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**Red medicine, blue medicine: Pluralism and the future of healthcare**

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Recent headlines regarding the case of Terri Schiavo exposed startling disagreement within our society about the proper scope and ends of medicine. Indeed, it seems that the lines pundits used to divide the country into red states and blue states extend into the practice of medicine itself, where we find, for example, controversy regarding pharmacists who refuse to fill prescriptions for certain contraceptives. These conflicts are particularly unsettling because American medicine has, in recent history, enjoyed extensive moral consensus regarding the proper scope and aims of the application of medical technology.

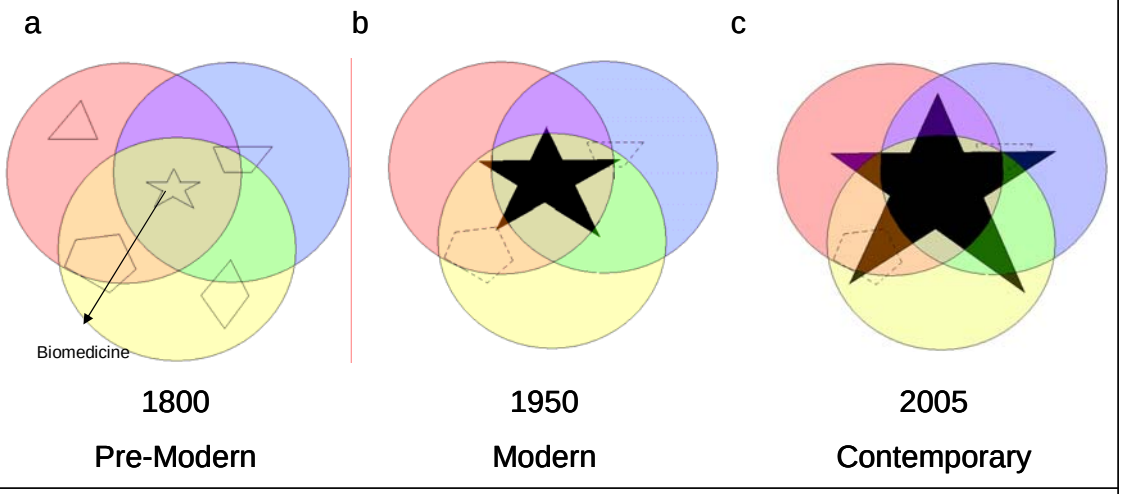
In this working paper, we will examine some of the reasons that the moral hegemony conventional medicine once enjoyed now appears to be disintegrating, and in so doing suggest that American medicine is at a critical juncture in its development.[1] Ironically, the very expansion of medicine's technical powers and the scope of its application is the dynamic that will likely unravel what remains of medical hegemony. In the face of this, at least two reactions are possible. If pluralism is perceived primarily as a threat, leaders within the medical profession may circle the wagons and attempt to reassert medical hegemony through a monocular focus on medicine as technique rather than moral practice. We will argue that this, the most prevalent response so far, is short sighted and potentially quite destructive. On the other hand, if pluralism within medicine is perceived as a resource, it might serve to focus renewed attention on the moral dimensions of medical practice and thereby catalyze the recovery of truly humane practices that begin to redress some of the deep dissatisfaction of patients and physicians regarding contemporary medicine.

To begin, we need to trace the history of our current situation, focusing on the rise of medical hegemony in the modern era. We will then critique some of the philosophical assumptions of this hegemony before examining the implications of the emerging divisions within contemporary medical practice. We will argue that medicine, as a moral practice, is more than mere technique. By this we mean that the practice of medicine seeks to clarify what is "good" for the patient, and then to seek patients' good through the use of available medical technology.[2] In many ways, the technical success of modern medicine has obscured the unavoidable moral dimensions of medical practice. As a result, patients seek (and physicians provide) medicine in pursuit of moral ideals that have often been unrecognized or unchallenged. However, the growing disagreement within the practice of medicine may serve to remind patients and physicians alike that medicine is, at root, a moral practice.

To help clarify our thesis, we have included a schematic illustration (Figure 1) of the dynamics that distinguish and connect three stages of medical history which we will call Pre-modern (1800), Modern (1950), and Contemporary (2005). The narrative we will sketch intentionally oversimplifies the history of medicine, not to hide alternate hypotheses but to focus on the forest rather than the trees. As represented by the overlapping circles, American society has always included a plurality of coexisting moral traditions - different comprehensive, self-referentially complete understandings of human life.[3] For our purposes, the language we use to refer to these (religions, worldviews, cultures, traditions, value-systems, etc.) is not as important as the reality that they have points of overlap and points of divergence. Similarly, there has also always been a plurality of healing traditions. Although the disease centered, scientifically refined, and

technologically mediated tradition of allopathic biomedicine (hereafter – *conventional medicine*) is the dominant tradition in our day, it was not always so.[4]

**Figure 1: The historical development and logical limits of medical hegemony**




Circles represent differing worldviews. Star represents biomedicine. Other shapes represent other healing traditions.

Pre-modern medicine (1800) was characterized by a panoply of rival healing traditions - illustrated in Figure 1 by the smaller shapes within the circles. From barber-surgeons to botanists to bonesetters, from naturopaths to homeopaths to allopaths, practitioners of different traditions engaged in ongoing competition for the patronage of patients. In this setting, medical pluralism existed partly because the principles and practices of particular healing traditions were more acceptable to some moral traditions than others. Yet, pluralism existed equally because no tradition was able to persuasively demonstrate its superiority over its rivals. In the pre-modern era everything worked equally well because nothing worked very well at all. Pluralism was as much the product of mutual ineffectiveness as moral disagreement.

Between 1800 and 1950, profound changes in the medical landscape gave rise to a clearly dominant *modern* medical profession. The intrigues and complexities of this historical process are described in Paul Starr's landmark book, *The Social Transformation of American Medicine*,[5] where Starr argues persuasively that the cultural authority and privilege achieved by the new profession of medicine was less the inevitable result of disinterested scientific inquiry than the consequence of deliberate efforts by those within the emerging profession to legitimate and solidify their standing as the bearers of a socially valued field of knowledge and expertise. Starr's observation raises the question: why were leaders of conventional medicine able to establish medical hegemony where prior efforts had failed? The answer at least begins with the unmistakable technical triumph of conventional medicine. The road from pre-modern to modern medicine was paved by dramatic improvements in health outcomes which followed from the application of sterile surgery techniques, specialized hospital care, public health measures to prevent infectious diseases, and antibiotics – all of which were undergirded by the discoveries of medical science. Conventional medicine so persuasively demonstrated its therapeutic superiority that rival healing traditions either lost cultural legitimacy or disappeared entirely.

Yet the hegemony of modern medicine was not established simply on the basis of superior technical power. The application of that power required guidance from consensual moral commitments.[6] In this historical circumstance, the technical triumph of conventional medicine dovetailed synergistically with what McKenny[7] has called the "Baconian Project": As Francis

Bacon and René  Descartes had hoped and predicted, medical science and technology came to serve (and partially realize) the moral imperative to eliminate human suffering and to expand autonomous control over the contingencies of our bodies. McKenny describes how this Baconian Project accounts for both the powerful appeal and the moral confusion of contemporary medicine.

Although McKenny's critique is particularly apt for the contemporary context, it does not give a full account of how the current state of affairs came to be.  As shown in Figure 1b, medicine enjoyed almost complete moral consensus during the period when emerging medical technology was applied to a limited scope of medical problems such as the treatment of acute illness and injury, the prevention and treatment of communicable diseases, and the surgical removal of diseased organs. In this limited context, diverse moral traditions shared consensus that it was a prima facie good to relieve such suffering, injury and illness. Diverse traditions were able, therefore, to look beyond their real and persisting disagreements in order to cooperate in this limited domain. Toward that common goal, they ceded control of the specialized knowledge and techniques required for conventional medical practice to a unitary profession which "professed" a commitment to minimizing suffering and bodily contingencies. To put it simply, a patient with a broken leg did not (and still does not) care so much whether his physician was Roman Catholic, Muslim, or Secular Humanist, so long as the physician was *competent* to set the broken bones.

The transition from modern to contemporary medicine has severely strained and ultimately unmasked the limits of this partial moral consensus. As illustrated in Figure 1c, the rapidly advancing technical power of contemporary medicine has resulted in a dramatic expansion of both its scope and application. It is now technically possible to control human reproduction, enhance physical capacities, and even surgically change sexual morphology. With the expansion of such technical power, the definitions of both suffering and contingency have likewise expanded, bringing moral challenges that were not expected in previous eras.

The further conventional medicine extends beyond its original domain of "obvious" medical problems, the further it ventures into areas about which different moral traditions disagree. At the center of medical practice (see Figure 1c), there is substantial inter-traditional consensus that it is a prima facie good to apply conventional medicine's technical powers to the treatment of acute, severe, organic illnesses. Yet on the margins there is marked disagreement regarding whether and how biomedical science should be applied to regulate sexual function and reproduction, employ life-sustaining technology in the end-of-life context, enhance physical and mental capacities, reshape bodily form, modify human appetites, and control behaviors.

In the contemporary medical context, different moral traditions may agree about the range of legitimate clinical strategies, but disagree about which is to be recommended in a given moment. For example, physicians from different moral traditions may agree that pharmacological therapy, referral to a psychologist, and referral to a clergy person are all legitimate ways of responding to symptoms of what conventional medicine calls "depression," yet physicians of one moral tradition may be much more likely than those of another to recommend one of the clinical strategies in a given case.

Despite the technical and scientific proficiency of contemporary medicine, the persistence of such disagreement emphasizes that medicine is always an *applied* science, and different moral traditions can and will disagree regarding the proper application of that science. Such disagreement will likely increase as medical technology extends its reach and aspiration, and

ironically, the extension of technological power may eventually unravel the moral consensus once enjoyed by conventional medicine.

These historical developments in medicine reflect a broader shift within contemporary society to abandon substantive moral *traditions* in favor of individualistic moral commitments that devolve to relativism.[8] As narrated by Robert Bellah,[9] contemporary American culture prizes the boundary-defying expressions of individual spiritualities over the ostensibly limiting and repressive effects of substantive religious traditions. As a result, moral consensus is no longer a goal of our plural culture. Within medicine, this trend leads to an almost absolute commitment to individual patient autonomy whereby each patient becomes the architect of his or her own moral framework for determining which bodily contingencies ought to be controlled and which conditions ought to be relieved.[10] Indeed, such reverence for autonomy is codified by what some have called "standard[11] bioethics."[12]

In his book *Better Than Well*,[13] Carl Elliot describes the fruit of the union of expansive medical technologies and an ethic of maximizing individual choice. In a culture which has adopted as its motto, "To thine own self be true," medical technologies become means of achieving the moral ideal of *authenticity* - that self-defined condition of maximal self-actualization. As a result, "a variety of drugs and procedures … are employed by doctors not just to control illness but also to improve human capacities or characteristics."[14] Conditions such as male sex, short height, slender build, undesired breast size, shyness, distractibility, melancholy, or even the possession of unamputated legs,[15] can all be defined as impediments to an individual's pursuit of authenticity, and therefore as sources of suffering which require relief.

Although an ethic of self-actualization theoretically allows for unlimited applications of medical technologies, not all physicians will endorse or be willing to participate in these moral projects. Elliot's well-chosen examples expose how the expansion of technical power unmasks the pluralism which is ever-present (and perhaps widening) within society and medicine itself. In response to this concrete reality, the medical profession faces a choice: it can either engage pluralism as a resource for the reconstitution of practices which do justice to medicine's moral dimensions or it can treat pluralism as a threat to its power which must be resisted. Unfortunately, recent history suggests that the profession is choosing the latter course.

**The Medical Profession's Response**

Given the remarkable benefits derived from its position of cultural authority, it is not surprising that the medical profession is slow to embrace the implications of the dynamics already described. If the profession admits to a plurality of visions *within* the profession regarding how to apply its technical powers, it may thereby undermine the moral authority that physicians enjoy simply by virtue of membership in the guild. If pluralism exists within medicine, a patient will no longer be able to trust a doctor as a doctor, but only as a doctor of a certain persuasion, with a certain set of normative commitments about the human condition – commitments which are not *professed* by all medical professionals. In the light of this destabilizing threat, medicine has seemingly circled the wagons in an effort to maintain medical hegemony by focusing on medicine as a strictly technical practice whose application is to be guided by the autonomous choices of patients.

The medical profession's conception of itself as a scientific, technical enterprise fits with standard bioethics' emphasis on individual patient autonomy as the first principle of medical care. For example, a series of related movements in medicine call for a more patient-centered,[16] culturally competent,[17] narrative,[18] and holistic[19] medicine. These movements encourage physicians to accommodate the ways that the plurality of languages, cultures, communities, and

traditions guide patients' decisions related to illness. In order for conventional medicine to accommodate this external pluralism without undermining its own limited consensus, it must markedly limit physicians' moral agency. That is in fact what medicine has done. In the contemporary era, patients are not only the source of pluralism but also the locus of moral authority for clinical decision-making. Thus disempowered, physicians are therefore, encouraged to take pains to prevent their own beliefs and values from influencing patients' decisions - particularly in areas of societal controversy. For example, in response to recent controversies regarding emergency contraception, Michael Goldrich, chair of the American Medical Association's Council on Ethical and Judicial Affairs, responded, "Physicians should recognize all the biases they may have and try to suspend them to provide the best potential care for the patient."[20] By encouraging physicians to be *non-directive* in their interactions with patients, these efforts attempt to minimize the implications of any pluralism within the profession. Physicians' commitments matter less if in practice such commitments are to be suspended.

In the face of societal controversies about the proper application of conventional medicine's technical powers, editorials from medical leaders have repeatedly called for the separation of moral and ideological "biases" from deliberations that should be made through a straightforward reading of "the data" by objective, morally neutral scientists. In the past year, variations on this theme of calling for medicine to remain unsullied from the biases that exist *out there* in the political, religious, cultural realm, have accompanied controversies regarding emergency contraception,[21] end-of-life care[22] and government funding of human embryonic stem-cell research.[23] Ironically, even the President's Council on Bioethics has been impugned in the medical literature for having too many moral philosophers and not enough scientists.[24] This pattern of emphasizing a neutral technique over a moral practice is not unique to medicine. As epitomized by the "no child left behind" initiative, Dunne describes how educational theorists have similarly tried to forge a unified professional ethos by focusing almost exclusively on educational technique (teaching objectives, classroom technique and standardized assessment).[25] Yet, quite apart from technical excellence, there remains societal disagreement regarding what it would be good to know. As medicine is approached primarily as technique, physicians become "providers" who render discreet, commodified services to healthcare consumers (clients, not patients) to be used by those consumers in any way the consumer sees fit.[26] Apart from the shared commitment to autonomy, and the limited boundaries imposed by the law, there is no moral framework that stands outside and constrains the physician or patient.[27]

The depth of the contemporary commitment to individual patient autonomy is most tellingly and ironically displayed in those situations in which such autonomy cannot be exercised. For example, regarding the decision to stop artificially delivering food and water to Terri Schiavo, a woman who could neither articulate nor carry out an autonomous choice, Timothy Quill invokes the judgment of standard bioethics: "In considering this profound decision, the central issue is not what family members would want for themselves or what they want for their incapacitated loved one, but rather what the patient would want for himself or herself."[28] Likewise, a leading textbook of clinical ethics teaches that in cases in which family members or physicians must act as *surrogate* decisions makers, they "must be careful to avoid the common ethical pitfall of injecting their own values and beliefs into the decision-making process, as only the patient's values and beliefs are relevant to the decision."[29] Even when autonomy is not possible, it remains as the desired ideal. For example, after noting that "The biggest thief of autonomy is sickness," Eric Cassell concludes that the practice of medicine must "help [sick] patients reassert their autonomy – including their ability to make authentic decisions."[30] To the extent

that medicine aims at maximizing individual self-determination, it serves the moral ideal embodied by the quest for "authenticity."

The emphasis on medicine as a technique has also had profound effects on the medical profession's normative concept of the physician. The Norman Rockwell notion of a *good* physician *(*with its attendant ideas of a certain moral integrity, wisdom, and genuine care) seems self-righteous in the contemporary context, where physicians' pretensions to goodness are perceived as threats to patients' autonomy. Terms like *virtuous* or *ethical* are suitable descriptors of moral agents working toward that which they judge to be good, but if medicine is mere technique, such terms are not appropriate descriptors for physicians. The moral character and wisdom of the physicians are now perceived as secondary to their *competence*, a more limited and manageable concept in a world of disagreement. It is therefore no surprise to note that medical education has replaced the ideal of the *good* physician[31] with that of medical *professionalism,*[32] wherein physicians strive to master concrete behaviors which are ostensibly essential to becoming *effective* clinicians.

**Problems with the profession's response**

Medicine's efforts to minimize the implications of pluralism are bound to fail because they are predicated on an impossible ideal of moral neutrality and a misguided insistence on medicine as a technique rather than a moral practice. Claims to the contrary notwithstanding, the appropriate practice of medicine cannot be strictly derived from scientific data. As such, the practice of medicine is never morally neutral.[33] Rather, medicine's data must be interpreted and its technical powers applied in reference to particular moral commitments. Where consensus exists, moral commitments ("biases") are often left unspoken, but are operative nonetheless. For example, in the core domain of acute severe illness, conventional medicine is directed by biases toward treating the sick rather than ignoring them and alleviating pain rather than exacerbating it. That such commitments are good may be obvious to all, but it is not because they are derived from scientific data, nor is it because they are required to make sense of medicine as a technical practice.

Even the ancient Hippocratic commitments to seek patients' good (beneficence) and avoid doing harm (nonmaleficence) require judgments that depend on moral frameworks which medicine as mere technique cannot provide. And as medicine extends out from its core domain (Figure 1c), it encounters increasing disagreement regarding what constitutes patients' good and patients' harm. For example, in the Schiavo case some argued that the artificially-administered nutrition secured the patient's good (continued life) while others argued that it only served to perpetuate the patient's suffering. What beneficence required for one, nonmaleficence prohibited for the other. Such disagreements are not limited to the margins of life. For example, physicians may disagree about whether mood-altering drugs are required to serve the good of patients suffering from severe melancholy. Physicians may also disagree regarding the use of supplemental growth hormone to serve the good of children likely to be much shorter than their peers. Indeed, physicians might even disagree regarding whether it is good for patients to use contraceptives. None of these clinical judgments can be derived strictly from scientific data, but require interpretation of morally freighted aspects of the human condition such as melancholy, short stature, or sexuality. Here and elsewhere the pretense to moral neutrality is unmasked by the fragmentation of moral consensus regarding the proper scope and aims of conventional medicine's technical powers. In the end, physicians and patients alike must decide if the moral imperatives of the Baconian Project are sufficient to guide medical practice.

It is not reasonable to expect physicians to divest themselves of their responsibilities as moral agents in the practice of medicine. The sickest patients will always depend on their physicians'

ability and commitment to discerning and seeking their good—perhaps most especially when severe illness markedly limits their ability to autonomously direct their medical care. For example, gun shot victims in the trauma bay are entirely at the mercy of the trauma surgeon. In a similar, but less emergent setting, a patient with prostate cancer will always depend on the counsel of his physician—the physician may involve the patient in the decision-making process, but truly "informed" consent is unlikely because choosing between radiation therapy, chemotherapy and radical surgery requires practical wisdom attained only through the practice of medical oncology. Unfortunately, the reverence for patient autonomy has encouraged some physicians to abdicate their responsibility to make medical decisions. After explaining the various technical options, physicians step back and insist that the patient (or family) decide which option to pursue. Such efforts to avoid the burdens of medical decision-making can constitute a form of moral abandonment.[34]

In the core domain of acute or severe illness, we know intuitively that such abandonment is egregious because moral consensus regarding such illness persists among the plurality of moral traditions in American society. However, many "patients" seen by physicians are not sick in the usual sense of the term. Patients seek preventative medicine to ward off future illness. They also seek technical control over their bodies through reproductive science and enhancement therapy. In these settings, the moral responsibility of physicians is perhaps even more acute, but there is far less consensus regarding that responsibility. Rather than seeking the wise care of a physician, much of contemporary medical practice encourages patients to purchase particular medical goods and services from the physician-providers who retain professional and technical control over those services. In such cases, the ethic of autonomy obligates physicians to follow patients' wishes so far as those wishes do not violate the law. Yet this approach is but another example of moral abandonment. Even though "healthy" patients preserve the autonomy often robbed by acute illness, physicians are not free (or able) to abdicate their moral responsibility to provide wise counsel—counsel that can never be completely divorced from the wider moral framework of that physician. As Pellegrino[35] and others in a long line of ethicists remind us, between a coercive paternalism and a utilitarian ethic of autonomy, there is another and better way. Out of a commitment to the good of their patients, physicians must embrace their moral responsibility to both discern and respectfully seek their patients' good as best they understand it.

**An alternative proposal**

The existence of moral pluralism in medicine does not require a focus on medicine as mere technique nor a commitment to patient autonomy as its first principle. Rather, disagreements can serve to remind physicians that the practice of medicine embodies fundamental notions and commitments regarding the human person. That recognition can catalyze the recovery of practices of medicine that do justice to our deepest commitments and highest aspirations. This would require the medical profession to foster or at least concede a robust, self-conscious medical pluralism in which medical practitioners would self-consciously and candidly seek to articulate their understanding of the human condition and the attendant implications for the practice of medicine. Those who are bound together by mutual adherence to a particular moral tradition (religious or otherwise) might draw on their shared theological and philosophical resources to imagine and publicly work out forms of medical practice that are congruent with their commitments "all the way down."

Increasing medical pluralism will certainly have destabilizing implications for medicine. The profession will likely retain cultural authority as such only insofar as it continues to clarify the data and refine medical techniques. Attempts to enforce a particular interpretation of that data by "circling the wagons" are not likely to succeed in the long term. Rather, authority to interpret

and apply medical technology will most likely become decentralized, distributed among the various moral traditions in which physicians practice. Likewise, medical education will likely remain univocal only insofar as it clarifies data and passes on technical skills. Beyond technical competence and in the context of growing moral plurality within medical practice, it will be increasingly important for medical educators to foster self-conscious dialogue regarding moral ramifications of the *potential* applications of medical data and technique. It is quite possible that the fragmentation of medical consensus will be followed by a decline in federal and institutional support of the profession. Despite the intoxicating promise of the Baconian Project to relieve the human condition of suffering and contingency, as moral pluralism increases, legislators may find it difficult to muster sufficient political consensus to make health-care policies that bind all.

Despite the pains of destabilization, the encounter with increasing moral pluralism may catalyze needed reform. As the profession comes to grips with the moral dimensions of medicine and the very real disagreements about its practice, inter-traditional dialogue can replace the pretensions of neutrality that otherwise flatten that dialogue. By recovering and redeploying neglected capacities to reason philosophically (and theologically) about suffering, illness, and the practice of medicine, physicians and patients alike may begin to create the necessary space to develop practices of medicine that do justice to the different traditions' content-full conceptions of human life. The unavoidable reality of medical pluralism will serve as a constant reminder of the importance of our particular answers to humanity's deepest questions. The doctor-patient relationship will likely benefit from increased candor about the ways that physicians' and patients' commitments shape their clinical encounters. This candor among physicians and patients may allow them to negotiate accommodations which do not compromise the commitments of either. To be sure, there will be substantial inconveniences and limitations for those patients who do not have access to physicians who can accommodate their own moral framework. Yet, the increased candor and transparency that will follow from a robust pluralism will at least allow patients to know where their physicians stand, and to make the necessary effort to find a physician who can provide the kind of counsel they require.

In the face of moral pluralism, the expansion of conventional medicine's technical powers and the scope of their application will likely unravel the moral consensus which the medical profession has briefly enjoyed. Rather than resisting the implications of this reality, the medical profession can take advantage of the opportunity to engage moral pluralism as a resource for the renewal of medical practice. It is quite possible that the conscious development of plural practices of medicine will reverse the current trends toward physician anomie and patient dissatisfaction. The joy of medical practice depends on the experience of doing good for others, but contemporary medicine has suggested that even making judgments about the good of others is beyond the scope of medical purview. If medicine is simply a technical practice, then patients are objects rather than subjects, and it is no wonder that patients experience medical care as sterile and dehumanizing. An openly plural medicine offers the possibility of practicing medicine in ways that do justice to the deepest commitments of patients and physicians alike, and more importantly, to the mystery and meaning of the human condition.

Notes

[1] The argument presented here proceeds within the context of the medical literature which is admittedly not the most sophisticated theological or philosophical resource. Many of the ideas we reference are more adequately and definitively explored outside the medical literature, but because this forum is decidedly inter-disciplinary, we reference the literature with which we are most familiar.

[2] Curlin FA, Hall DE. Strangers or friends? A proposal for a new spirituality-in-medicine ethic. *J Gen Intern Med.* 2005; In press. Dunne J. *Back to the rough ground: Practical judgment and the lure of technique*. Notre Dame, IN: Univ of Notre Dame Press; 1993.

[3] Hall DE, Koenig HG, Meador KG. Conceptualizing "religion": How language shapes and constrains knowledge in the study of religion and health. *Perspect Biol Med.* Summer 2004;47(3):386-401.

[4] Kaptchuk TJ, Eisenberg DM. Varieties of healing. 1: medical pluralism in the United States. *Ann Intern Med.* 2001;135(3):189-195.

[5] Starr P. *The social transformation of American medicine*. New York: Basic Books; 1982.

[6] Curlin FA, Hall DE. Politics and science cannot be separated (letter). *Obstetrics and Gynecology.* 2005; In press.

[7] McKenny GP. *To relieve the human condition: bioethics, technology, and the body*. Albany, N.Y.: State University of New York Press; 1997.

[8] MacIntyre AC. *Three rival versions of moral enquiry: encyclopedia, genealogy, and tradition: being Gifford lectures delivered in the University of Edinburgh in 1988*. Notre Dame, Ind.: University of Notre Dame Press; 1990.

[9] Bellah RN. *Habits of the heart: individualism and commitment in American life*. Berkeley: University of California Press; 1985.

[10] McKenny.

[11] In response to the ethical quandaries of modern medicine, standard bioethics attempts to resolve moral disagreement through the principles of autonomy, beneficence, and justice. Given the plurality of definitions of both beneficence and justice, autonomy often emerges as the final arbiter of moral decision-making in the medical setting. The limits of this approach have been noted by many critics, perhaps most persuasively by H.Tristram Engelhardt, Jr.)

[12] Engelhardt HT. *The foundations of bioethics*. 2nd ed. New York: Oxford University Press; 1996.

[13] Elliott C. *Better than well: American medicine meets the American dream*. 1st ed. New York: W.W. Norton; 2003. p. xvii.

[14] Ibid.

[15] Elliot describes the hopes and practices of “apotomnophiliacs” who claim that they feel alienated from their body until one or more of their limbs are surgically amputated.

[16] Laine C, Davidoff F. Patient-centered medicine. A professional evolution. *JAMA.* 1996;275(2):152-156.

[17] Kagawa-Singer M, Blackhall LJ. Negotiating cross-cultural issues at the end of life: "You got to go where he lives". *JAMA.* 2001;286(23):2993-3001; Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: a patient-based approach. *Ann Intern Med.* 1999;130(10):829-834; Crawley LM, Marshall PA, Lo B, Koenig BA. Strategies for culturally effective end-of-life care. *Ann Intern Med.* 2002;136(9):673-679.

[18] Charon R. The patient-physician relationship. Narrative medicine: a model for empathy, reflection, profession, and trust. *JAMA.* 2001;286(15):1897-1902.

[19] Gordon JS. Holistic medicine: advances and shortcomings. *West J Med.* 1982;136(6):546-551.

[20] Robeznieks A. Battle of the conscience clause. *American Medical News*; 2005:9-10.

[21] Lockwood CJ, Greene MF. Playing politics with women's health: The FDA and Plan B. *Contemporary Ob/Gyn.* 2004;49:11-15; Grimes DA. Emergency contraception: politics trumps science at the U.S. Food and Drug Administration. *Obstet Gynecol.* 2004;104(2):220-221; Dickerson VM. *Statement of the American College of Obstetricians and Gynecologists on the failure of the FDA to approve OTC status for Plan B*: American College of Obstetricians and Gynecologists; May 7 2004.

[22] Annas GJ. "Culture of life" politics at the bedside--the case of Terri Schiavo. *N Engl J Med.* 2005;352(16):1710-1715.

[23] Blackburn E. Bioethics and the political distortion of biomedical science. *N Engl J Med.* 2004;350(14):1379-1380.

[24] Ibid.

[25] Dunne.

[26] Childress JF, Siegler M. Metaphors and models of doctor-patient relationships: their implications for autonomy. *Theor Med.* Feb 1984;5(1):17-30.
[27] The moral fragmentation constitutive of modernity has increasingly forced the legal system to bear the burden of resolving moral disagreements throughout our society, including medicine. In the absence of a shared moral tradition, legal license is forced to stand for moral license. Yet it is not clear that the legal tradition can or should sustain this burden because the legal system itself codifies a particular moral tradition that may not be universally acceptable despite the claims of Enlightenment political philosophers. Indeed, to the extent that the American legal tradition emphasizes property rights and autonomous agency, it reinforces the contemporary bias in medicine for patient autonomy without resolving the moral disagreements confronting contemporary medicine.
[28] Quill TE. Terri Schiavo -- A Tragedy Compounded. *N Engl J Med.* 2005;352(16):1630-1633.
[29] Jonsen AR, Siegler M, Winslade WJ. *Clinical ethics: a practical approach to ethical decisions in clinical medicine*. 5th ed. New York: McGraw Hill Health Professions Division; 2002. p.85.
[30] Cassell EJ. Consent or obedience? Power and authority in medicine. *N Engl J Med.* 2005;352(4):328-330.
[31] Although patients rarely look for a “good” physician, many people recommend “great” doctors, but this subtle change sidesteps the moral character of the physician to describe great technical competence (perhaps in surgery), great bedside manner or great diagnostic acumen.
[32] Inui TS. *A flag in the wind: Educating for professionalism in medicine.* Washington, D.C.: Association of American Medical Colleges; February 2003.
[33] Curlin FA, Hall DE. Politics and science cannot be separated (letter). *Obstetrics and Gynecology.* 2005; In press.
[34] This pattern of moral withdrawal, though driven primarily by a reverence for patient autonomy, is exacerbated by a punitive legal system that encourages physicians to limit their legal (and financial) liability by shifting the responsibility for medical decisions onto the patient.
[35] Pellegrino ED, Thomasma DC. *For the patient's good: the restoration of beneficence in health care*. New York: Oxford University Press; 1988.