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BIOETHICS AND VIRTUE ETHICS: AN INTERVIEW WITH DR. EDMUND D. PELLEGRINO

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ABSTRACT

Edmund D. Pellegrino, professor emeritus of Medicine and Medical Ethics at the Kennedy Institute of Ethics of Georgetown University, is one of the most influential and outstanding bioethicists in North America and worldwide. In this interview, we tried to know Dr. Pellegrino's opinion on various topics of bioethics, virtue ethics and philosophy of medicine.

KEY-WORDS: Edmund D. Pellegrino, Bioethics, Virtue ethics, Philosophy of Medicine.

RESUMO

Edmund D. Pellegrino, professor emérito de Medicina e Ética Médica do Kennedy Institute of Ethics da Universidade de Georgetown, é um dos autores mais influentes e representativos da bioética norte-americana e mundial. Nesta entrevista, procurámos conhecer a opinião do Doutor Pellegrino sobre vários temas da Bioética, ética das virtudes e filosofia da medicina.

PALAVRAS-CHAVE: Edmund D. Pellegrino, Bioética, Ética das Virtudes, Filosofia da Medicina.

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Interview

Jorge Cruz: *Dr. Pellegrino, you are considered by many to be one of the world's leading bioethicists. Could you please explain how your interest in medical ethics developed?*

Edmund Pellegrino: My interest in medical ethics was a natural development for someone with my college education at a Catholic university in the late 30s of the last century. I was (happily) required to take four years of philosophy and four of theology in addition to my major field of study which was chemistry. Ethics, therefore, was for me part of the intellectual equipment of an educated man. Medical ethics was a mandatory study for any Catholic physician. My own work derived from formal ethical reflections during my years in medical school, residency and teaching of medicine. As a result of my university studies in arts and sciences I have pursued medical science, philosophy and ethics and the philosophy of medicine throughout my career.

What do you regard as the most urgent area of concern in biomedical ethics today?

My major concern about bioethics is in the drift away from the discipline of ethics into psychology, politics, sociology and the confusion of strong opinions as self-justifying moral imperatives. Also at the most fundamental level bioethics needs a moral philosophy to ground its ethics more securely.

In the next decade, what do you believe will be the most pressing issues?

The most pressing issues are those I have just mentioned: a drift away from formal ethics, lack of a moral philosophy, confusion of ethics with public policy. Bioethics in a short time has become a subject of global discourse since biotechnology has such widespread impact on so many areas of personal, societal and community life. Too many have entered the field with good intentions but have confused their beliefs and

values. "Values" ought to be transformed into public policy or law. Their assumption is that if they believe something is good then it is automatically morally valid. The absence of formal, systematic, critical analysis necessary for valid ethical discourse is simply short circuited as "bioethicists" become social and political activists. This is the direction of a group of American bioethicists who call themselves "progressivists".

If "bioethics" is to be truly a branch of ethics then it must use the methodology of ethics – not that of sociology, politics, psychology, etc. As I have argued some years ago, ethical discourse can reach out to sociology, politics, etc. to factual data but not for moral truth *per se*. In sum, as others have pointed out as well, bioethics does not have a distinctive method of its own. Ethics is that branch of philosophy that uses the methods of ethical reasoning. To conflate scientific, political, social fact into moral truth demands argument using the method of ethics.

Jacob Rendtorff and Peter Kemp coordinated a project called Basic Ethical Principles in European Bioethics and Biolaw (1995-1998). They proposed 4 principles that express dimensions of the human being which must be respected: autonomy, dignity, integrity and vulnerability. Although the principle of beneficence was not included, do you think these principles add something valuable to the original (American) version of principlism?

The Rendtorff & Kemp 4 principles of themselves are commendable. They supplement and overlap with some of the Beauchamp and Childress principles. I like their inclusion of dignity and integrity. Vulnerability is not a principle; it is a state of being shared by those who are ill. This is the way I interpret it in my philosophy of medicine. Leaving out beneficence is however a serious defect. I have developed my reasons for this in my writing, especially with David Thomasma. It is crucial to health care ethics and has a phenomenological and existential ethical significance none of the other so-called principles carry.

What books on ethics would you recommend to medical students and physicians interested in the field of biomedical ethics?

There are a multitude of books but the only one universally known and used is Beauchamp and Childress' *Principles of Biomedical Ethics*. While I think it has shortcomings it is in fact the basis for a *lingua franca* of bioethics all students should be aware of. With Warren Reich's *Encyclopedia of Bioethics* the Beauchamp/Childress book come close to being the foundation texts for bioethicists worldwide so far as American bioethics is concerned.

How would you define "quality of life"? Who should decide what it means?

Quality of life, for me, is a definition which can only be given with rectitude by the person whose life's quality we are supposedly inquiring about. In effect therefore there is no general definition of quality of life except that which each person gives of himself personally or in writing. Expression of quality of life by a surrogate, however well supported they may be, are valuable but cannot replace the patient's own words. In the case of infants and young children we must depend on family surrogates – but always with caution. Forecasts of assessments of future quality estimates for infants are especially untrustworthy. Any "quality" of life predictions from patients without decision-making capacity must be suspect or checked against a well formulated futility assessment.

To answer the last part of your question, you can see that I am very cautious about any source of quality of life except that expressed by the patient himself.

Is it ethical for developed countries to spend billions of dollars in highly technological medicine while the developing world faces basic needs to survive? What could be done to reduce the gap?

Let me answer this question in general as a matter of principle and then as a question of particular decision. In principle I think the developed countries to the extent possible have an obligation to their fellows in underdeveloped nations.

Such an obligation cannot be stated as an open ended obligation more suitable to ideological than ethical discourse. I do believe in the idea of solidarity, i.e. responsibility for the plight of those who are less well off. This having been said, I would judge the urgency and degree of obligation by a number of factors, a few of which are these: size of surplus in the well off nation over and above needs of that country; uses of the money in the poorer nation; a plan for best distribution of the donated money; alleviation of disparities in wealth in the donor country first; protection of the donation from dishonesty of the government of the receiving country, etc. The better way to reduce the gap is to provide aid fixed to specific needs of the poorer country that close the gap between its citizens first.

If you were going to publish a second edition of "The Virtues in Medical Practice" (almost 2 decades after it was first published) would you maintain the same list of virtues or would you make some changes? Do you think those virtues apply to practicing physicians anywhere in the world?

I would maintain the same list of virtues because my conception of the virtues is their relationship to the ends and purposes of human acts. The virtues relevant to medical ethics are those required to achieve the ends of medicine, i.e. the cure, care, prevention of illness in individuals and public. The virtues are character traits. They do not change by societal choice or individual inclination. My position is to follow the Aristotelian conception, supplemented by the infused virtues according to the teachings of Thomas Aquinas.

It seems you're skeptical about the reliability of empirical research to assess the outcomes of teaching virtues to medical students due to methodological difficulties. What are your views on the Jefferson Scale of Physician Empathy and similar instruments for measuring some virtues in medical practice?

I am equally skeptical of the Jefferson scale as I am of all methods to measure virtue. Virtues are character traits, predispositions to act well with regard to the ends of

human acts. The measure of the medical virtues is their effectiveness in attaining the ends of medical acts as described in our book. The measure of the quality and existence of the medical virtues is whether or not they are present in the physician's medical acts. Only the doctor's contemporaries or his patient can testify to his degree of fidelity to the good of the patient.

Robert Veatch in his controversial book "Patient, Heal Thyself: How the New Medicine Puts the Patient in Charge" (2008) claims we are in the early stages of a new medicine in which doctors no longer know best and the patients will be empowered to decide what they want. Do you see this trend in medicine today? Is this an extreme form of the contractual model that ignores some key features of the doctor-patient relationship such as the vulnerability of the patient and the inherent inequality of this professional relationship?

Vis a vis Dr. Veatch's exaltation of the "sovereignty" of the patient I have much to say. Indeed Dr. Veatch and I are writing a book together in dialectical form examining his proposal. I hope you will forgive me if I do not answer your question in detail. Suffice it to say that I believe both the doctor and the patient are entitled to respect for their autonomy – since both are humans. The doctor must not violate the moral right of the patient to refuse recommended treatment. But the patient's moral entitlement to autonomy does not extend to demanding treatment or micromanaging care as is happening in certain situations today. Patient and families must recognize that the patient cannot violate his judgment of what is proper or needed treatment. Nor can the physician be asked to violate his conscience simply because the patient wants a particular treatment.

In my view, therefore, autonomy is a reciprocal moral claim – both members of a dyadic relationship are entitled to the same respect. When they do not agree they must discontinue their relationship without rancor. The physician cannot abandon the patient and must remain in attendance until an equally competent replacement is secured. In the interim neither the patient nor the doctor can demand that the other

violate his/her conscience. In short, the rights of conscience and conscientious objection must be preserved for both doctor and patient. In life saving situations, however, the physician must be careful to attend to the patient until he is certain the capacity for responsible decision making has returned to the patient.

Much more about this will be addressed in my book with Professor Veatch – especially my response to his challenge to whether or not the doctor can know what is good for the patient.

Dr. Pellegrino, thank you for your graciousness in granting this interview.

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