essence of medicine. For if health is a property of an integrated well-being of a "whole person", then it becomes evident that the personal impact of disease and illness (not simply its objective characteristics) is critical to the act(s) of providing health care. Medicine, and in particular clinical medicine, is not adequately characterized without recognition of the action of a physician towards the person that is the patient, for the purpose of providing right and good treatment (Pellegrino 1983). There is historical support for a philosophy of medicine tied closely to the physician-patient relationship (Ten Have 1998). The tradition that recognizes the patient as the subject of medical action(s) performed by a physician also viewed the patient as an irreducible person. From this perspective, a philosophy of medicine is well served by identifying the telos of medicine and the experience and interests of the patient. Specifically, the notion of health as a telos of medicine is of most use when taken in context of the physician-patient encounter. If we take it as such, we expand the telos of medicine to include not just curing but also the act(s) of healing.

The essence of medicine at which we have arrived—medicine as a humanitarian act of healing within the context of the physician-patient relationship—is presented in its most developed form in the work of Edmund Pellegrino. Pellegrino contends first that there exists a discernable philosophy of medicine that is distinct from the philosophy of science, and second, that it consists of more than goals and purposes of medicine (Pellegrino 2001a). A philosophy of medicine must be informed by content, method, concepts, and presuppositions of medicine (Pellegrino 1998). When medicine is examined from this essentialist perspective, we see that the clinical encounter defines the discipline and makes possible further epistemological and ethical conclusions. In this way, the clinical relationship is the starting point for a philosophy of medicine.

Admittedly, this is a somewhat rudimentary presentation of Pellegrino's position, but it is enough for our purposes to recognize the clinical nature of medicine and also the emphasis on the patient's good that is explicit to this relationship. All activities have an aim towards which they are directed, and the aim of medicine is the restoration of health to the sick patient (Pellegrino 2001a). The impossibility in some cases of restoring health does not diminish the importance of medicine in achieving an even more proximate end: the promotion of the patient's good. Only through a careful examination of the different aspects of this good can medicine faithfully and successfully fulfill its end, whether it be restoration of health or humane care at the end of life.

By introducing the concept of the patient's good, it might appear as if this philosophy suffers from a certain degree of subjectivity and ambiguity, especially amidst a remarkable plurality of values and moral theories that specify the good in very different ways. If the end of medicine is fluid and subjective, then we might ask whether a philosophy of medicine is possible at all. So, we turn now to the questions of whether such a philosophy is valid and whether it can be sustained in the modern world thus described.

A Philosophy of Medicine

There has been considerable debate as to whether a philosophy of medicine actually exists or should exist. Caplan (1992) has stated that a philosophy of medicine does not make any claim to issues that are unique from science or the humanities, has not contributed a historically relevant body of information or discourse (beyond that which is addressed through a philosophy of science or the humanities), and thus does not have the properties and characteristics of an independent field. However, Caplan has failed to recognize the contributions of the Polish School (i.e., Biegannski, Chalubinski, Fleck, and Kramsztyk) during the nineteenth and early to mid-twentieth century (Lowy 1990) and subsequent work of several others on problems specific to medical practice. This latter point speaks to the need for, and substantiation of a philosophy of medicine not merely as a discussion of the philosophical issues that arise in medicine, but as "…a critical reflection on the matter of medicine—on the content, method, concepts and presuppositions peculiar to medicine *as* medicine—philosophy of medicine seeks to understand what medicine is and what sets it apart from other disciplines and from philosophy itself"(Pellegrino 1998, p. 325–326). In other words, the philosophy of medicine defines medicine according to its reality.

Any philosophy must encompass metaphysical, epistemological, anthropological, and ethical domains; Ten Have (2000) has noted that such traditions are meaningfully preserved in contemporary approaches to a philosophy of medicine. Several scholars have a common allegiance to the philosophy of medicine as a distinct field of inquiry, while maintaining a definitive perspective that speaks to a particular philosophical domain. The philosophy of medicine as described by Engelhardt (1986a, b) is broadly epistemological and represents 'medicalized" logic, axiology, aesthetics, ethics, and metaphysics that affect intellect, society, and the interpersonal interactions within medicine as a culture within cultures. Engelhardt seeks to explore how medicine derives knowledge, and uses such knowledge in the relationships between patients, physicians, and society. Engelhardt adopts a somewhat Kantian perspective and views the patient as a "noumenal ego", establishing a deontological libertarian ethics that focuses upon restoration and maintenance of the autonomy of the patient as the philosophically defined ends of medicine. In this way, the medical relationship is viewed as a contract between autonomous, moral agents. We recognize the importance of a deontology to medicine, but we tend to see such a deontic foundation as more applicable to the professional structure of medicine (Giordano 2007; Maricich and Giordano 2007). It is important to note that this structure of physician and patient in relationship is indeed enacted between moral agents, but this relationship is asymmetrical in multiple dimensions of power and ability (e.g., wellness, knowledge, and skill). Thus, even in a strict Kantian sense, the obligation for self-acknowledgment of moral responsibility toward vulnerable others (as a basis of moral character) is evident, and this speaks to the importance of medical relationship and an agent-based ethic.

This interpersonal nature of the patient-physician relationship, the structure(s) and demands of that relationship, and the position of medicine as a humanitarian endeavor in society are the foci of philosophical approaches that uphold the anthropologic tradition. The work of Alfred Tauber (1999) is deeply committed to explicating the anthropologic dimensions of medicine—and securing this to an equally important ethics. Grounded in the philosophy of Levinas, Tauber's perspective of the philosophy of medicine is one that defines the intellectual, pragmatic, and moral grounds of the medical relationship as being dedicated to a meaningful "other". Philosophically, the humanistic interaction between patient and physician is understood a priori and compels responsibility, empathy,

reciprocity, and trust. In this way, Tauber's philosophy of medicine rests upon the meaningful nature of persons in relation (i.e., the anthropologic domain) to establish and support instantiated ethical dimensions.

The ethical domain is built upon and incorporates both epistemic and anthropologic dimensions and, in many ways, is most closely tied to questions of what medicine is and what medicine should be. Certainly, both Engelhardt and Tauber's philosophical contributions to the ethics of medicine are important, although a detailed discussion of the strengths and limitations of each are beyond the scope of this paper. Briefly, each has applied a particular philosophically based normative ethic to medicine (i.e., Engelhardt's reliance upon Kantian deontology, Tauber's Levinasian orientation) and in so doing "fit" a philosophical formulation to medicine. While these approaches may provide premises upon which to structure goals and/or ends, they seek to define medicine somewhat extrinsically, and do not account for "…the realities, phenomena, and data of medicine itself…to define what medicine is ontologically and morally" (Pellegrino 1998; p. 328). Thus, they fail to access the "essence" of medicine. In contrast, Pellegrino (1983) uses the phenomenologic method of eidetic reduction to reveal that the essence of medicine lies in the elements of the clinical relationship, namely: (1) the fact of illness, (2) the act of profession, and (3) the act of medicine. From this starting point, the philosophical premises that establish medicine as an act of healing can reflect that (1) patients are persons made vulnerable by illness who seek the physician for care and healing; (2) the medical relationship is one of discrepancies of knowledge, health, and therefore power; (3) the physician's act of profession is an authentic declaration of fiduciary beneficence to steward knowledge and utilize skill and power to heal; and (4) such knowledge, skill, and power will be used in the best interest of the patient. In its essentialist approach, Pellegrino's philosophy of medicine clearly embraces epistemologic and anthropologic traditions and identifies the internal ethical dimensions that define the *telos* of medicine to be the provision of care that is both technically sound and morally good.

Thus, the essence of medicine may define the premises and ends that are inherent to its practice as a science, art, and act of therapeutic and moral agency. In this way, medicine does not provide health; it provides care that is needed to individuals in society, and therefore affords a social good, but if globalization has resulted in an admixture of values and polyglot ethical discourse, how can we determine the nature of "good" care, and how can we adhere to ends that are consistent with such a definition? What moral affirmations could provide ethical guidance for contemporary medicine? Rules and principles are useful, but in light of the intricacies of patient care in a pluralist environment, how are these to be derived, established, and ordered so as to maximize good? And if market forces continue to impinge upon medicine (including the use of medical technology), what moral grounds will insulate the probity of the medical relationship against liberal consumerism and commodification to enable the articulation of care that is consistent with the *telos* and philosophy of medicine?

One Philosophy, Which Ethic?

Alasdair MacIntyre (1980) recognizes that a relevant feature of our predominantly liberal moral philosophy is a lack of foundation. As a result of the contemporary project to describe and order our moral intuitions, we seem to have abandoned our search for a moral foothold. Furthermore, attempts to ground moral philosophy in rationality are often met with skepticism and disinterest. Evidence of this trend is endemic in bioethics

literature and is found in assertions against the plausibility of systems of "common morality". Gert et al. (1997) posit a public system of morality rooted in general acceptance of the moral principle of non-maleficence. Beauchamp and Childress's principlist system (2001) also is justified by an appeal to our commonly held intuitions about what comprises good medical care, but we must be cautious against interpreting or establishing common moral precepts—particularly in the case of altruistic acts of medicine—as purely social constructs. This reliance on variable social determination is indicative of the current trend in the philosophy of medicine: society invents rather than discovers the world with regard to both the essence of medicine and to the normative forces that dictate good clinical action.

Social construction of medicine is seen most clearly in attempts to subordinate medicine to a larger societal end. Arguments of this type maintain that the state of medical care and the general quality of societal life requires a reexamination of our priorities and of our expectations with regard to the utility of medicine (Callahan and Parens 1995). The medical treatment of individuals should be seen as part of the loftier goal of improvement of societal welfare (Callahan 1990). In advancing this point, Callahan nonetheless emphasizes the importance of returning medicine to its traditional goals of non-abandonment and individual care, which are certainly consistent with the philosophy of medicine that we advocate here. However, for Callahan, these goods are imposed on medicine from society, which implies that medicine is plastic and relative to the society in which it is practiced. This perspective stands in contrast to teleological descriptions of medicine and to objective standards of health, however broad they may be, that are advocated by the WHO and Kass.

Pellegrino (2001a, b) counters similar social constructivist arguments made by Kevin Wildes (2001). Pellegrino's arguments hinge greatly on those mentioned above regarding the need for a discernable philosophy of medicine that is grounded in the clinical encounter. A realist account of medicine—what medicine *is* rather than what happens in medicine—does not change with changing circumstances, in different locations, or with different people. Medicine has definite boundaries that are relatively refractory to revision despite changes in moral intuitions or social priorities. If the needs of society require something of medicine that exceeds its telos, that specific function should not be construed as a manifestation of medicine in the first place.

There is good reason to insist on such a teleological formulation of medicine. Social formulations of medicine entail social moral boundaries on the physicians who are the agents of action in the clinical encounter. This sort of boundary typically resembles moral contractarianism of one of two types. One is grounded in assumptions of self-interest and rational agreement explicit in the theory of David Gauthier (1986). If the principle of minimax relative concession were at work in the clinical setting, however, we can only imagine the degradation of beneficent and just care when these interests conflict with personal interests of the physician. A more realistic contractarianism is the one advocated by Robert Veatch (1981), who argues for a triple contract in which all members of (1) society, (2) society and the profession, and (3) physicians and patients forge relationships and agreements that are amenable to all parties involved. Although he disposes with Gauthier's unpalatable assumptions, Veatch still allows for a certain degree of relativity with regard to the operational function of medicine. In his theory, two societies might construct similar basic contracts and yet arrive at contrasting versions of societal-professional agreement, and allow for further variation under physician-patient contracts. Without teleologically defined ends of medicine, we leave medical ethics up to societies

and individuals and provide little or no constraint on self-interest or other damaging influences such as commodification.

It is easy to see how a teleological philosophy of medicine insulates the medical discipline from social constructivism. Rather than appealing to a common conception of medicine in order to define its goals and its ethic, the teleological approach determines what medicine means regardless of which culture, country, or society one is being treated as a patient. The telos of medicine is the same everywhere, and therefore appropriate action within the field is the same while acknowledging variance(s) due to cultural custom. Like ethics and etiquette, drawing the line between ethics and custom can be difficult in some circumstances; nonetheless, a distinction can and should be made. Furthermore, a teleological philosophy of medicine does not preclude a contractarian medical ethic, but any level of contract involving the profession of medicine or individual physicians must be constrained by telos of medicine—specifically, by the ethics internal to the clinical encounter.

The Intersection of Two Worlds: Morality and the Patient and Physician in Community

To appreciate the special relationship of the clinical encounter, it is important to assume the proper perspective. Quite simply, the clinical encounter is not an exchange of two persons of equal or equivalent power—rather it is by its nature a relationship of knowledge and power differences and vulnerability. As Tauber (1999) has noted, it is a unique circumstance of relational selves, each defined ontologically and pragmatically. The world of the patient is one of loss: loss of health, loss of control and familiarity of the lived body and life world, and loss of particular intimate boundaries so as to disclose the bodily and emotional manifestations of illness to the physician (Zaner 1988). The world of the patient is also one of insecurity punctuated by questions of "what is wrong?", "what will happen to me?", and "can the physician help me?". The patient is sick; illness is the existential reality that drives the patient to seek care, and in so doing, defines the world of the physician. For without the patient, the physician cannot exercise the profession or practice of healing and caring. It is because of the relationship with the patient that the physician acts as steward of knowledge, arbiter of power, and bears the responsibilities of therapeutic and moral agency. In the world of the clinical encounter, patient and physician exist in community, literally an enjoinment of persons with common interests: both patient and physician are committed (albeit form differing positions of power) to the provision of care as a fundamental good that is attainable (as a practice) within the relationship. The needs, desires, and expectations of the relationship are what determine its moral values. In this way, the medical relationship is a contained moral community, and as any community, maintains a commonality of moral values (Clouser and Gert 2004). The foundational moral value of the relationship is that the physician acts in the best interest of the patient, and the patient trusts the physician to do so in ways that not only to provide treatment that is technically right but to render care that is good for each patient as an individual person. Such morality is constructed "from the ground up", according to the phenomenal nature of the community of patient and physician, focal to the needs of the patient, and "grounded in the relationship of healing" (Pellegrino and Thomasma 1988, p. 130). Thus, the *value desiderata* of this community reflect the intersection of the life worlds of patient and physician. We argue that such common moral affirmations and values are not only possible, they are the reality of the medical relationship, and as such reflect its internal morality.

The Internal Morality of Medicine

As already mentioned, a socially constructed concept of medicine does not entail a medical ethic in which the patient's good is focal. It is true that one of many possible constructions could lead to a conception of medicine that looks very much like the one we have argued for here, even with an emphasis on the patient's good. However, such a conception of medicine is subject to modifications with the changing social and political climate. The method employed by such a philosophy of medicine differs greatly from a philosophy in which an objective and static telos is discovered rather than invented. For this latter philosophy, the patient's good is always primary because that is what is specified by medicine's telos (Pellegrino 2001b). In this light, a medical ethic derived from Pellegrino's teleological conception of medicine is internal to medicine; that is, it derives from the essence of nature rather than from some domain, i.e., society, law, or politics, that is external to medicine.

Veatch (2001) eloquently contests the possibility of arriving at morality internal to any practice, including medicine. He makes three arguments to this effect. First, he notes that medicine has more than one role and therefore more than one telos. These ends differ enough in kind such that different moralities can derive from each. He contends that the possibility of multiple moralities of medicine is incoherent, or at least impractical for formulation of a medical ethic. Second, determining the single end or even multiple ends of medicine is too difficult to be useful. Especially in the clinical encounter, an internist cannot easily decide on the best course of action by merely contemplating the end(s) of medicine. Third, Veatch makes the epistemological point that the ends of medicine come from outside of the practice. He writes, "it is impossible to know the goal of medical intervention in any case, without asking the nonmedical question of what the end of human living and flourishing is" (Veatch 2001, p. 636).

Pellegrino's contentions address many of Veatch's concerns. Pellegrino (2001a) acknowledges the existence of other uses of medical knowledge and their independent ends, but the internal dimensions of medicine are qualified by a restriction to the clinical encounter and apply (only) to cases of sick patients who seek treatment from a physician. Extension of this philosophy to more 'cosmetic' and enhancing aspects of "medical" care merely for societal good is a misapplication. Undoubtedly, there will be difficulty in drawing the line between treatment and non-treatment/enhancement, but we maintain that this practical problem does not detract from the theoretical distinction. This response segues nicely to the response to the second question; that is, that difficulty in the determination of the ends of medicine does not preclude the existence of such ends and the moral principles that follow.

Veatch's third argument maintains that any attempt to establish a definition of health or of healing necessarily involves understanding how the society construes the good life and human flourishing. Therefore, he concludes, ends and morality are external to medicine. We believe that Veatch's argument is valid enough—even in a classical construct of medicine, a primary imperative is first seeking to do "good" for the patient, and that may change as a consequence of time and society, but, what does not change is the primacy of doing good, and we feel that here, Veatch may be in error by attributing to society the ability to define health and healing. Health and healing have their own objective end: the good of the patient in terms of physical, emotional, and spiritual well-being (Pellegrino 2001b). While different aspects of the good will include a subjective element unique to each patient, this does not entail that medical morality is externally determined. Certainly, medicine is not an end in itself, and certainly, it serves the greater end of health whose good is the patient's well-

being. Morality is not external to medicine because these precepts are not reached solely through determining the best use of medical knowledge for society. Instead, they are reached through recognition of the facts that clinical medicine necessarily involves a sick person seeking the help of a physician; medicine is a means to achieving the end of healing and health of the sick person, and the optimal end of healing is the good of the patient, not the good of society. But, as noted, medicine does not exist in a vacuum, so if we are to affirm that (1) there is a morality internal to medicine, (2) this morality reflects the intersectional values of patient and physician in relation, and (3) this defines and insulates the integrity of medicine in and across societies and cultures, then we must ask what *is* the role of medicine in society?

Medicine in Society

In spite of a substantial discourse and strong claims for the social construction of medicine (Callahan 1990; Callahan and Parens 1995), we argue that absolute constructivism denies the ontological and moral significance of the medical relationship. In the extreme, such constructivism could lead to a social definition of medicine, de-construct the fiduciary of care, and add political imperatives to exploit the biopolitics of medical power. This is not simply a caveat in the face of a potentially de-humanized, technocratic, or market-driven tentative future, but an exhortation to learn from the past—we need only to look at National Socialist medicine as a realistic reminder of the possibilities that absolute social constructivism could incur.

Similarly, we impugn the liberal consumerist model that establishes medicine to be a solely contractual enterprise within the market model and situates physicians as "providers" and patients as "clients" on the following grounds. First, the moral framework of medicine is in sharp contrast to the economic framework of the market. The problem here is that if the market subordinates the moral fabric of medicine, it will crowd out the legitimate non-market sphere of healthcare. Such absolutization will threaten extant values of altruism that are fundamental to medicine. Second, such altruism is based upon the fact (and reality) that disease and illness do not operate in market dynamics. Thus, while economic and social status can affect health, other non-socio-economic factors (such as genetic-phenotypic interactions, and injury) are equally viable determinants of sickness and wellness. By virtue, medicine is dedicated to providing care to those who need and seek it. This does not fit into the competitive paradigm of the market model that out of necessity generates "winners" and "losers". Having "losers" would imply non-provision of care which is frankly incompatible with the ends of medicine. Third, the market works if participants act in a rational, self-interested mode, and if everyone is self-capable. Clearly, this is not the case given the vulnerability and unequal circumstances, knowledge, and abilities incurred by the patient's fact of illness. Fourth, the patient as consumer creates moral and legal strains upon the medical relationship and may create conflict in the definition and validity of patient and physician autonomy. As Jerome Kassirer has noted, "…market-driven health care creates conflicts that threaten…professionalism…increasingly physicians will be forced to choose between the best interests of their patients and their own self-interest".

How then can medicine survive in a market-driven world that is most likely not to soon change? Daniel Callahan calls for a "…softened, humane working of the market" to be applied to accommodate the business-aspects of medicine, in which some of the market's more useful tactics and strategies may be adopted, while others (such as its anthropological values, ethos, and ethics) are not. While we recognize that there is

indeed such a business aspect to medicine, we firmly note that medicine is not business: its ends differ (Giordano 2007; Giordano and Neale 2007), but if medicine is to serve a social good within a society that is market-based, it must maintain core foundations that preserve its extra-market values and capacities. As William F. May (2003) has noted, medicine is not the *only* social good and thus competes with others. However, this is not grounds for commodification; recognizing that medicine provides a social good does not define it as instrumental. We agree with May that the fundamental good that medicine provides is defined by and articulated through its practice, and thus reflect its *telos* and core philosophical premises. As such, medicine cannot, and should not, simply bow to social contexts in conformity.

Society is becoming increasingly pluralized and is influenced by technological imperatives and market incentives (as well as post-modern philosophical ambiguities). Contemporary culture has divergent value systems and constructs of rationality and morality. No single ethical system can possibly accommodate such diversity. Thus, while we have argued elsewhere for the importance of moral and intellectual virtues in medicine (Giordano 2006a, b), we reiterate that such agent-based virtue ethics cannot and should not exclude other ethical theories, systems, and approaches. Yet, the use of any ethical system in the absence of a core philosophy to provide a moral grounding will be necessarily hollow and subject to bastardization. To be sure, such a philosophy assumes social importance in that it defines and formalizes the essence, premises, and *telos* of medicine amidst other social forces. Perhaps then, the success of medicine's future role lies in the philosophical roots of its past.

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