Cultivating character in medicine through practical wisdom by delineating goals of care, concepts of health, and flourishing in morally pluralistic contexts

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1. Introduction

In this paper I apply a framework of practical wisdom in medicine which appreciates the moral character of medical practice and the moral agency of health professionals and patients, highlighting a teleological trajectory of intentionality which connects treatments and tests, goals of care, concepts of health, and human flourishing. This framework encourages a balanced approach to shared decision making in a morally pluralistic world in which goals in healthcare are increasingly variable in definition and scope and sometimes contested. By cultivating practical wisdom, healthcare professionals can improve their communications with patients and reduce misunderstandings in the course of shared decision making. Practical wisdom in medicine reinforces the need for a virtue-based approach to medical ethics for clinicians – the need for moral character that enables the flourishing of healthcare professionals and sustains their fiduciary concern for the patient’s good. Based in virtue ethics, practical wisdom encourages an agent-centered approach to ethics which respects the role of the practitioner’s conscience as a core human capacity for moral reasoning, emotion, and motivation, reflecting the virtue of integrity.

2. Teleology and the Need for Goal-Oriented Healthcare

In a healthcare culture that is serious about patient autonomy and informed consent, it may seem strange to suggest we ought to be more deliberate about the beliefs, values, and goals that guide patients and clinicians in the process of shared decision making. But such is my suggestion in this article, which aims to engage the virtue of practical wisdom to make sense of healthcare as a practice that depends on a teleological basis. For healthcare should not only be patient-centered and evidence-based but also ends-based, which means that healthcare decisions should be made within a purpose-oriented landscape shaped by a stream of intentionality connecting treatments and tests, goals of care, values, health, and ultimately (albeit indirectly) a flourishing life.

To speak of the purpose-oriented landscape of healthcare focuses attention on healthcare as a teleological endeavor, i.e., a practice oriented toward ends or goals. This perspective contrasts with healthcare that focuses so predominantly on immediate actions (e.g., tests, procedures, medications, surgeries) that decisions about interventions may risk (at least sometimes) being dis-located from goal-oriented frameworks that give interventions a larger, more meaningful purpose. When we fail to attend to the ‘bigger picture’, healthcare decisions may focus on what is available, routine, or expeditious rather than what is advisable in light of a patient’s more enduring beliefs, values, and goals.

To illustrate, one can listen to debates surrounding “medical futility” that demonstrate how contrasting beliefs and values about health lead to different preferences for healthcare. These beliefs and values guide assessments of the dimensions of decision making – goals of care, probabilities of outcomes, and burdens of suffering related to treatment – which are open to contrasting evaluations and prioritizations that determine not only whether a specific treatment is considered reasonable but also whether a given prognosis and life trajectory are considered worthwhile (Kaldjian 2014).

The relationship between goals of care and concepts of health within a purpose-oriented landscape of healthcare depends ultimately on a vision of human flourishing which reflects the capacities, commitments, and satisfactions that give our lives our deepest sense of meaning and fulfillment. There are times in healthcare when disagreements about treatments or plans stem from deeper disagreements about goals of care which in turn arise from contrasting concepts of health and visions of human flourishing. These deeper disagreements tend to manifest as conflicts between patients' expressed preferences (autonomy) and clinicians' assessments of the patients' best interests (beneficence, nonmaleficence). The desire to navigate such disagreements wisely invites the need to trace the connection between interventions, goals of care, concepts of health, and flourishing to gain a shared understanding that can improve communication and shared decision making. The frequency of such disagreements can be expected to grow in societies that are increasingly morally pluralistic.

3. Moral Pluralism and Its Implications for Healthcare, the Patient's Good, and Concepts of Health

Diversity of moral frameworks among individuals and between communities creates the challenge of moral pluralism in society. Though healthcare enjoys a substantial degree of moral and professional consensus organized around traditional approaches to curing diseases and caring for patients, the challenges of pluralism regularly affect healthcare professionals, whose diverse beliefs and values have implications for understandings of health and the goals of care that promote it. Each person speaks from some moral vantage point, and a value-neutral position is not available in a moral practice like medicine that is inherently laden with moral meaning. And it is important to point out that moral pluralism pertains to all moral frameworks, whether described in philosophical or religious terms, because such frameworks make assumptions about what is real and good in this world. As a result, these frameworks play fundamental roles in our moral reasoning (Reeder 1998). We can call these basic assumptions *foundational* beliefs and values - foundational because they are unavoidable and irreplaceable in moral frameworks. Foundational beliefs and values give us our moral starting points (explicitly or implicitly), even if acknowledgment of these beliefs is minimal or absent when ethical issues are discussed. If ethical deliberation in healthcare is to do justice to moral frameworks, it needs to be ready to engage the foundational beliefs and values that guide the way we view the world and our place in it as moral agents.

Some may suggest that moral pluralism should be managed through conformity to prevailing social norms. Along such lines, the obligations of healthcare professionals are often examined in terms of a "social contract" between society and the health professions, in which society grants professions special privileges in return for certain benefits. Some may favor an interpretation of the contract that exerts greater degrees of control on physicians and other health professionals, adopting a social constructivist view of the health professions that claims health professionals should be viewed as civil servants and obligated to provide legally available medical services, in conformity with society's expectations. But others favor an interpretation of the contract that provides greater degrees of clinician autonomy, viewing professionals as stewards of a practice who are entitled to establish the boundaries of professional obligation based on professional and individual beliefs and values that serve as a framework to interpret medicine's purposes and practices, especially when contested concepts of health pertain to controversial medical services which entail competing assessments of the patient's good. The tension between society's prerogative to impose its will on medicine and the health professional's prerogative to exercise independent judgment invites careful examination of the relationship between patients, health professionals, and society. Such examination should be mindful of the pervasiveness of moral pluralism, acknowledge the existence of controversial areas of practice, and provide space for conscientious practice – especially at the level of the patient-physician relationship, where the bilateral moral agency of patients and physicians should be characterized by mutual respect and freedom.

4. Concepts of Health and Disease

Philosophical, historical, and sociological assessments reveal the extent to which the meanings of health and disease have been debated. Sometimes these debates represent a competition between disease as an objective reality versus disease as a socially-constructed standard defined by deviations from whatever society considers normal (Cohen 1981). Observing how meanings of health and disease change over time indicates the degree to which societies may apply values to identify undesirable conditions (considered diseases) and desirable conditions (considered manifestations of health). History suggests that concepts of health and disease arise from multiple sources, including scientific, statistical, and cultural norms – making health the absence of disease, and defining disease as “the aggregate of those conditions which, judged by the prevailing culture, are deemed painful, or disabling, and which, at the same time, deviate from either the statistical norm or from some idealized status” (King 1981:112). Some sociologically-based interpretations go so far as to suggest that health is “the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized” (Parsons 1981:69). By contrast, those who are persuaded by a more objective and less culture-bound concept would argue that health is an objectively discernable quality, entailing “the well working of the organism as a whole,” and reflecting a natural norm arising from specific excellences of the human body rather than value judgments imposed by a person, culture, or society (Kass 1981:13, 15, 19).

Regarding contemporary literature in the philosophy of health, it can be suggested that three main proposals for concepts of health dominate the discussion. These are often referred to as naturalist proposals (such as the biostatistical concept developed by Boorse (2014)), normativist proposals (such as an enablement or well-being concept as developed by Nordenfelt (2007)), or hybrid proposals that combine aspects of both (such as that favored by Stegenga (2018)).

The biostatistical concept of health defines disease in biological and statistical terms that allow us to define bodily and mental states that cause subnormal functioning. On this view, health is seen as the absence of disease, and both health and disease are viewed as objective and value-free; and the purpose of healthcare is to eliminate those conditions that are physiologically abnormal. By contrast, an enablement or well-being concept of health defines health as the ability to realize one’s most essential goals and identifies as diseases those states that are likely to reduce health. On this view, both health and disease are seen as value-laden and socially-determined; and the purpose of healthcare is to promote health (enablement/well-being) based on an individual or social analysis of persons’ most essential goals.

Clinicians are amply justified in relying on a biostatistical concept of health to assess the problems patients bring to the clinical encounter in order to determine whether these problems are medical problems. Such assessment is part of the “accommodation” that occurs in the patient-clinician encounter described by Siegler (1981). But it is also important to acknowledge that judgments about health and disease also depend vitally on the patient’s own beliefs (Pellegrino 2001) and his or her assessment of the presence or absence of well-being. As decisions about healthcare need to be shared between patients and clinicians, so do assessments about what constitutes health.

One of the ways in which this sharing can be articulated is by maintaining that the clinician has a twofold task when providing care: “to understand patients and to understand their diseases” (Levenstein et al. 1989:107-109). This dual obligation is sometimes framed by contrasting notions of ‘disease’ (as the objective concern of biomedical science) and ‘illness’ (as the subjective experience of the patient). The two aspects of this twofold task map onto the biostatistical and enablement/well-being concepts of health, and the responsibility of caring for patients in their objective-subjective wholeness can then be seen as entailing a hybrid concept of health.

In patient care, discussions of goals of care, and (if needed) concepts of health, have the potential to facilitate the integration of frameworks between patients and clinicians in ways that promote shared decision making when patients and clinicians have contrasting views about what a problem is and how it should be treated. Through careful dialogue, clinicians have the opportunity to explain the grounds of their recommendations by reference to the goals of care they believe are reasonable and the concept of health advanced by those goals, along with the biomedical knowledge, professional standards, and ethical values that determine what they believe are appropriate or acceptable courses of action.

One point of clarification is in order. For those clinicians who rely firmly on a biostatistical concept of health, there need be no competition between convictions about an objective basis for health and disease, on the one hand, and the multidimensional needs of the patient as a person, on the other. One can (and I believe should) endorse a concept of health that simultaneously incorporates objective features of human biology and subjective features of human valuing. In doing so, we can also endorse the importance of a multidimensional concept of the patient as person which appreciates that the biological substrate of disease affects and is affected by an individual's psychological, behavioral, and social contexts (Engel 1981), as well as his or her spiritual beliefs (Sulmasy 2002). Though a clinician's professional expertise will focus primarily on biological and psychological dimensions, the interrelatedness of all four dimensions invites the clinician to keep the broader range of a patient's needs in view (O'Rourke 2000:18). Another way to put the matter is to distinguish between the scope of a clinician's *expertise* (which for physicians and nurses usually favors a biostatistical concept) and the scope of a clinician's *concern* (which we would hope favors a broader, whole-person perspective of the patient's needs, even if all of those needs are not to be addressed directly by the clinician because the clinician's expertise is more limited than the extent of the patient's needs).

5. Shared Decision Making and Limits of Patient Autonomy

In shared decision making between patients and clinicians, the two aspects of a hybrid concept of health need to be joined so that healthcare is guided by goals valued 'subjectively' by patients and grounded 'objectively' by professionals trained in biological sciences. Both concepts of health should be appreciated, and when taken together, they can reflect a twofold view of the patient as an embodied person. This twofold view provides a balanced approach to shared decision making which may be disturbed if allowed to tilt inordinately toward either one of these two aspects of a hybrid concept of health. If clinicians impose interventions that promote objective biostatistical parameters but are contrary to the patient's wishes, the patient as a person is harmed even if medical objectives to improve bodily functions are well-intended. Conversely, if a notion of patient-centeredness leans so heavily toward a patient's autonomous choice and sense of subjective well-being or preference that objective biostatistical parameters are undermined, serious disagreements may impede shared decision making.

To better understand the implications of a purpose-oriented landscape in healthcare in the context of shared decision making between patients and clinicians, it is useful to recall how shared decision making is usually conceived. Shared decision making is seen as a process whereby a patient (or his/her surrogate) and a clinician share information and take deliberative, consensus-building steps to reach agreement about a plan for medical treatment or testing (Charles et al. 1997). The sharing of information is bidirectional, allowing patients and clinicians to describe their respective assessments and explain their rationales for preferences or recommendations (Charles et al. 1999). The emphasis in current conceptualizations is on empowering patients by informing them of their choices and options, helping them articulate and clarify their preferences, and trying to facilitate decisions that allow patients to achieve what matters most to them (Elwyn et al. 2012). The clinician is responsible for providing information about the patient's diagnosis and prognosis, treatment options, and likely treatment outcomes along with their probabilities and possible burdens, side effects, or complications. The patient is encouraged to express the goal or goals of care that are most important to him or her and is expected to make an individualized assessment of treatment options based on preferences regarding likely outcomes, probabilities, and anticipated burdens.

This process of deliberating and choosing depends on the values and beliefs of both the patient and the clinician. There is no 'neutral' vantage point from which to judge since goals, outcomes, probabilities, and burdens must be assessed and prioritized, which requires evaluation based on the patient's and clinician's convictions about what goals are worth achieving, what probabilities are worth accepting, and what burdens are worth bearing. This process is therefore also an ethical process of evaluation, rather than 'merely' a scientific process of factual description or calculation.

At the center of usual renditions of shared decision making is an ethical commitment to the principle of respect for patient autonomy which assumes individuals can achieve self-determination if they are properly informed within a supportive patient-clinician relationship. Despite the confidence in rational choice and individual self-determination that such commitment to autonomy demonstrates, there is also sometimes and expression of awareness that patients cannot execute their role in shared decision making as if they were independently capable of finding and making their way through the landscape of healthcare (Elwyn et al. 2012). The asymmetric dynamics of the patient-clinician relationship with respect to information, access, and ability remind us that there is a significant degree of interdependence in shared decision making. Acknowledging this interdependence helps moderate overly individualistic conceptions of autonomy and invites reflection on the need for a concept of "relational autonomy" that reflects the inherently social character of agency (Mackenzie 2008). Such acknowledgement accepts our universal reliance on the knowledge, care, and support of others (including healthcare professionals) when we are ill or disabled.

6. Practical Wisdom in Healthcare

When patient care is provided by clinicians who are guided by the virtue of practical wisdom, healthcare professionals can be more intentional about engaging in shared decision making in a way that not only respects patients as persons but also appreciates the potential for competing goals of care and contrasting concepts of health and notions of flourishing. As part of a virtue-based approach, practical wisdom in healthcare also recognizes the need for moral character and an agent-centered approach to medical ethics (Kaldjian 2010; Kaldjian 2014; Kaldjian 2019a) which respects the role of the clinician's conscience (or the virtue of integrity) as a core ethical capacity which entails reasoning, emotion, and motivation (Kaldjian 2019b).

Practical wisdom involves deliberation directed toward goals that lead to flourishing, accurate perception of context and circumstances, integration of moral virtues and principles, and good motivations that are sufficient for action. It is a virtue which speaks directly to the question of concepts of health by highlighting the teleological character of goal-oriented healthcare because it is a *telos*-guided virtue which seeks to identify the best means to achieve good ends. In its perceptiveness, it allows us to respond realistically when faced with challenging decisions in the practicalities of actual existence. It also allows us to see how other virtues should be integrated and expressed based on moral values that pertain in a given situation (Kaldjian, 2014, pp. 61-75). This includes the virtue of humility which makes us open to the world and responsive to the needs of those around us, in contrast to the vice of cunning which seeks to impose its will (Pieper, 1966, pp. 19-20).

In medicine, Pellegrino and Thomasma describe practical wisdom as the indispensable virtue that allows physicians to "attain the truth for the sake of action" and facilitates the coordinated expression of all other virtues in the pursuit of a right and good healing action for a patient (Pellegrino & Thomasma, 1993, pp. 84-90). They understand a right action as being determined by what is scientifically and technically appropriate, and a good action as being determined by what is in the patient's interests. Hence their claim that the main cognitive activity of the physician, clinical judgment, requires practical wisdom, for it unites the intellectual and moral aspects of the physician's work.

Drawing from the Aristotelian and Thomistic traditions of virtue ethics, practical wisdom can be understood as a purpose-driven approach to decision making that is focused on ends, bounded by moral principles and virtues, informed by concrete circumstances, shaped by deliberation, and empowered by virtuous motivation. Seen this way, it can be understood as containing five core elements (Kaldjian, 2014b, pp. 225-239):

(1) pursuit of worthwhile ends (goals) derived from a concept of human flourishing;
(2) accurate perception of concrete circumstances detailing the specific practical situation;
(3) commitment to moral virtues and principles that are interdependent and form an integrated moral framework;
(4) deliberation that integrates ends (goals), concrete circumstances, and moral virtues and principles; and
(5) motivation to act in order to achieve the conclusions reached by such deliberation.

The elements of this framework indicate that practical wisdom depends on the foundational beliefs and values that patients and clinicians bring to shared decision making – beliefs and values that determine their understanding of human flourishing, ethics, and the purposes of healthcare. The elements of this framework are consistent with Pellegrino's rendition of practical wisdom (Pellegrino, 1985) and broadly harmonious with the four dimensions of the Jubilee Centre's framework of practical wisdom comprising a constitutive function, integrative function, blueprint, and emotional regulation (Jubilee Center 2020; Kristjánsson 2024).

7. Conclusion

When practical wisdom is conceptualized within broad dimensions that encompass goals, circumstances, and ethics, its relevance for healthcare is clear. Seen this way, practical wisdom is that virtue which allows clinicians to understand patients as embodied persons, recognize the twofold reality of the objective facts of disease and the subjective experiences of illness, and focus on a teleology of healthcare that prioritizes the patient's good without losing sight of the clinician's integrity. Taken together, the perceptive and deliberative dimensions of practical wisdom identify goals of care in medicine relevant to a specific patient in a particular context and discern how goals of care relate to concepts of health and promote flourishing. And being grounded in virtue ethics, practical wisdom in healthcare reflects the existence of moral agency in patients and clinicians alike. From the vantage point of the clinician, it is outward-facing by integrating virtues which attend to the needs and preferences of patients, and it is inward-looking in its concern for moral integrity which requires conscientious practice.

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