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Veatch Hates Hippocrates

by John D. Lantos

Robert Veatch hates Hippocrates. In his new book, he gleefully imagines that Hippocratic physicians and all they believe will end up on “the ash heap of history” (p. 34). His animus towards all things Hippocratic is absolute and impassioned. He makes more references to Hippocrates—a total of thirty-three—than to all other physicians combined. He finds the Hippocratic ethic “esoteric, potent, and dangerous” (p. 35), “of dubious merit,” and “downright offensive” (both on p. 12).

Why such umbrage? In Veatch’s mind, Hippocrates and his followers commit two unforgivable sins. First, they claim to know what is best for their patients. Worse, they feel a moral obligation to act on that knowledge. Veatch, by contrast, is quite sure that physicians almost never know what is best for patients. He writes, “We now know that even in the ideal case, physicians generally have no basis for knowing what would benefit their patients” (p. 35). And again, “There no longer exists any basis for presuming that the clinician can even guess at what is in the overall best interest of the patient” (p. 92). The Veatchian physician rejects the pretensions of old-school physicians who presume to know that it is bad to smoke or that it is good to exercise. All such opinions are based on values, not facts, and the post-Hippocratic physician should not bring values into her interactions with patients. Only the patient’s values should be considered. Puzzlingly, there do not seem to be any facts, either, in

Veatch’s medical world. Since every so-called fact inevitably and inherently incorporates values, postmodern physicians must forswear those as well.

To thrive in Veatch’s world, patients would not only need to have well-developed value systems. They would need to be able to communicate their values on the occasion of each and every clinical decision because they would not—and *should* not—trust their doctors to assume anything whatsoever about those values. One imagines the following dialogue between a Veatchian patient and her ideal physician:

Doctor: I notice that you are coughing, that you are using your intercostal muscles when you breathe, and that you are breathing sixty times per minute. I don’t want to impose my values upon you. How do you value that state of being?

Patient: (gasping for air) I . . . can’t . . . breathe . . .

Doctor: Can’t breathe? Well, for me, that would be unpleasant, but I happen to value oxygenation. I wouldn’t want to impose those values on you. I could give you a little oxygen. Or I could give you morphine. Or I could give you a nebulizer treatment. Which would you prefer?

Patient: I just . . . want something that . . . will make me feel . . . better . . .

Doctor: I want to help. Tell me—what does “better” mean to you?

Most contemporary American physicians are not so reluctant to bring their own values to the clinical encounter. At their core, they believe that health is good, disease is bad, and they can often tell one from the other. Just as Veatch charges, they act as if such assumptions are central to their profession and create a moral obligation to act.

So which will it be in the twenty-first century? Will Veatch’s assertions carry the day? His opponents are no slouches. In his paper, “Regarding the End of Medicine and the Pursuit of Health,” Leon Kass writes that “Health is a natural standard or norm—not a moral norm, not a ‘value’ as opposed to a ‘fact.’” He believes this natural standard defines the goals of medicine: “Health and only health is the doctor’s proper business.” Kass warns that “the movement towards consumer control of medicine runs the risk of transforming the physician into a mere public servant, into a technician or helper for hire.” The transformation he fears is the future Veatch pursues.

Edmund Pellegrino also rejects Veatch’s view of the paternalistic physician. His focus is less on the ends of medicine and more on the physician’s virtues—as defined by the profession, not the patients. In “Professionalism, Profession, and the Virtues of the Good Physician,” he writes that the ideal physician “enters a moral community whose defining purpose is to respond to and to advance the welfare of patients—those who are ill, who are in need of help, healing or relief of suffering, pain or disability.” The Pellegrinian physician determines what is required of him not by asking the patient but by learning the virtues of the medical profession.

Mark Siegler presents a possible compromise between these positions on the

Patient, Heal Thyself: How the “New Medicine” Puts the Patient in Charge. By Robert M. Veatch. Oxford University Press, 2008. 304 pages. Hardcover. \$29.95.

one hand and Veatch's on the other. In his paper, "Searching for Moral Certainty: The Doctor-Patient Accommodation," Siegler describes a case in which a woman with asthma sees two different doctors. One sets out to achieve maximum control of her respiratory symptoms. He succeeds, but she is on so many medications that her life is a misery. Another doctor suggests that she cut back on medications, even knowing that it might lead to some exacerbation of her asthma symptoms, but also hoping that it will decrease the intolerable side effects. She and the second doctor reach an "accommodation" that includes both of their ideas about health, disease, and its various treatments. In this model, the physician accommodates the values of the patient as Veatch wants, but as in the models of Kass and Pellegrino, she remains a moral agent, seeking to discern and encourage the patient toward what she believes is the best possible decision.

Veatch's model would not seem to allow for such moral agency on the physician's part, except perhaps as a commitment to competence and full disclosure of medical options. Yet in a telling admission, Veatch acknowledges that "There surely are at least a few situations in which the doctor really does know best. If those situations, no matter how rare, can be identified, then the ethic of doing what is best for the patient would not only permit, but would actually require, that the physician act on his or her judgment" (p. 49). Alas, Veatch doesn't specify what those rare situations might be. He also suggests that "the physician should not be forced to violate unjustly his or her own conscience" (p. 62), but again, doesn't elaborate or give examples of what situations might constitute "unjust" violations. Given his otherwise relentless critique of the moral agency of physicians, these exceptions beg for explication. How might such situations be identified? What limits might be applied to a physician's conscientious decisions? And what sorts of moral arguments might ethically justify such physician behavior in a world where no treatment is ever medically indicated or medically necessary (as he claims on p. 254)?

These debates are about the very nature of the medical profession, the moral ideals of the doctor-patient relationship, and the future we seek. They offer very different views of what doctors ought to be and do, and of what patients need and want. Patients are not at all what they used to be. In the old days, they were sick—diagnosed by doctors based upon worrisome symptoms that led them to believe they needed help from a trusted advisor and healer. Patients who are sick are compromised in their ability to advocate for themselves and to act autonomously. Today, patients are often diagnosed with a disease through routine screening tests before they have symptoms, so they are less compromised by illness and more able to think and act as they always have. And between acutely ill patients and those diagnosed without symptoms, there is a wide range of intermediate states, each demanding a different response from both doctors and patients.

Given the way that the practice of medicine and the experience of illness have changed, debates about autonomy versus paternalism seem dated. Medical information has become more complex and, at the same time, more democratized. Patients surf the Internet and read medical journals. Soon they will have access to detailed information about their own genetic makeups. A patient's task will not be to resist her doctor's values in order to live by her own. Instead, it will be to make good decisions based on complex personal and epidemiologic data. The doctor's task will be to help the patient understand this data and risk-benefit tradeoffs and to make the best decision based on the medical facts and the patient's values. The subtle nuances of communication between them—their choice of words, vocal tone, gestures, and facial expressions—will shape the decision and thus be where the ethical action is. That shaping process may lead to surprising results.

Joseph Carozza, a cardiologist, and Frank Sellke, a cardiac surgeon, wrote in the *Journal of the American Medical Association's* "Clinical Crossroads" series of a patient who had to decide between bypass surgery and different sorts of stents.

Her doctors—two cardiologists and a cardiac surgeon—presented the data and made recommendations but acknowledged that the decision was the patient's. She was quoted in the article as saying, "I must decide. Either I go in for bypass surgery or I have a stent put into that artery and open it up. . . . You don't make a decision about this very easily. You wake up at 4:00 in the morning, and you ponder and you worry." The surgeon and one of the cardiologists recommended bypass surgery as the "treatment of choice." The patient nevertheless chose a stent. Why? "I had to go with what I felt in my heart. Not so much what was being told to me. . . . I had to do what I felt was the right thing for me. As this surgeon said, the decision was 100% mine." Three years later, *JAMA* published a follow-up. The patient was doing fine. The surgeon was not surprised, yet he continued to say that "CABG surgery remains the treatment of choice for patients with significant left main disease."

Such essays illustrate how a doctor can evaluate a patient, discuss treatment options, make recommendations, listen to the patient's values, allow her to make a choice, respect that choice, still believe that the facts of the situation make one treatment option preferable to another, and not really understand how the patient arrived at a treatment decision. Patients today are clearly empowered to make decisions in ways that they never were before. That does not, however, change the doctor's obligation to evaluate the patient's condition and make recommendations about the preferable treatment. What has changed is the expectation that those recommendations will be uncritically followed. This presents new dilemmas. Doctors need to learn new communication and negotiation skills. Patients need to learn how to use their new power to accept, reject, or modify doctors' recommendations. Both changes shift the moral foundation of clinical encounters, but they don't obliterate it. For doctors, Hippocratic commitment to the patient's health, rather than the patient's desires, is more necessary than ever—but not sufficient.