The Goals of Medicine

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> "I don't think a medical student is ever told what his mission in life is. Certainly no one told me when I was a medical student what was expected of me as a lifetime goal in assuming the role of a physician."
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> C. Everett Koop, M.D., 1976

Dr. Koop recognized a glaring and serious omission in modern medical education: the goals of medical care for physicians. That is, what are physicians to set as their standards so that they will know what they are to accomplish with their patients?

In an earlier issue of this Journal, I told of my own surprise when I began to see patients and found that my medical training had little prepared me for the majority of the patients that I would encounter. Perhaps, a better understanding of my goals with patients would have eased that transition. Other than one's own philosophical premises, is any subject more important for a physician than his goals with patients? Unfortunately, physicians who are Christians have paid as little attention to this subject as non-believing physicians.

My own conclusions are not final. My first intention when I started to write this article was to develop a Biblical argument. On further reflection, however, the goals of medicine cannot rest directly upon Scripture because there are no explicit instructions for either physicians or patients relative to medical care. Thus, the goals of medicine are a derivative ethic. Such goals could be supported with Scripture, e.g., to relieve suffering is clearly identifiable as a responsibility for all Christians. However, such support would be somewhat artificial when general instructions for all Christians are narrowed to the field of medicine. The more important application, however, is that the means used to achieve these "ends" (goals) must be consistent with and not violate any Biblical principles that relate to these issues. (See discussion below) It seems that a physician's goals are a two-step process: to diagnose and then, according to that diagnosis, to manage the patient according to this diagnosis. (I am purposefully avoiding "treat" for reasons to be explained below.) Obviously, management will be a more complex task because of the variety of options and possibilities that may or may not be available.

First, To Diagnose

To say that a physician must first diagnose what is wrong with the patient that comes to him is to say the obvious. We must assume this goal as an axiom. No one can solve another's problem, whether medical or not, without first having some understanding of the cause of the problem. A common example in medicine is the patient with pneumonia caused by a bacteria called Pneumococcus pneumoniae. When the patient presents with chest pain, I may diagnose simply that he is in severe pain. Thus, I can give him a narcotic that will totally relieve the pain, but he may die from the infection. If, however, I proceed to diagnose the Pneumococcus as the cause, then penicillin will quickly assist him to full recovery.

Before passing on, to diagnose is not so simple. If a person with a form of arthritis goes to an acupuncturist, he will be treated to correct some imbalance of yin and yang. If he goes to a chiropractor (of the "old school"), then his spine will be adjusted. If he goes to a medical doctor, he will be treated with an anti-inflammatory medication.

Thus, one's fundamental understanding of what is normal and abnormal or health and disease determine one's diagnosis. A discussion of this subject would take us too far afield. It, too, has been discussed on these pages, although the subject is far from exhausted.

Let us assume then, that the first goal of the physician is to diagnose.

Second, To Manage

The second goal of the physician is to manage (assist) the patient. I have avoided "treat" because, as we will see, the role of the physicians is more comprehensive relative to patients.

First, and perhaps most obviously, the physician is to heal. The patient presents with a problem and the physician does whatever is necessary to heal him. The difficulty is that physicians are rarely able to heal. I have written a chapter on the "Empirical Uncertainties of Modern Medicine" where I discuss this subject in some detail. Thus, I will not go into it here. In the large majority of instances, we do something else. These, "something elses" are the primary goal of my discourse here.

If a physician does not cure, then he may: 1) relieve suffering, 2) prognosticate (including reassure), 3) rehabilitate, 4) prevent illness, injury or further deterioration, and 5) do research.

Perhaps, the most common role of the physician is to relieve suffering. This goal may be carried out in a variety of ways. First, it overlaps with the goal to cure. Surely, the best way to relieve suffering is to cure the patient of his illness or injury. Second, a physician may relieve suffering simply by making the diagnosis. Most people accept and learn to live with a condition if they know what is causing their suffering. Third, a physician may alleviate pain directly or indirectly. He may give an analgesic (a medication that is primarily given to lessen or alleviate pain) and one that acts indirectly, but does not cure. For example, aspirin decreases and may entirely alleviate the pain of arthritis both by its analgesic and its anti-inflammatory effect.

Fourth, a physician may relieve suffering by other modalities. The blockage of an intestine by cancer may be removed, while the cancer continues its malignant course. Cancer that has invaded the bone may be relieved by radiation that shrinks the tumor, but does not kill it entirely. Special wheelchairs, beds, and other appliances may be designed to make life more comfortable for patients. Modern technology has surely helped in this regard.

Fifth, the physician relieves suffering by his very presence. I remember when I had infectious mononucleosis. I had run high fevers and been in bed for several days. (I fully expected that I would die before I could get better!) Just seeing the doctor and knowing the diagnosis made me quite hopeful for recovery. Of course, he could not "cure" my illness, but I had seen the doctor. In my mind, that of itself was almost as good as a "cure."

The role of the physician is to prognosticate. Medical education, including specialty training, teaches a physician something of the usual course of specific disease processes. His experience thereafter usually becomes an even better teacher. Obviously, however, this role is quite imprecise. Many people know a patient who had only a few months to live, yet lived for many years beyond that prognostication.

Prognostication, however, does have value. In general, diseases and injuries do follow some, albeit variable, pattern. Again, knowing something about the unknown (the future course of the affliction) lessens anxiety and enables the patient and his family to prepare. The prognosis that death is imminent seems especially useful. Wills and living trusts can be set up, life support measures that are or are not wanted can be discussed, and special efforts at reconciliation should be made with those whom the patient has unresolved conflicts (especially between husbands and wives).

The role of the physician is to rehabilitate.

Perhaps, modern medicine has made more progress here than anywhere else. Intensive physical therapy,

progressive re-education, and "space age" appliances go far beyond anything possible in the past. People who would have had to spend their lives in wheelchairs and/or confined indoors now function at a much higher level and with little need for constant care.

The role of the physician is to do research. If physicians did not build upon their predecessors, then medicine would not advance. Research, however, is more than that performed in the laboratory or in clinical settings. Research includes the physician in his everyday practice. He notes patterns of diseases and responses to medications and manipulative procedures. He also notes iatrogenic disease and injury, as many modalities of management cause their own unintended effects, some quite severe and even deadly.

Perhaps, the greatest distinction between "orthodox medicine" (that generally practiced by physicians licensed by the state) and "alternative therapies" is the unwillingness of the latter to do research. Yes, orthodox medicine has its problems of iatrogenic diseases, ineffective and expensive treatments, unscrupulous practitioners, all of which have not been avoided by extensive research.

Nevertheless, without some systematic, scientific approach to disease and injury, we actually know nothing. The courses of disease, the people who have them are too variable to make any conclusions, otherwise. While I am not totally opposed to alternative therapies, their great weakness is their unwillingness to design and carry out any kind of formal study and publish its results for others to scrutinize. Under the goals that I am presenting here, then, these alternatives approaches would not fulfill the goals for medical practice and, on this basis, be relatively disqualified as a valid means of medical treatment.

To Subscribe to an Objective Ethical Value

Non-Christians likely would not differ with the above goals, although Christians and non-Christians might differ on the emphasis given to each or allocation of resources for each. It is the means to these goals that divides the Christian from the non-Christian. Thus, the final goal for physicians in their care of patients should be to commit to a stated standard of objective value.

Why is this goal necessary? First, the above goals are quite general and the means to their end can be quite varied. For example, a physician may interpret an abortion as "relieving and suffering" of a woman with an inconvenient pregnancy. For the Biblical Christian, however, "Thou shalt not kill" (Exodus 20:13) proscribes that means. The same would be true of euthanasia to "relieve the suffering" of a severely ill patient. While the goal is acceptable, the means is not. God says, "Thou shalt not commit adultery" (Exodus 20:14). Thus, the counsel and practices of Christians are not to encourage or assist fornication in any way. "Honor thy father and thy mother" (Exodus 20:12) means that minor children must not be treated without their parents' permission (except in an emergency).

Why should this goal be objective? Again, choices or means (especially by fallen men and women) are too diverse to be left to individual (subjective) choice. While an objective standard cannot prevent wrong (unbiblical) practices, it will serve to restrict choices. For example, the Hippocratic Oath is an objective standard. If physicians subscribed to it, we would not have abortions today, as it states, "I will not give to a woman a pessary to cause abortion." The problem, then, is to call physicians to an objective standard and the Christian to the Biblical standard.

What must be realized is that we may agree with non-Christians on most of our goals, but we are strictly limited on means to those goals. In fact, the failure of modern medicine to subscribe to an objective standard causing an increasing difficulty for the Christian to practice medicine without offending his peers or even violating the laws of the state. It also allows the pursuit virtually any means to achieve these goals.

Preservation of Life as a Goal

The goal of medical care is not to preserve life. Perhaps, more confusion exists today among Christians and non-Christians on what is not a goal of medicine

than the above goals that I have already stated. "Heroic measures" are commonplace in virtually every hospital and nursing home where severely ill patients are simple "kept alive" with no reasonable hope of improvement in their condition.

That preservation of life cannot be a goal for medicine is simply proved by the fact that all patients eventually die. To strive toward a goal that is ultimately doomed to failure hardly seems consistent with any rational or reasonable argument. Yet, that goal seems to be assumed by physicians. Early in their training, medical students experience the breast-beating that goes on when a patient dies. "If only I (we) we had done this, the patient would still be alive." This thinking is rarely carried to its logical extreme, that medically correct decisions can prevent all deaths. Stated thusly, the futility of that argument is apparent.

The Bible does not support the simple preservation of life as a goal either. Men and armies are called into battle to defend righteouis causes (e.g., Judges 1:1-9; I Samuel 17). Paul goes on missionary journeys that severely imperiled his life (II Cor. 11:22-33). Modern missionaries answer the same call, often to situations that endanger their health and their lives (as well as their families).

Further, the Commandment "not to kill" (the positive side of which is the value of human life) cannot be carried out if an action violates another Commandment. For example, I may not steal from others to provide for myself or my starving family. A woman may not commit adultery to preserve either her life or that of her husband or children.

The sanctity of human life is a high value, but there are other values equally as high, such as honesty and sexual fidelity. There are even higher values, such as the worship of God and the righteous works to which He calls and directs us, such as missions.

The Relief of Suffering as the Comprehensive Goal

Perhaps, all of the five other goals can be included under the relief of suffering. To diagnose is to relieve the anxiety associated with an unknown illness or injury. To prognosticate is to relieve the anxiety and uncertainty of the course and outcome of the illness or injury. To rehabilitate is to lessen pain, improve function, and give objective hope to patients. To do research is to improve all the means to all the other goals.

I have said nothing new here. Summary statements, however, focus our attention for agreement, debate, and further refinement. Dr. Koop was correct. Goals for physicians are virtually ignored except as they are implied by medical training and medical behavior. It is past time for Christian physicians to clarify their goals and within that structure to delineate Biblical means to those goals.

References

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5. Payne, Franklin E., Jr., *Biblical/Medical Ethics*, pp. 33 - 50.

6. Adams, Jay E., *Shepherding God's Flock*, Phillipsburg, New Jersey: Presbyterian and Reformed Publishing Company, 1974, pp. 128 - 256.

7. Payne, *Biblical/Medical Ethics*, p. 111.

8. "Fornication refers to sexual sin of any and all sort ... (not just) sexual sin by unmarried persons (as it is used in American law) ... Scripture writers used the word fornication (porneia) to describe sexual sin in general, and in the Bible it referred to cases of incest (I Cor. 5:1), homosexuality (Jude 7), and even adultery (Jeremiah 3:1, 2, 6, 8 ff) as fornication." Jay E. Adams, _Marriage, Divorce and Remarriage_ in the Bible, Phillipsburg, New Jersey, 1980, pp. 53 - 55.