Nebraska Law Review

Volume 63 | Issue 4 Article 3

1984

Competency in Medical Care

Daniel Callahan
The Hastings Center

Daniel Callahan*

Commentary

Competency in Medical Care†

There can be no doubt that one of the greatest achievements of medicine is the successful application of a scientific methodology to both basic biomedical research and clinical application. The Flexner Report of 1910, and the increasing application of scientific thinking to medical problems that came in its aftermath, are the principal reasons for the success of contemporary medicine. The triumphs of biomedical research are real and obvious, and the radical improvements in mortality and morbidity data since the turn of the century provide all the evidence one could ask for about the efficacy of scientific medicine. Nonetheless, as we move into an era of chronic disease, and apparently past the point where inexpensive vaccines or cures for widespread disease are still likely, we will be forced to reevaluate some aspects of the efficacy of scientific medicine, and also take a fresh look at some of the problems it may have caused.

Among those problems has been a sharp sundering of the technical from the human side of medicine, and in particular on that aspect that bears on the care of human beings as a whole. Competency in medical practice has come to connote almost exclusively the ability of a physician, or other health care worker, to bring to bear on the treatment of illness a rational, analytical method and a careful deployment of scientific skills. To be "competent" means, in effect, to be a good technician. That is the general thrust of contemporary medical education. It is a clear message that one can

* Director, The Hastings Center, Hastings-on-the-Hudson, N.Y. B.A., Yale; Ph.D., Harvard. Dr. Callahan is an elected Member of the Institute of Medicine, National Academy of Sciences, and author or editor of 24 books.

† This paper was originally delivered by the author on March 16, 1984, at the University of Nebraska-Lincoln as part of an interdisciplinary colloquium on Professional Responsibility. The colloquium, entitled "Current Problems of Professional Ethics: An Interdisciplinary Approach," was supported in part by private donations to the Colleges of Architecture, Dentistry, Engineering, Law, and Medicine, and in part by a major grant from the Nebraska Committee for the Humanities. The assembled colloquium papers and proceedings, including this commentary, will appear in the Fall, 1984, issue of the NEBRASKA HUMANIST.

gain by examining medical journals, and a general attitude well in keeping with a society that prizes scientific knowledge and its application to human problems.

Just as the history of much twentieth century philosophical and scientific thought has been marked by an allegedly sharp chasm between the "is" and the "ought," between facts and values, so too there has developed an equally great chasm in medical practice between the supposed empirical solidity of scientific medicine in the diagnosis and treatment of illness, and the far more subjective, relatively intractable side of medicine represented by subjectivity, personal values, and medical ethics. The former are thought to be "hard," and the latter "soft." That phenomenon is hardly unique to medicine, but cuts through much of our contemporary thinking. An important consequence, however, is that it has helped to abet a general tendency to ignore the whole person and to focus instead on particular illnesses or organ systems, and to be relatively indifferent to all of those personal and subjective factors that influence the way patients are actually treated, or at least the way they perceive their treatment.

Viewed crudely, one might well ask just what difference does it make anyway, and why ought one not worry exclusively about the scientific side of medicine? That kind of an attitude might make perfectly good sense if one's aim is to vaccinate people against a plague or a cholera epidemic. There the aim is to save as many lives from a potentially fatal disease as possible, and the personal relationships, or the desires of patients, are relatively unimportant. But in an era of chronic illness, where people are not going to be saved readily or inexpensively, and where death will be for most people a long drawn-out phenomenon, an exclusively technological attitude is not only conducive to professional insensitivity, but is not likely to meet the genuine needs of patients.

If it was ever valid in the past to distinguish sharply between the technical and the human side of medicine, that distinction is no longer tolerable. Put more pointedly, it is impossible to say that a health care worker is competent if that person is not able to grapple effectively with the moral problems involved in medical care, or able to deal with the human dimensions of that care. Every medical decision, either tacitly or explicitly, must find an appropriate blend between the technically correct course of treatment and that which is morally defensible. In almost no case will it be utterly irrelevant to ask for the technically appropriate approach, and in almost no case will it be irrelevant to ask what the best moral course would be. The major difficulty will be to find the right blend between the technical and the moral.

Implicit within this is the assumption that it is of the essence of

morality to ask the question: what is the good of human beings? That broad question encompasses such issues as choosing that behavior that most advances the human good, determining how to make decisions in the face of conflicting possibilities of the human good, and in deciding what character traits or virtues are most conducive to a seeking and an achievement of the good for human beings. Inevitably, any attempt to define an ultimate good will be problematical, and probably controversial, at least in a pluralistic society; but that social reality does not absolve us of a responsiblity to make the effort. It also will force us to grapple with such fundamental questions as the nature of human life, the meaning of such concepts as "health" and "illness," and the relationship among physical, psychological, and spiritual or philosophical goods.

In a medical context, moral questions arise both implicitly and explicitly. They arise implicitly when, in making what seems to be an obvious treatment decision, we affirm a set of values that may be widely shared but rarely articulated. No one, for instance, will ordinarily start a moral debate about saving the life of an otherwise perfectly healthy child who is the victim of an accident when it is easy and inexpensive to do so (or even when it is not). It is taken for granted that saving the lives of healthy children is a valid moral enterprise, and anyone involved in such a decision would immediately move to the technical problems in doing so, not pausing for a moment on the underlying ethical conditions that stimulate a decision to treat in the first place.

In those morally obvious cases—"obvious" at least because of a general social agreement—medical competence will be displayed not simply in having the correct values, but much more dominantly in those simple situations involving a choice of the right methods of treatment. The real and only *issue* in such cases is the technically appropriate course of action, not the morally appropriate course. The technical methods chosen simply implement and bear out the basic moral decision, and the technically best decision then becomes the morally best means to achieve the good of a particular individual.

At the other extreme, of course, would be situations in which there was great uncertainty about the appropriate moral goal to be sought (e.g., whether to keep alive a very elderly, debilitated, vegetative patient), and perhaps also about the appropriate technical means to achieve a hazy moral goal. Indeed, when one looks at the wide range of possible medical decisions—on people of different ages, physical conditions, religions, and so on—it makes considerable sense to think in terms of a continuum. At one end of the continuum would be those decisions that command universal, or

almost universal, moral agreement, leaving the only important issues those that bear on the best technical care. Saving a life of a dying healthy child, or setting the broken leg of a healthy adult, would fall on one end of the continuum. At the other end of the continuum would be decisions where the moral good was uncertain, and perhaps the technical choices no less uncertain even if one could determine the moral good to be sought. The most difficult ethical dilemmas, of course, are those where one is in doubt about what will genuinely serve the welfare of patients, and the dilemma is made all the more complicated if there are a number of treatment possibilities available as well. A decision, for instance, that would involve some kind of trade-off between the mere extension of life, and a shorter life without the radical disfigurement that might be the result of some life-extending surgery, would pose an enormously difficult choice, blending in an exceedingly complex fashion the technical and moral aspects.

To envision the decisionmaking mix between the technical and moral aspects of medical care as part of a continuum by no means solves the problem of how one ought to determine the extent to which a particular medical problem ought to be seen as essentially moral, or essentially technical. In their enthusiasm to break down a fact-value dichotomy, some commentators like to argue that all medical decisions are essentially nontechnical. Even in the most obvious kinds of situations—that of saving the lives of healthy babies—there is a fundamental moral choice made, even if not stated. All medical decisions, viewed that way, are moral decisions, and the technical always remains secondary. That is probably true enough; but it is not a very interesting truth. For it is no less a fact that the technical does exist, that technical decisions must be made, and that the range of technical options available will in great part determine the possibilities for advancing human welfare. If the moral shapes the technical, we ought to know from contemporary medical practice that the technical possibilities shape the moral choices as well.

The care of the chronically ill, or of the dying, pose some of the most difficult kinds of questions. For in both of those cases one knows that there is nothing that medicine ultimately can do to save the life of a patient, and that it is simply a matter of caring for the patient in the most effective way possible when the eventual outcome—death—is known with certainty. In the case of the chronically ill, death may not be imminent at all, but many months or even years into the future. In the case of those we determine to be terminally ill, death will be more imminent. In either situation, however, the main point will be to choose those technical means that will provide the best comfort and care, and the highest quality

of life, compatible with the fact of an inevitable end. That is a particular challenge to medicine, because the ethos of technical medicine is to treat aggressively with the most sophisticated means—means which, in the case of the chronically ill, may be perfectly inappropriate to achieving their moral or spiritual welfare.

A brief commentary of this sort is not conducive of a detailed examination of the myriad problems that confront anyone who tries to find the right balance between moral and technical considerations in the providing of "competent" care. Suffice it to say that medical training that does not introduce students vigorously and rigorously to that issue will be remiss. Since all medical decisions will entail some value commitment or other, the more conscious the understanding of those values the more likely it is that the care given will be appropriate to the patient. In some cases, the choice will be very difficult. Competency, therefore, can be defined not simply as an ability to master and manipulate technological means of providing cures, but also the capacity to relate those technologies to the needs of individual patients, through some view of the good of human beings, and in the light of some method of relating moral and scientific values.

That is an enormously difficult task, and the notion of competency suggested here is not one that is easily achieved. Nonetheless, if we can at least agree that a notion of competency that focuses exclusively on technical skills is an inadequate one, and perhaps as likely to do harm as to do good, we would at least have made a great advance, and set the stage for a different way of treating patients in the future. For all of its services in the past, an excessively technical outlook on medical care is not likely to be appropriate in light of a rapidly aging population, a growing proportion of the chronically ill, and a citizenry that is increasingly conscious that it must make medical decisions in the light of personal and social moral values.