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THE "TELOS" OF MEDICINE AND THE GOOD OF THE PATIENT

INTRODUCTION

"Do good and avoid evil". This is the ancient dictum of *synderesis,* and, implicitly or explicitly, the indispensable transcendental ground for any system of ethics of moral philosophy. This is because the good is the end or *telos* of moral science, that which gives it its distinctive identity among human activities. One may locate the good in many places - in natural law (Aristotle and Aquinas), in the will (Kant), in the affect (Hume), or intuition (Moore). But no ethics can avoid the concept of the good, since, without the good as *telos,* the word "ought" is without direction, and morality, itself, dissolves in the acid of skepticism.

Medical ethics has its own construal of *synderesis* in the first moral precept of the Hippocratic Oath. Here, it states:

> I will follow that system or regimen which, according to my ability and judgment, I consider for the benefit of my patient and abstain from whatever is deleterious and mischievous.... (Francis Adams's translation)

All the moral precepts of the Oath, the other deontological books of the Corpus, and the entire subsequent history of medical ethics are elaborations of this first principle. This medical *principium primum* enjoins upon doctors the primary duty of acting to benefit the patient, in a word, always to act for the patient's good. The patient's good is, therefore, the end of medicine, that to which medicine, by its nature, tends and that which gives it its definition.

Until the beginning of the modem era of bioethics, some thirty-five years ago, this notion of the primacy of the sick person as the good of medicine, the end toward which it should tend, would have been unchallenged. Today, this assertion is increasingly under attack by changes in moral philosophy as well as in our social and political mores. The ends of medicine, the good it should tend to, and, consequently, the ethics that should guide it, have become problematic. There is now a great danger that the good of the patient as the architectonic end of clinical medicine will be severely compromised or lost entirely.

Redefining the end of medicine has, thus, become the central problem in the philosophy of medicine. What for centuries seemed so certain is now problematic. Historians, sociologists, ethicists, physicians, policy-makers, and the public are asking the same questions: What should physicians be - primarily healers or servants of societal good, businesspeople, entrepreneurs, bureaucrats, scientists, *etc*.? How should medical knowledge be used, who should decide, how, and by what criteria?

C. Viafora (Ed.), Clinical Bioethics. A Search for the Foundations, 21-32.

These questions imply an altered conception of the good that medicine should serve, the roles physicians should play in serving those ends, and the ethical obligations that should bind them. Recently, these questions were examined seriously in a cooperative, international, interdisciplinary report under the aegis of the Hastings Center (Hanson and Callahan 1999). No consensus was reached on the goals or purposes of medicine. There was agreement, however, that the preferred method for determining goals is through some form of social construction, *i.e.,* by public dialogue, negotiation, or debate. With one exception, the contributors rejected the classical notion of ends in favor of goals or purposes. (Pellegrino in Hanson and Callahan 1999)

In this essay, I will attempt to recover the ancient notion of a teleological ethics. I will do so by turning my attention to ends, rather than goals or purposes, and by addressing four questions: (1) What are the roots of the current conceptual confusion and the need for redefinition of ends? (2) Within the framework of an Aristotelian-Thomist teleological ethic, how do we define the ends of clinical medicine? (3) How do we define the good as the telos of medicine? (4) What implications does the teleological approach have for the ends of the other learned professions - ministry, law, and teaching? (5) What are its implications for virtues and principles in medical ethics?

The conclusions I will reach are these: (1) The roots of the current confusion about the ends of medicine and the need to redefine them lie in the erosion of the classical conception of ends. (2) Recovering that classical conception leads to the conclusion that the end of clinical medicine is the good of the patient. (3) The good of the patient is a quadripartite idea, and this idea grounds the ethics of medicine. (4) The teleological approach can be fruitful in defining the ends of other branches of medicine as well as other professions.

SOME PROPEDEUTIC DISTINCTIONS

I will confine this inquiry to clinical medicine rather than "medicine" generically. By *clinical medicine,* I mean the use of medical knowledge and skill for the healing of sick persons, here and now, in the individual physician-patient encounter. Clinical medicine so defined is the activity that defines physicians *qua* physicians - and other clinicians - and sets them apart from other persons who may have medical knowledge but do not use it specifically in clinical encounters. Clinical medicine is the physician's *locus ethicus* whose end is a right and good healing action and decision. Moreover, clinical medicine is the instrument through which public policies come to affect the lives of sick persons. Finally, no matter how broad or socially oriented we make medicine, illness will remain a universal human experience, and its impact on individual human persons is the reason why medicine and physicians exist in the first place. (Cf. Hippocrates, On the Art)

Using clinical medicine as a paradigm case is not to neglect the other branches of medicine, each of which has its own distinctive end. Thus, for basic scientists, the end is the acquisition of fundamental biological knowledge of health and illness. This knowledge becomes a part of clinical medicine specifically when it is applied to the needs of a particular human being here and now. Similarly, preventive

medicine has as its defining end the cultivation of health and avoidance of illness. Social medicine has its end in the health of the community or the whole body politic. When the knowledge and skills of any of the other branches of medicine are used in the healing of a particular person, then the ends of that branch fuse with the ends of clinical medicine. But in clinical medicine, the good of the patient is the end, *primus inter pares.*

Some of the difficulty of the Hastings Center group in arriving at a consensus arose because these distinctions were not made clearly enough. The group tended to expand the definition of medicine so broadly as to absorb or "medicalize" almost all aspects of life. Such an expansion defeats any attempt to define ends. It places ends in conflict with each other and weakens any attempt to establish a hierarchy of goods among the many ends "medicine" may serve. (Ingemar Nordin).

Finally, it is necessary to clarify my use of the term "teleological ethics." By this, I do not mean any form of consequentialism or its major expression in utilitarianism. Nor do I mean a simplistic biological teleologism. Rather, I refer to an ethic based in the notion of the good as the end of moral acts wherein "good" is defined in terms of the nature of the activity in question, that for which the activity exists. Such an ethic is the antithesis of an ethic of social construction in which the good is defined externally to the activity in question by what we wish or intend the activity to achieve. Elsewhere, I have spelled out the problems with a socially constructed notion of the goals, purposes, or good of medicine. (Pellegrino in Hanson and Callahan, 1999).

THE NEED FOR A REDEFINITION OF ENDS

Today's confusion about the ends of medicine and the need for their redefinition lies in the erosion of the Classical-Medieval notion of ends, their relation to the good, and the relation between the idea of the good and ethics. If the end of medicine is to be redefined, the ancient concept of ends must first be retrieved from exile by modern and contemporary philosophy.

As is well known, Aristotle begins the Nicomachean Ethics with the proposition that the good is that which all men desire. The good is the end or telos of human activity, and the end is that for which a thing exists, that which an act is designed to bring about. Ends are in the nature of things themselves. They answer the question, "What for?" (Jonas 1984, p. 52). We do not impute ends to things; they are not good because we desire them. We desire them because they are good. We may put things, like medicine, to certain goals and purposes, but whether these are good or bad uses depends upon whether they fulfill the ends for which medicine exists and which define it *qua* medicine. Aristotle uses the familiar example of medicine to illustrate his meaning of ends. Medicine, he asserts, is a *techné* whose end is health, just as the destination of a ship is the end of navigation. These ends are also the good for each activity since they are what men seek by engaging in the activity, and the activity is so structured that, by its very nature, it is ordained to the end that defines it.

Aristotle and Aquinas, in a similar fashion, were concerned chiefly with the larger conception of the good for humans as the end of human activity. Both structured their moral philosophies on the good as the end of human life. That end in

its ultimate sense was, for Aristotle, a life consistent with the natural virtues, which led to happiness. For Aquinas, it was a life lived in accord with the natural and spiritual virtues which led to the beatific vision and fulfilment of the spiritual nature of humans.

Both Aristotle and Aquinas anchored the virtues in the ends of human life and the good. Thus, they linked metaphysics with ethics. The virtues became habitual dispositions to act in such a fashion that the end of human life, the good, that to which it tended by its very nature, could be attained. Both Aristotle and Aquinas used medicine as an example of a human activity with a definable end and good, a lesser good, of course, than the ultimate good of human beings as such. They defined the end of medicine as health, that toward which the activity of medicine tended, that which made it what it was and which distinguished it from other human activities.

Thus, in determining the ends and good of human life, and in the realm of lesser good in everyday life, ends and the good are intimately related. For our purposes in this essay, we can pass over such questions as: the apparent contradiction in Aristotle between the primacy of intellect or will in perception of the good; whether the good is determined because we choose it, or we choose it because it is good (cf. Plato, "Euthyphro," p. 391); and whether *telos* and end are coextensive in Aristotle (Hardie 1980, pp. 254-257). Those are important questions, but their answers are still within the teleological tradition.

However, from the late Thirteenth and Fourteenth Centuries to our times, the foundations for a teleological ethic have been seriously eroded. The Nominalists began the process by rejecting any grounding for universals or essence in the nature of things, thus disarticulating the connections between ends and the good. This process accelerated in the Eighteenth Century and has continued to the present. (MacIntyre 1966). The history of the erosion of the teleological ethic is too complex for citation here. Four conceptual shifts over the centuries seem particularly relevant: (1) The rupture between ethics and metaphysics in Kant's insistence on locating the good in the will and ethics in reason alone. (2) Hume's denial of any logical connection between "is" and "ought," between fact and value, and his preference for affect over reason in ethics. (3) G. E. Moore's declaration that the good is an indefinable quality. And (4) the discrediting of any stable foundation for moral philosophy as well as extreme skepticism about the possibility that moral truth is ascertainable by the use of human reason.

The upshot of all of this has been profound for moral philosophy, particularly for Anglo-American ethical theory. Emphasis on the good has been shifted to an emphasis on the right or to the act of commending or valuing out choices and preferences. Morality, itself, becomes the creation of our choices and the mores of a liberal society. The good is revealed in the choices we make

On the modernist view, especially in Anglo-American philosophy, moral choices are simply our preferences among the sentiments dominant in our society at a particular time. Our differences are differences of language or interpretation of a set of facts. This is the "foundation" for the now-dominant social construction theory of morals. It is a direct antithesis of the natural law tradition which recognizes a transcendent moral reality. The moral person is expected to discover that reality by

the use of reason and to be guided by it. And, *pace* Hume, moral truth can be derived from existential fact.

THE END OF CLINICAL MEDICINE

Aristotle and Aquinas both define the end of medicine generically as health. Kass defines this end more specifically as the well-functioning of the human body. These definitions are general enough to encompass clinical medicine as well as the basic sciences related to medicine, including social and preventive medicine. But they need to be refined further for our project which is to define the ends of clinical medicine.

Clinical medicine, as we have defined it, centers on the clinical encounter between someone with medical knowledge and someone who needs that knowledge to restore health, the well functioning of the human organism which has been disturbed by dis-ease. For the sake of that end, a more proximate end must first be gained, that is, a right and good healing decision must be made and safely implemented by the clinician and the patient. This is the more immediate end of the clinical encounter. It is that which the ill or sick person needs and that which the clinician *qua* clinician is ordained to provide.

Medicine is, indeed, a *tekné* as Plato and Aristotle said. It is, in medieval terms, a *recta ratio factibilium,* a right way of making or doing a thing. Clinical decisions must, therefore, be technically right, *i.e.,* scientifically correct, but also morally good. This fusion of the technical and the moral good is effected in the interest of a vulnerable, anxious, dependent, exploitable person. This is the indispensable starting point of the further end of healing and health.

Healing is the act of acts whereby the disruptions of bodily, mental, and spiritual harmony of present health is disrupted by disease. If the patient is to be healed, the disruption of disease must be ameliorated and the violence lessened or, if they are irreversible, healing may still take place, although its focus will shift from curing to caring, coping, and alleviating pain and suffering. These are wounds to the patient's humanity which can be healed even when the patient is dying. Cure may become futile, but care is never futile.

The end of healing is the good of the whole person - physical, emotional, human, and spiritual. The good is, therefore, quadripartite, healing at four levels of human being and living: the lowest level is the medical good; above that is personal good as perceived by the patient; next is the good of the patients as a human being; and the highest good is the patient's spiritual good. The good of the patient is therefore an hierarchical good in which each level must be in proper relationship with the others**.**

DEFINITION OF THE PATIENT'S GOOD
THE MEDICAL GOOD

The medical good is that which relates most directly to the art of medicine, that part which is uniquely medical. The medical good aims at the return of physiological function of mind and body, the relief of pain and suffering, by medication, surgical interventions, psychotherapy, *etc.* At this level, the patient's good depends on the

right use of the physician's knowledge and skill, those which are intrinsically part of the medical *tekné.*

But the medical good must be brought into proper relationship with the other levels of the patient's good. Otherwise, it may become harmful. What is medically "good" simply on grounds of physiological effectiveness may not be "good," if it violates higher levels of good, like the patient's good as he perceives that good. This perceived good is the second level of patient good.

THE PATIENT'S PERCEPTION OF THE GOOD

The medical good serves the many, complex facets of what the patient perceives as his own good. Here, we are concerned with the patient's personal preferences, choices, and values, and the kind of life he wants to live, the balance he strikes between the benefit and burdens of the proposed intervention. These qualities and values are unique for each patient and cannot be defined by the physician, the family, or anyone else. They are determined by the inter-relationships between and among age, gender, station in life, occupation, *etc.* To serve the general good of the patient, the medical good must be placed within the context of *this* patient's life-plans.

THE GOOD FOR HUMANS

Medical good and the patient's perception of the good life must be related to the good for humans as humans. This was the good Aristotle and Aquinas sought to define. At this level, we are concerned with the good peculiar to humans, like preservation of dignity of the human person, respect for his rationality as a creature who is an end in himself and not a mere means, whose value is inherent and not determined by wealth, education, position in life, *etc.* The patient is a fellow human with the physician to whom he is bound by solidarity and mutual respect.

It is at this level that some of the familiar principles of medical ethics are philosophically rooted, like autonomy, beneficence, non-maleficence, and justice. In American bioethics, these principles are taken to be *prima facie* principles rather vaguely grounded in a "common morality." This suggests that they could be changed if the common morality were to change them. For others, this is not the case. The good for humans is not subject to social construction. It lies within human nature and is a requirement of the natural law.

In the clinical encounter, the medical good and the personal good must, in their turn, be consistent with, and protect, the good for human beings. Physicians who ignore the patient's notion violate the good of the patient to self-determining rational being. Denial of care to the poor violates their dignity and value as human beings. Devaluing the lives of the handicapped does the same. Putting patients at risks that outweigh potential benefits, even with patient consent, violates the duty of beneficence and avoidance of evil.

SPIRITUAL GOOD

The highest level of good which must be served in the clinical encounter is the good of the patient as a spiritual being, *i. e.,* as one who, in his own way, acknowledges some end to life beyond the material. This may, or may not, be expressed in religious terms. But all, except the most absolute mechanistic materialists, acknowledge a realm of "spirit," however differently they may define it.

This realm of spirit gives ultimate meaning to human lives. It is that for which humans will often make the greatest sacrifices of other good things. For many people, the realm of the spirit is religion. They would be guided by a set of specific beliefs or doctrines that carry ultimate weight in every kind of decision. From the perspective of natural law, the spiritual destiny of man is his highest and ultimate good. Indeed, the dictates of the natural law are, themselves, that portion of divine law ascertainable by human reason.

Whatever the origin and content of one's spiritual beliefs, the three lower levels of good I have described must accommodate to the spiritual good. For example, blood transfusion might be medically "indicated" for the Jehovah's Witness, abortion of a genetically impaired fetus for a Catholic, or discontinuance of life support for an Orthodox Jew. But in these cases, the mere medical good could never be a healing act since it would violate the patient's highest good. Similarly, the Muslim, the Buddhist, the Hindu, or the humanist patient has his own spiritual good which must be encompassed within a clinical decision if it is to serve the "good" of the patient.

SOME COMPLEXITIES

In many clinical encounters it may not be possible to assess each of the four levels of patient good and establish the order of priorities among them. This is the case with infants, children below the age for responsible decision-making, the retarded intellectually, the elderly, or those in permanent vegetative states. In these circumstances knowledge about the patient's personal preferences or spiritual beliefs may be lacking. Yet clinical ethics imposes the duty to come as close as circumstances permit to an estimate of the patient's good as a whole.

In such cases, two levels of the good are still accessible - i.e. the medical good, and the good of the patient as a human being. In the case of infants it is impossible to know about preferences, etc. Parents, surrogates, and others must be relied on to represent the particularities of the other two levels from prior knowledge of the patient. How these are best balanced against medical good is a matter for more extended analysis than permissible here. Suffice it to say, that surrogates to be morally valid representatives must be without significant conflicts of interest. In the end the physician is still responsible for what is done and must therefore remain a guardian of the welfare of the most vulnerable patients.

In a pluralist society another issue centers on the degree to which a particular patient's preferences, world-views, and religious practices impinge on the physicians own beliefs about what is good for the patient. While I have emphasized the primacy of the good of the patient, the good as perceived of the patient and the physician himself must be respected as well. The dictum of the primacy of the good of the

patient, does not eradicate the physicians judgment of what is good medicine, what he thinks of the human life ìssues and the spiritual destiny of himself and his patient.

In short the end of the clinical encounter is a subsidiary good, a part of the more complex realm of the good for humans. The physician therefore cannot be used as a mere means any more than the patient. The physician is entitled to respect for his autonomy, religious beliefs and scientific integrity. The complexity of resolution of conflicts between and among patients, physicians, families and other health workers is a growing problem in clinical ethics. But the existence of complexities cannot be used to justify a utilitarian, legalistic or libertarian definition of the ends of medicine or the physician's or patient's good.

Similar difficulties are encountered in the interpretation of clinical futility - which is a central factor in deciding the medical good. Clinical futility in any patient can be defined as the balancing of a relationship between the effectiveness, benefits and burdens of intervention. But this calculus may result in different or opposing conclusions about whether it is morally permissible to discontinue treatment

From the moral point of view there is no obligation to provide futile, or disproportionately burdensome treatments. This would be to do harm, not good. Yet some patients families want "everything" done, including cardiopulmonary resuscitation even when the data show it would be unsuccessful. These and many other conflicts in the interpretation of the "good" of the patient accompany the clinical encounter today. They promise to become ubiquitous in our morally polyglot society.

All of these complexities emphasize the need for greater clarity in the ethics of the process of decision-making. They do not vitiate or trivialize the importance of a definition of the ends of medicine. Indeed without some clarity on the ends of medicine and the good of patients as the end of medicine, the process of ethical decision-making will be even more difficult to establish.

This paper confines itself to a definition of the ends of medicine and the good of the patient. It does not engage the issues of the ends of investigative medicine or social medicine. These are realms in which medical knowledge and physicians are involved for ends different from the immediate ends of clinical encounters. However, in research and social medicine, the quadripartite conception of the good that I have developed in this essay must be preserved. The good is of a piece, and its unity must be intact even though, in practice, there may be tensions between and among its components.

IMPLICATIONS FOR THE OTHER HELPING PROFESSIONS

The conceptual schema proposed in this essay to redefine the ends of medicine in terms of the good of the patient has applicability beyond medicine. With proper redefinition of the ends peculiar to each profession, this schema can be used to define the good of the lawyer's client, the teacher's student, and the minister's penitent or parishioner. As with medicine, the ends of these other helping professions are linked to a particular activity specific to each profession.

Those who seek out these professionals share a certain common phenomenological ground. They all deal with human in compromised existential

states. The persons they serve are dependent, anxious, in distress, and lacking something essential to human flourishing. That lack in medicine is health; in law, justice; in education, knowledge; and in ministry, union with God. Humans in these compromised existential states are eminently vulnerable and exploitable. Persons in that state are invited to trust the professional and, indeed, *must* trust him in order to be helped or healed. In each instance, the untrustworthy professional could exploit the patient's vulnerability for personal power, profit, or prestige. In each case, the character of the professional is the final safeguard. In each case, the end of professional activity is the good of the person in need of help.

As with the medical relationship, the "good" in each of the other three helping professions is a quadripartite concept: (1) the level of technical good, (2) the good perceived by the person served, (3) the good for the person as a (flourishing) human being, and (4) the spiritual good. Each profession operates most directly on one or other of the four levels. But, regardless of its specific focus, each profession must also attend the totality of the good of the person served by that profession.

For example, the lawyer focuses on obtaining justice for his client. Justice is a good of the client as a human being necessary to fulfillment of his human nature. But he cannot attain that end unless he is also concerned with the first level of the good - the legal good, *i. e.,* he must be competent in legal practice. He must be fully competent in legal procedures and in those techniques necessary to press his case in court, negotiations, or depositions. These are necessary for a right verdict but not entirely sufficient for a good verdict, for the lawyer must also be aware of the other levels of the client's values.

Thus, at the second level: What does the client deem justice to be in his case? To what degree does he wish to risk gain or loss, to settle out of court, to demand retribution? At the third level, the lawyer's success or failure is attendant on the degree to which he can gain for his client the human right of justice, freedom, vindication, or, if his client is guilty, a fair sentence. Finally, at the fourth level, to the extent that his client's religious or spiritual beliefs shape his plea for justice, they must be taken into account. For example, the client may be willing to forego certain of his claims in the name of charity for his opponent. Thus, as in medicine, all four levels of the good must be factored into the outcome or ends of the morally valid lawyer-client relationship.

Teaching may be similarly treated. As the possessor of knowledge and skill, the teacher's major emphasis will be at level three. Knowledge and truth are goods essential to human flourishing and fulfillment. To help others to achieve those goods, the teacher must, at the first level, possess the knowledge and skill he purports to teach. He must have mastery of the teaching methods, sources, and technical apparatus without which the end of knowledge transmission cannot be attained. At the second level, teachers must also adapt, to some significant degree, to the interests, learning modes, work habits, and preferences of the student. In the interests of the good of the student, teachers also may have to modify, restrain, or replace values that interfere with the end of learning. At the third level, that of the good for humans, teachers are required to respect their students with the dignity owed to persons, to treat them fairly, honestly, *etc.* Finally, at the fourth level,

spiritual beliefs must be respected, allowed to flourish, and integrated with the more technical or academic dimensions of the student's education.

Finally, the priest-petitioner relationship(I am using the priest-penitent's relationship as an example of the relationship of the minister as spiritual healer. There is no conventional noun parallel to doctor-patient, lawyer-client, or teacher-student relationship. Priest-penitent stands here as symbol for the personal moral relationship of any minister of religion to the person who seeks his help) has its moral dimension most specifically at level four, the level of the spiritual good. This is what the penitent seeks from the minister: counsel on his relationship with God; how to be reconciled with God after sin; how to grow in the spiritual life; how to decide moral questions in light of revelation or church teaching; how to adapt to death, hardship, *etc.* in accordance with Divine Will. To attend to the spiritual good takes precedence over the other levels of good. But the other levels cannot, by that fact, be ignored since they are part of the integral good of the person served.

At the first level, therefore, priests must be skilled in the ends of the activities specific to the priestly vocation, *i.e.*, mastery of the theological or pastoral skills required to make their counsel serve the good of the penitent. At the second level, they must take into account the patient's unique values, the uniqueness of his spiritual predicament, his station in life, preferences for spiritual charisma, styles of prayer, life situation, *etc.* At the third level, the priest must protect the good of the patient as a human being, *i.e.,* maintain the seal of the confessional, help the penitent to integrate his spiritual and his temporal good, appreciate his dignity as a child of God, *etc.*

In each profession, the four components of the patient's good are arranged in lexical and hierarchical order. The spiritual good takes precedence over all, followed, in descending order, by the good for humans, the personal evaluation of the good, and, at the lowest level, the technical good specific to each profession. Moral decisions in the course of professional activities are "right" if they conform to the *tekné* of each profession at the first level. But to be "good," they must conform at the other three levels as well.

PATIENT GOOD, VIRTUES, AND PRINCIPLES

Thus, there is another facet of professional conduct common to all helping professions, the fusion of a technically night and morally good decision and act on behalf of a vulnerable human being. This fusion requires certain virtues or character traits in the practitioners of all the healing professions. David Thomasma and I have examined the question of virtue in general and specific virtues in the health professions elsewhere good of the person (E. Pellegrino and D. Thomasma, 1993, 1996), so I will only enumerate the professional virtues here.

I understand virtues as Aristotle did when he said " ... the virtue of man also will be the state of character which makes a man good and makes him do his own work well" (Nicomachean Ethics 1106a22-25). In the professions, the virtues are, therefore, those traits that dispose the professional - doctor, lawyer, minister, teacher - habitually to be a good person and do his work well, that is to say, to achieve the

ends to which his work is directed. To be "good," the professional must predictably exhibit certain dispositions, those which enable his "work to be done well."

The virtues of the professions are entailed by the end of professional activity, *i. e*., the good of the person served. Some of the most essential virtues would be: (1) fidelity to trust, which is ineradicable in healing relationships; (2) some suppression of self-interest, since the person served is in a vulnerable state and dependent on the power of the professional; (3) intellectual honesty, since professional practice beyond one's expertise is injurious; (4) compassion, since understanding and feeling something of the unique predicament of the person's need is essential to healing; (5) courage to pursue the good in the face of today's commercialization, depersonalization, and industrialization of professional life; and (6) prudence in every act so that the measures chosen are best suited to the technical and moral good of the person served.

Finally, a clear perception of the good of the patient, client, student, or penitent provides a moral grounding for the commonly employed "principles" of medical ethics. The good of the patient is a stronger foundation than the "common morality" adduced these days (Beauchamp and Childress). After all, the common morality is a social construction subject to change and unpredictability.

The good of the person served is linked ontologically to the end of the professional activity. It is not subject to change at will. With the good as the end of professional activity, autonomy becomes essential since to violate autonomy is to violate the dignity and humanity of the person. Justice is tied to the good for humans *qua* humans and is critical to every professional act for individuals and human society. Beneficence becomes the *primum principium* of all ethics, professional as well as general, since its end is doing good.

In sum then, the four helping and healing professions have a common end - the good of the vunlerable persons in need of professional help and expertise. Each profession deals with humans in vulnerable states; each confronts the most personal, intimate recesses of the lives of other humans; each is permitted access to the inner life of another human being; each promises to help and invites trust; each is judged by the degree to which the good of the person served is attained by their professional activities. Although each profession functions most directly at one or another of the four levels of human good, each professional also must, in its own way, serve the other levels as well.

We are speaking, here, of a common devotion shared by each helping profession to the good of the persons served. That good is the end of all professional activity. Subsidiary ends may be different for each profession depending upon which level of the good is its major focus. Whatever that subsidiary end, however, certain virtues and principles are necessary, and they are defined in terms of the being served.

CONCLUSION

Do good and avoid evil is the *primum principium* of all ethics. All ethical systems, medical ethics included, must begin with this dictum, which means that the good must be the focal point and the end of any theory or professional action claiming to be morally justifiable.

Since the Hippocratic Oath, the good of the patient has been the end of medical activity in clinical medicine. This paper attempts to define the good of the patient in concrete terms related to the phenomenology of the clinical encounter. The good of the patients is found to be a quadripartite good, a complex inter-relationship between medical, personal, human, and spiritual good, hierarchically arranged. This concept generates the duties of the clinician. The complexities of its application in medical practice are described. A theory of the good of the patient also has applicability for the ethics of the other healing and helping professions and the virtues and principles pertinent to their practitioners as well.

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