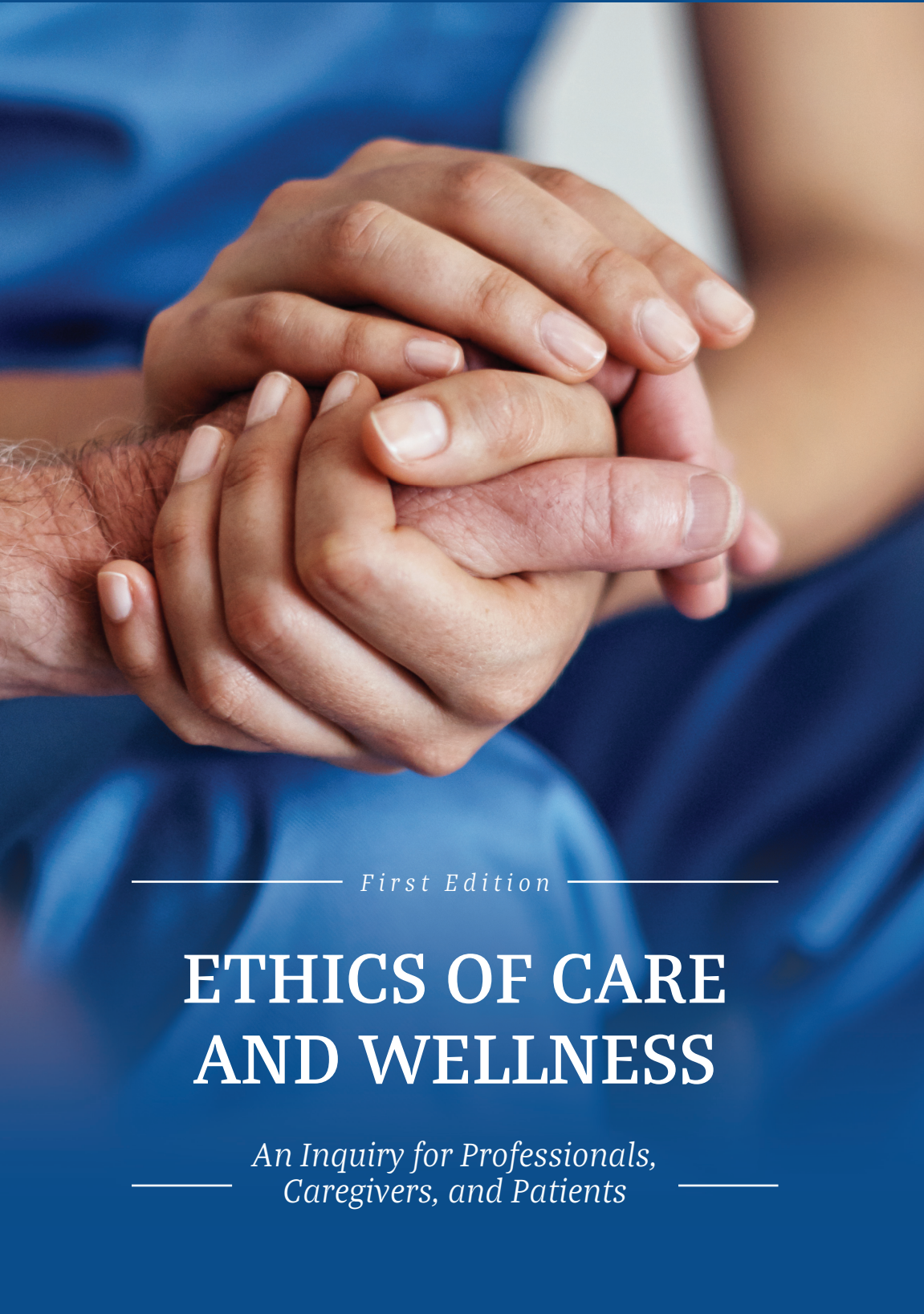


STEPHEN BUJNO



First Edition

ETHICS OF CARE AND WELLNESS

*An Inquiry for Professionals,
Caregivers, and Patients*

Ethics of Care and Wellness

AN INQUIRY FOR PROFESSIONALS,
CAREGIVERS, AND PATIENTS

FIRST EDITION

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AUTHOR'S PREFACE

A mother singing to her child creates a bond through her singing. The two rock back and forth to its rhythm; the sound is internalized by the child as mother's sound, the sound of safety. A woman who can bond with her child in that way gives the child an added source of security, and the two cling to each other more firmly when the moment of crisis arrives.

Sir Roger Scruton, PhD, *The Soul of the World*

No practitioner of medicine wants to turn a person into an object, an object that he subjects to technological manipulation in the ICU.

Jeffrey P. Bishop, PhD, MD, *The Anticipatory Corpse*

I am a first-generation college graduate. My father never made it out of his sophomore year of high school. At sixteen he lied about his age and enlisted in the service to fight in WWII. Before his eighteenth birthday, he had witnessed more than most should. He made all of his children go to college. As for myself, I took a nontraditional approach to my education. Growing up in an Italian section of a small town known for high school football and fabricating rail cars, I quit college due to the cost. I did find work and returned to finish a bachelor's degree. After starting a family and a business, I managed to continue course by course, completing two graduate programs and finally earning my PhD. It took some time. I am thankful for those who are able to pursue their academic career with more ease, but I also quietly celebrate those who cannot.

I have learned something peculiar over the years of teaching. One singular common thread that most all of those in my classroom had was the intuitive gift of ferreting out authenticity. *Authenticity* is not a clear word. Here it means to the extent a professor's passion is admired in the classroom, and

pretention equally despised. That goes both ways. I am fortunate that some students have never lost touch and personally visit, nurturing both my mind and spirit at my home library/bar. Presently, I teach ethics and philosophy *in* the classroom, both in Philadelphia and Reading, Pennsylvania. But I also teach asynchronous online courses at both the undergraduate and graduate level. One deficit of the latter is that there is no automatic experience for the student to sense my style and tone. This means that if you are not an in-class student then it is impossible for me to know how my style and tone will be perceived. And perhaps even more importantly, with this text of mine all the reader has is words. I cannot read the room, sense perceived ambiguity, expand where needed, and use one of my hundreds of personal stories and anecdotes to illustrate the point; my mother said I came out of the womb telling stories and that on my tombstone the epitaph will read, “He would talk to anyone.” She was correct. But writing, like teaching, is a performance art, and one must use what skills they have. Here, although writing is a type of teaching, it is more akin to those asynchronous classes where the essential aspects of tone and reading the room are rather difficult to translate into words on a page. Why does that matter? To mimic the characteristics that are easier to create in a live class I have done my best to anticipate where the reader will have clarity issues and present the material in a way that unveils the theme or point. That means some themes may seem labored and others terser. I sensed it simply took more to make the case with some sections and less so with others. There are case studies peppered throughout for practical illustration. And there is Anna’s story, which is not my story but an important one, nonetheless. There the reader can follow the diagnosis, care, recovery, and cure(?) of Anna’s health journey with infant leukemia. That is a rhetorical move and helps with setting that style and tone.

My motivation for writing this text is two-fold. First, my approach offers philosophical considerations that are not typically found in medical ethics texts, but that I nonetheless see as crucial for a medical professional to have considered. For example, physicians, nurses, and caregivers are persons who themselves are treating and caring for persons who seek care and wellness. There are persons on “both sides.” So, an entire chapter is dedicated to this understanding of the human person—which is not as obvious as one may think; philosophy uncovers what is often missed in “the obvious.” The second motivation is that some chapters are nearly standalone mini courses. That is

not to suggest they are long, but they are comprehensive and self-contained. It has been my experience that even if most nursing and pre-med programs require an ethics course, the substance of them can be wanting. Some of the foundational thinking that is required to make the professional obligation and applications sections clearer and more digestible needs prerequisite treatment. There is a lot of required coursework for medical professionals to digest in their academic training, and as I often hear from practitioners and professionals, “We were told we would learn it on the job.” There is some truth in that as legal parameters and workplace protocol often become the practical guides. But being a medical professional is not simply a job, and patients are not merely files to close. This text attempts to humbly fill in the gaps of those things that may not be part of the on-the-job training. It is also true that though everyone wants to be critical thinkers, few know how to think logically. It is not a matter of lacking intellectual acumen, as many people with a PhD, MD, RN, and so forth, have never taken a logic course. I also teach logic and critical thinking, and as my students soon realize, logical thinking is also not an obvious or intuitive endeavor. To accommodate that concern there is a full chapter on syllogistic logic and fallacies—technically it is not part of a medical ethics course, but some of the material (and arguments) in the other sections will make more sense if the contents of that chapter are understood.

The fact that this text is a philosophical approach should not lead one to think there are different types of ethics, those focusing on clinical ethics and those focusing on philosophical ethics. Ethics is ethics, and clinical and philosophical are the approaches. My hope with the philosophical approach is to move beyond standard concerns of only covering what will be “needed” in clinical care; as stated, there is truth to skills being acquired on the job, but I want to expose the reader to foundational thoughts and considerations. I will offer background and historical context. I endeavor to explain how ethical thinking has evolved and will continue to evolve as presented with ever new challenges. I also want to inform the reader as to the role of technology (what it is and what is the goal), and to consider the applications of past and present, along with the rapidly approaching and unpredictable future. Without a proper and intentional ethical approach both understood and applied, the rapid advances in treatment, therapy, and future applications will make any present ethical text seem outdated or even archaic in the near

future. The foundational merit of this text's approach are three things to help the professional and caregiver in that regard: (1) to *think critically* and originally, (2) to *know how to question*, and (3) to *know what questions to ask*. Developing those skills applied to health care and wellness will keep the contents of these pages relevant for the medical professional into the future.

I purposefully want this text to be a resource. I have also offered extensive footnotes, which should be interpreted as source transparency. The advantage is twofold. First, the reader can follow the research progression in how the arguments and supporting ideas were formed. Second, the citations provide the reader a direct path to verify the points or to fill in any gaps the present text was unable to expand on further. Together this approach allows the reader to personally check the veracity of the claim and/or the study cited. Let that be my proposal of credibility. Philosophy is the love of wisdom. Ethics is applied philosophy. Further extended to medical ethics as *The Ethics of Care and Wellness*, I offer this text as a means to uncover what is wise (or not) in the ethical application of health care, treatment, and research for the sake of medical professionals, caregivers, and patients.

ENDORSEMENTS

In writing *Ethics of Care and Wellness: An Inquiry for Professionals, Caregivers, and Patients* Dr. Bujno has provided a comprehensive resource that will prove to be valuable in many settings. While written to mimic the rhetorical approach to classroom lecture, it will also serve as a ready-resource that can be pulled off the shelf when the need arises. Dr. Bujno's book invites the reader into a deeper understanding of what it means to be a "human" in its deepest sense, and then uses this understanding to navigate the challenging world of health care ethics. Most fortunately, Professor Bujno has provided for us an in-depth analysis of both the philosophical underpinnings of bioethics as well as specific questions that arise in the clinical setting. Many of the books on my shelf fail to achieve this balance. As a neurosurgeon and bioethicist, I am often called upon to accompany patients and their families at the end of life and the section on "End of Life Care" is especially well done. Decision making at the end of life is not always straightforward and having a firm foundation in philosophical principles helps guide clinical decisions which are often quite nuanced and cannot be made based on some boilerplate protocol. This book will no doubt have numerous protruding "sticky notes" that will quickly bring me to my favorite sections.

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Nebraska Medical Center; Bioethicist,
Archdiocese of Omaha, Nebraska

INTRODUCTION

THE APPROACH AND THE INTENDED READER

The approach of *The Ethics of Care and Wellness* is philosophical. That is to assert that the presentation, explanations, and arguments will be premised on rational claims. Even if not argued here, that is not to assume that the use of theistic elements is irrelevant. Such elements are appropriate, as are cultural and social factors, which can also be in line with reason. But none of those will be offered here as premises. Staying true to that approach, this text does not take for granted that the meanings of the terms *ethics*, *care*, and *wellness* are either self-evident or commonly agreed on. If stating the use of a rational method seems obvious, or if the concern for those terms comes across as pedantic or perhaps elementary, then this text is not only useful but also essential for an inquiry into the ethics of care and wellness. I will follow up on those notions shortly, as they offer an important illustration of the strategy used.

AUDIENCE OF BOOK AND APPROACH TO ETHICS OF CARE AND WELLNESS

First, the target readers are **medical professionals, caregivers, and patients**. That is intentionally all-encompassing, as I will argue briefly that this interrelationality needs emphasizing and those groups need to be considered together. But the point here is to ask the question, “What ethics training have adult members of those groups received?” The differing levels of education might give one the impression that physicians have the most, nurses somewhat less, and for medical technicians it depends on the application. Caregivers’ and patients’ ethical training would simply depend on their own educational experience. Assuming for the sake of argument that all have an undergraduate degree, it may be surprising to discover that they likely share a similar level of formal ethical education. Solid comparative data are difficult to acquire, but most colleges or universities require a single

three-credit course in ethics. That course could cover anything from health ethics to criminal justice ethics, to environmental issues. All of those are important, but hardly foundational. Private institutions, particularly those with a Roman Catholic affiliation, will typically require both six credits of theology and philosophy each, where issues of justice and ethical evaluations are central to the courses. But as higher education becomes less liberal and more vocational, it may be the case that broad ethical studies in particular suffer at the expense of what is thought to be practical and therefore more narrowly focused.

This observation is not meant as a critique of ethical training or college curriculums, though there is a point to be made. Rather, all of the groups mentioned would agree on the importance of ethical training, but they will have minimal exposure to the methods and analyses that are philosophically used in an exacting manner. What does that discrepancy between the necessary value of ethical preparation and the comparatively scant actual preparation reveal? It is true that medical professionals will learn more in their practice. And generally speaking, for all individuals, formal training does not guarantee ethical behavior any more than a lack of it implies unethical behavior. But ethics is not just “one more thing” to know. It is the lens for all human thinking and acting. It imbues worldviews, it forms and is formed by concepts of the human person, and it solicits judgments on objective truth—all the while employing the rigor of rational argumentation. Common sense cannot satisfy those elements, nor should it. The point is that the rules of logic and critical thinking constrain the approach and method; understanding that point is neither obviously known nor reducible to common sense.

As to the term *ethics*, it encompasses an understanding of a practical application of philosophy where systems and principles govern human activity. But that really does not easily translate into how those ethical principles are formed, or what ethical systems are to be accepted. Further, ethics cannot be so subjective that its judgments have no export to another person or situation, or so encompassing that it barely rises to the level of a general agreement. Every ethical evaluation requires a judgment, and a rational truth is the foundation of that judgment. Though ethical appraisals need not *always* fall into the false dichotomy of being licit or illicit—even if that is certainly true at times—it is likely that *some* judgments will ethically be better than others. That further requires two more ethical considerations:

the standard and the goal. That will not be argued here, but an agreed-on standard has been elusive in our pluralistic society, where rational truths are too often deemed subjective. And as for the goal, that differs by both a “value” placed on the goal (Is it worth it?) and whether that goal is “good” for the human person (Does it fulfill an authentic need?). This implies that the person must identify the goal (“I will do x ”) along with choose how it will be achieved (“To do x , I will use y ”). The point is that to know and claim that ethics is important really only begins the conversation. Part of the strategy in this text is to never assume that all one needs is mere information and facts presented to intellect. This is not that type of systematic text. The individual’s mind requires interrogation. The intellect must be made pliable, with an appetite for the quest of essential elements necessary for comprehension. Therefore, this approach is much more explorative; ultimately, it is an *inquiry*.

To the other two terms, then, one’s understanding of *care* and *wellness* cannot be limited to “being offered a cure” or “living without an ailment.” To say that curing is important is an understatement, but to equate medical *care* with a cure is rather reductionist. What, then, can be meant by the statement “I am healthy; I am well”? Wellness cannot simply be the experience of living in the absence of an infirmity or a pathology. It is also not a matter of merely helping the individual person to live free from a physical or mental infirmity. Those are quite noble goals, but it remains the experience of a precious few, if any. So, an undercurrent of this text is to aid in reorienting an approach to medical ethics where the professional enters a *relational endeavor of care and wellness* with the caregiver and the patient. This necessarily extends beyond office visits and procedures, allowing all to reach mutual goals with common values.

That last point possesses an embedded notion that, again, may sound obvious when first stated: that *health care and wellness is an inherently relational endeavor*. But how is this relationality understood and practiced? It has various facets, and often between one medical professional and another it is merely role-oriented; each has duties and professional expectations where rightful respect flows from one person’s proficiency working in tandem with the proficiency of the other. When relationality is thought to be necessary between the professionals and their patients, it is recognized that bonds that are too personal are hazards, yet if the relation is too distant the sterility is equally damaging. This is difficult to navigate, which unfortunately is

why relationality is often thought to be peripheral—or worse, relegated to sentiment that is detrimental to good care. Then market forces arise where professional rapport and consumer experiences are expected to “close the gap” for patients who have mistakenly accepted that their relationship with medical professionals is based on cures and services, each seeking satisfaction.

BACKGROUND AS TO HOW THE BOOK IS ORGANIZED

Prior to some brief outtakes on the chapters, one more insight must be offered concerning the strategy of the text. The literary style is intended to mimic the rhetorical approach of a classroom lecture and dialectic. This is true within each chapter, and within the text outline as a whole. In fact, the text was born from course presentations, which perhaps is often the case. In a lecture-dialectic tactic, a topic is first framed in context. Then, what is thought to be the customary understanding is purposefully unseated. This is done by revealing some deficiency or error that, until it is recognized, camouflages the authentic comprehension, which can now be introduced. Typically, most individuals are unaware of their own preconceptions and prior prejudices. Having the other person walk them through their thought process results in both “essential points” and “conclusions derived from sequential arguments” being summarily dismissed. In other words, it avoids a knee-jerk reaction to reject what is initially disagreeable. If that tactic is used here, the topics at times may appear rather unsystematic or tangential. That is intentional. In matters dealing with such elevated goods as health, wellness, and inherent relationality, comprehension and right action cannot be expected to follow accurate information guided by principles and protocol; that is, complex ideas are not correctly understood by “following the rules.” There is something particular about narratives that embed a notion that otherwise is easily forgotten. Education, formal or informal, gathers so many factoids that often seem disconnected from some whole. So, the rhetorical approach here will use literary references and various case studies to make the points clear, and to make them easier to recollect in context.

A UNIQUE FEATURE OF THIS TEXT: ANNA'S STORY

The reader will recognize one narrative account distinctively displayed that is especially designed to that end: **Anna's story**. Anna was diagnosed with infant cancer at seven months of age. Her mother kept a journal from day 1,

and the family has generously allowed me to pull parts of *their* story (exposing the relationality) and embed those parts in relevant sections of the chapters of this text. Hopefully, that will make the sections concrete and also serve as a thread illuminating the interconnectedness of each chapter for the medical professional, caregiver, and patient. Also, to follow Anna's story will keep fresh in the reader's mind the idea that every patient is a person, and every person has a name. It may also buoy the notion that *theory is to preparation as experience is to the practical*. No doubt, practicing medical professionals, seasoned caretakers, and many patients will immediately sense similar stories from their own health and wellness experiences.

DETAILS ON THE ORGANIZATION OF CHAPTERS

The section title, chapter headings, and subheadings are important insights into this proposal for the ethics of care and wellness. In this introduction, I want to offer a brief exposition as to why. There are two sections: (1) "That Which We Are" and (2) "That Which We Do." On a surface level, they obviously are interconnected, as we are always "becoming" as we are "doing." But there is a primacy to the notion of the first section, "That Which We Are." It involves individual character, one's ability to reason, developing a worldview, and the ethical disposition of "That Which We Do" to both preserve the patient's dignity and tend to their care and wellness. So, the text begins in chapter 1 by addressing the notion of "What is health?"—asking what the "work" of health is, and how health has been understood through history. Then it explores the qualities that draw people to the service of others as being a necessary match to the vocation of care and wellness. The relation of ethics to health care will follow—which also may not be as obvious as first thought. Finally, the initial chapter addresses how the health care professional's and caregiver's individual conscience, free will, and (too often) moral distress fit into the schema. The content of chapter 2 may prove challenging. The acts of clear critical thinking and syllogistic logic are one area where no convincing is necessary as to their lack of widespread skill. But the goal here is not to be master logicians, but rather to glean how critical it is (1) that terms must be understood, (2) that the way they are grouped expresses a judgment that must be true, and (3) how those expressions must form a valid and sound argument. Even the notion of what an *argument* is will likely challenge one's previously held definition. In the end, one must "think about how to think"

1/11

ER-425~~8~~ white blood ct.

10pm Chest Xray Potassium elevated, EKG (good)

Oncology - 445 white count. Hemo + platelet low

- Blasts in smear - go to ICU Platelet transfusion

Aloperenol - decreases Uric Acid

Esther Berko - oncologist. Admit to ICU tonight

Platelets @ 6 - wants up to 30

Tomorrow Bone Marrow Aspirate & Lumbar Puncture

1/12 A

All organs ok. Blood gas 4.5 normal

- I am pumped milk

230 am. Potassium check

545 am will get Platelets.

6 am - want oxygen 90+ above - Put on oxygen

we got red blood cells over 4-5 hrs.

645 - pumped

830 am - Potassium 2.7

Rounds - Big liver + Spleen. Definite malignancy.

- Nursed 945 am (Poked)

tumorlysis

1225 - ✓ platelets if ok going for PICC line

ANNA'S STORY

In January of 2018, southeastern Pennsylvania found itself in the middle of a blustery winter storm. Temperatures were low, as an arctic air mass hovered over much of the East Coast. That is nothing exceptional for the region, nor would it be odd for the common cold to sweep through a family of seven hunkered down indoors during the winter months. The whole family was sick: the parents Jason and Carolyn Lesher, their oldest child, Gabriel, and on down through Sarah, James, Claire, and little Anna.

Toward the end of the month, Carolyn had noticed that their youngest, seven-month-old Anna, had been both sleeping and nursing more frequently than usual. They also had discovered a large rash-like spot (petechiae) on her thigh, and her stomach area felt hard to the touch. Gabriel, who was in fifth grade, had a scheduled wellness appointment that Thursday afternoon, so Carolyn took Anna along, hoping the pediatrician would **see them both at the same time**. The couple had lost a son, Francis, at birth in 2011. That only heightened the ever-present worry and health vigilance that parents have for their children. In short, the shock from that had not waned.

During the exam, the pediatrician immediately knew the potential seriousness of Anna's condition and ordered the nurse to draw blood; it was, in the parent's language, near sludge (they would later discover it was 95% cancerous). The physician calmly said that he suspected this was leukemia. Allowing the option of two regional hospitals, he phoned ahead to the Children's Hospital of Philadelphia (CHOP), telling the parents to take Anna directly to the ER.



Figure 0.1 This is Anna the morning after first being diagnosed. She is just seven months old. Carolyn, her mother, took this picture because she thought given the circumstances, Anna would not survive.

before one thinks and therefore acts. The premise of chapter 3 is to force the reader to consider the necessity of beginning with an understanding of the human person. Almost everyone, except ontological philosophers, uses the term *I* too easily—“*I* study,” “*I* want to know,” “Do you care what *I* think?”—without properly comprehending that there is no default understanding of this *I*. This chapter will examine the *I* of the *human person* and what is meant by *my personality*. A similar preliminary discernment in chapter 4 will begin with an exposition of what it means to “be ethical” and to “act ethically.” Here, too, there is no default ethical position. And the varied ethical postures are many, with different ethical systems often leading to differing outcomes. The point is that, regardless of the ethical judgment one is faced with, whether ordinary or a perplexing bioethical dilemma, it is crucial to “think about how to *be* and *act*” well before the predicament presents itself, or choices will devolve to what is advantageous or easier.

Moving on to the second section, in covering “That Which We Do,” chapter 5 will be concerned with professional obligations, although the term *obligation* will need some nuancing. But *obligation* is about how medical consent is attached to an understanding of the person, and the concepts of confidentiality and capacity are rooted in human dignity. Then the legal relation of confidentiality and capacity to privacy and competency will round off the presentation. The issues examined in chapter 6 tend to be perceived as “controversial” topics: reproductive technologies and end-of-life care, along with human research testing and studies. The fact that these topics tend to the polemic and are divisive is actually promising. People argue over them passionately because the topics express something central about an understanding of the human person, freedom, and rational capacity. In short, we argue over the things that are important, and we allow the more peripheral notions to be governed by taste. Finally, in chapter 7, concerns that are not always included in the treatment of medical ethics will be given space for development and deliberation. Of these “present and future” concerns, the text will engage the ethics of mental health and of persons with disabilities. Then the concept of access and allocation will be given a brief treatment, as it relates to justice and authentic human needs. Without trying to be overly predictive, there are legitimate concerns and hopes that lie within a generation’s reach, such as artificial wombs and transhumanism, so those emerging ideas will be framed as considerations. Finally, as part of those emerging concerns

115 - Discuss Picc line - Double lumen Hemo 5.6
2:20 Nursed + Blood transfusion started

345 talk Procedure Initiated for safety Ketamine
+ Fentanyl sedation. Potassium draws

DIAGNOSIS meeting

Lena Kemia Bcell Lymphoblastic ALL gene defect M22

Attending Lena Winstone MD.

515 pumped

530 started Ketamine & intubation.

945 pumped 1245, 230, 730

1/13

Social work - Cathy text her questions

Keep receipts for everything out of pocket

Rounds - 1030am - Good labs. Eyes swollen
but looks good

low fever 100 (not fever but hot) 7.41 blood gas
4.1 Potassium Kidney $\frac{4}{0.8}$ Krealanin 4.5 Uric Acid 108.9 white B

Hemo 5.6 Platelet 40 - Prednisone therapy.
+ Phosphorus

Calcium low but OK white Blood cells - things
working.

Weaning From vent off by end of day

- At risk for high Uric Acid. - take meds +
hydrate

ANNA'S STORY

By 9:00 p.m. on that first day, Jason and Carolyn found themselves in CHOP's Newborn/Infant Intensive Care Unit (N/IIICU). They watched Anna—hearing the beeping monitors, questioning the significance of every alarm they heard. This is a foreign environment for nonmedical professionals, and it's every parent's worst nightmare. Jason and Carolyn simply had to wait until the medical team made a specific diagnosis.

The young parents were brought to a consulting room, where two oncologists entered to speak with them. It was now Friday morning, 2:00 a.m. They were told that Anna has infant leukemia, specifically, B-cell acute lymphoblastic all gene defect (MLLr). At this point the oncologists did not speak about outcomes, only treatment. It was later that Carolyn, who researches things deeply, realized the rarity of this disease. Generally, leukemia of this type in infancy has a survival rate hovering near 50%, and only 150 infants are diagnosed each year. But that information has no bearing on the treatment, without which Anna would not likely survive until the end of the following week. They were told that chemotherapy would begin within the hour.

During this time, Carolyn was not able to nurse Anna. In what she expressed as a godsend, both oncologists caring for Anna were currently breast-feeding mothers themselves. Along with the other staff, they were kind and gave her tips and information for receiving donor milk. In the midst of this "storm," at least this remained one concrete way they could care for Anna as she began her journey to wellness. At this point, both Carolyn and Jason had been awake for thirty-six hours.

and hopes, the future role of technology will be presented in tandem with a developing tendency for an overreliance on care and wellness as “health perfection,” which falls under the umbrella of the “cult of health.”

Philosophy, and logic as its tool, has the ability to ferret out the essential from the obvious. As an approach, it also exposes the reader honestly to the structure of the argument—so, everything is laid bare, devoid of hidden constructions. That cannot mean that the judgments and arguments in this text are immune from refinement. But it is a respectful way to offer an inquiry in that it affords the reader the opportunity to accept or discount the judgment, while maintaining the willingness to have the reader enter the dialectic. This is especially evident in chapter 6, where the various options (judgments) of those controversial topics will be presented. The philosophical method is not neutral; rather, it is nonideological and nondogmatic. Place any controversial topic in as p . If one logically accepts or chooses p , then q and r flow necessarily from p . This means you must accept q and r if you think p is ethical, and you cannot accept p if you disagree with q and r . That is not a semantic trick, but logical consistency. It is much needed in *The Ethics of Care and Wellness*, where plenty of judgments are to be made. This inquiry is at your service.

PART ONE

"That Which We Are"



■ CHAPTER 1

Ethos and Moral Agency

HEALTH AND HEALTH CARE

In the summer of 2015, I attended an advanced small-group presentation of a Smithsonian Institution National Museum of Natural History traveling exhibit entitled “Exploring Human Origins: What Does It Mean to Be Human?” I was able to speak privately with an archeologist traveling with the presentation who had—though it sounds cliché—just returned from a dig in Kenya. This scientist told me of human remains from the early upper Paleolithic period. Researchers had discovered evidence that the individual whose remains had been found at the Manot Cave community [Neanderthal-like] in Israel apparently had recovered from a traumatic injury in the second metatarsal. This

suggests that the inhabitants of the site where the remains were found had a supportive environment, one with mutual responsibilities among the members. Being a philosophical anthropologist myself, I was keen on knowing something exceptional about the human species; I was told that *that* was it.

The human community is unique in giving care and aid to its own species. To do so, I was told, is a species-specific characteristic. Here is a story shared by the anthropologist Margaret Mead when she was asked what was the earliest *evidence of human civilization*. The expected response was the use of tools, community settlement, and so forth. But her answer was this:

It was a human thigh bone with a healed fracture that had been excavated from a fifteen-thousand-year-old site. For an early human being to have survived a broken femur, living through the months that were required for the bone to heal, the person had to have been cared for—sheltered, protected, brought food and drink. While other animals care for their young and injured, no other species is able to devote as much time and energy to caring for the most frail, ill, and dying of its members.¹

This notion prompts one to recognize the human species as exceptional. Current psychological trends in popular culture tend to disapprove of such a claim. That is because some people have incorrectly read that observation of exceptionalism as direct discrimination toward other living species. Along with that it is often added that this emphasis of exceptionalism has further led to the indiscriminate use of the “natural goods” in the environment. This has come to be known as *speciesism*, which sees the intentional valuing of the membership in the human species over other species’ members and perceives the misuse of the natural environment of the planet, which is a living organism in its own right. This human exceptionalism used to be referred to as *anthropocentrism*, which connotes the systematic bias of human domination over the nonhuman world, which resulted in exploitation.²

1 Byock, Ira. *The Best of Care: A Physician's Quest to Transform Care through the End of Life*. Avery, 2013, p. 255.

2 See Naess, Arnie. “The Shallow and the Deep, Long-Range Ecology Movement: A Summary.” *Inquiry: An Interdisciplinary Journal of Philosophy*, vol. 16, spring 1973, pp. 95–100.

But even if the notion of integral ecology can overcome the misapplication of priorities with other species and the profiteering of the environment, the concern stands. Though this concern is legitimate, it does not logically reduce the human species to simply one biological entity among other species—a mere part of the environment. Besides the obvious fact that no other species can both misuse the relationship and develop a solidarity with other living beings and nonliving things, the human species alone developed the capacity to heal others. *The undisputed exceptionality of humankind is the philosophy of health.* Yet, as with many concepts that the human has developed, the term *health* appears self-defining and therefore not thoroughly questioned. What *health is*, then, remains unconsciously vague, and for that reason it remains fundamentally misunderstood.

INTRODUCTION

In this opening chapter, the term *health* itself will be explored. I will argue that, along with well-being, if the concept is not clearly understood, then it is reduced to “curing.” Though at first glance that may be accepted as the goal of health care, in reality it leads to the misguided notion that health and well-being simply are the absence of a pathology or disease. By contrast, then, for the health care professional and caregiver this means that wellness and health are aspects of the body and mind, which together form the composite human person. How that significantly impacts the health care field will be explored, along with how familial and social circumstances enter that wellness as a “journeying with” the patient. The goal or purpose of the proper functioning of the human person is the *work* of health care. This text will then consider how the treatment of a disease or pathology reveals only biological functioning, which when isolated from other genuine needs and goods of the human person disorders the purpose of health care itself.

This has further complicated health care and wellness in that patients have been brought into a mind-set that they are “consumers” of medical care. This leads to their own desires and preferences developing a false relation to their own health and well-being, as well as a false relation with health care professionals and caregivers. The notion of patients *as* consumers, and of professionals offering medical care and wellness, severs health care goals from authentic human goods. It also fosters this consumer choice as

a false pretense of symmetry between professional and patient—the patient enters professional care with “suggestions” that have been gleaned from lay sources. The patient, expecting to be “fixed,” then will be satisfied either by the success of the treatment or by emotional compensation subjectively interpreted as capitulation to their desires. The restoration is a reorientation of medical goals and a reorientation of an understanding of genuine human needs. Although it might appear obvious to accept that medical ethics is situated in a complexity of relations and connections, if these ethics are not properly linked to the “goods” of the human person, then the practice of medicine devolves into a mechanistic activity. To stave off the human person being simply “serviced,” those “human goods” must relate organically to the “goods” of medical care and wellness; if they are not thus related, the goal and the person receiving care are not in sync with a proper understanding of health and well-being.

THE IDEA OF HEALTH AND WELL-BEING

Sometimes the terms *health* and *well-being* are used in conjunction, and at other times, for clarity, the nuance between them is useful. For example, sickness does not exist on a spectrum; there is no perfect health—maybe ideally, but not in actuality. Yet a person who does not have perfect health may still claim to be well—perhaps with the qualification “overall.” In that regard, a disease may be an objective assessment, and yet from the patient’s perspective wellness may be formed on the basis of their understanding. That is not to suggest that the patient is dismissing something objective concerning their health, only that wellness, as it is related to health, has the ability to adapt. Human society is always on the precipice of hope in terms of medical advances, and wellness can be a personal response to anticipated management and treatment. Both technology and “science has contributed to our understanding of well-being through an ingenious apparatus of techniques that reveal not only the causal pathways of ill health but also evidence for their amelioration.”³ In this way, health finds aspects of wellness in the web of social structures that offer support and perspective.

3 “What Is Health? The Ability to Adapt” [Editorial]. *The Lancet*, vol. 373, no. 9666, 2009, [https://doi.org/10.1016/S0140-6736\(09\)60456-6](https://doi.org/10.1016/S0140-6736(09)60456-6).

From that deduction, *health cannot be separated from the familial and social circumstances*—not even from the sphere of one’s physical environment. In a very real sense, it is impossible to consider health and wellness as an individual endeavor. A remodeled philosophy of health is in order, one that includes, but is not reduced to, curing. Think of health in terms of the overall goal, and what animates an individual to attain that objective within the medical field. If one accepts that the medical professional has *healing*, as opposed to health and wellness, as the goal, a misdirection arises. Historically, the human’s intent to be healthy and maintain wellness is nothing new, neither when confronted by a disease nor when seeking a cure. But in the ancient world, Aristotle held that the “work” of “medicine [is] health and not the act of curing and restoring to health.”⁴ For him, the language of “restoring to health” should be read as “healing.” So, this playing off of the terms of *health as wellness* and *healing as curing* may appear a semantic distinction, but “curing” can very easily devolve into a physical restoration understood in contemporary minds as “fixing.” It fosters a mechanical view of the human patient, where they arrive “broken” and must be returned to a previous state, “cured.” Margaret Mead’s observation did not merely express the primitive human with the fractured femur *returning*. The work of this “ancient medicine” was to care for, to shelter, to protect, and to provide both food and drink. The focus on health and wellness is a *journeying with*. Medical ethics cannot simply be a matter of practicing ethical conduct that is conducive to curing. Health, as a goal of the human person, is much more panoptic.

Returning to Aristotle, he understood *health* as the *virtue* of the body, meaning that for the body, health and wellness were the goal. The understanding of the terms *health* and *virtue*—that they are not the exclusive, but primary good of the body—is crucial. Though chapter 4 includes a section offering more depth on the subject of virtue, at this juncture it is enough to know virtue as a habit in balance between the extremes of excess and deficiency. In terms of these “extremes” and “goods of the body,” what affects the body affects the health of the human person. To a degree, then, external goods such as good fortune remain part of this health (as a virtue) of the

4 Aristotle, and Jonathan Barnes. *Eudemian Ethics* in *The Complete Works of Aristotle: The Revised Oxford Translation*, §1219a, 15–16. Oxford UP, 1984, pp. 1929–30.

body. But good fortune, as it can exist as one of the extremes, cannot be the same as happiness, which is the goal of life. As Aristotle explains it, one still “needs fortune as well as other things. Some people think good fortune is the same thing as happiness; but it is not that, for even good fortune itself when in excess is an impediment, and perhaps should then be no longer called good fortune; for its limit is fixed by reference to happiness.”⁵ This is characterized by the modern colloquial phrase “too much of a good thing,” which means, of course, that an excess of a good (fortune) is itself not good. For example, cardiovascular exercise is an important criterion for general health, but too much, or such that it is not age appropriate, can cause sickness. Extreme exercise can lead to cardiac remodeling that may predispose individuals to ventricular rupture and aneurysm formation.⁶ And then, in terms of the deficiency, there is little dispute as to the ill effects of a sedentary physical life. In either case, health and wellness as the goal of the body remains, albeit here in terms of a mean between extreme exercise and sedentary habits. Take note that this does conclude *health and wellness* as reducible to “not being sick” but requires other physical goods—and most importantly, immaterial goods.

For Aristotle, the immaterial *is* the soul (*psyche*) of the body. This cannot simply be equated with the theistic notion of the soul (*anima*), even though the early Christians did appropriate his metaphysics to explain the *hylomorphic* composite of the body in similar fashion. One way to frame it is to say that the soul is the *form* of the body (essence), and the body is the material observable aspect (substantial matter) of that union. Without delving into an exposition on this metaphysics, for the point here it is again enough to grasp that one affects the other. The *psyche*, even in secular modern sciences, is held as *the mind*—often understood as “the self.” There is little controversy to the claim, secular or theistic (though with much qualification), that what affects the mind will affect the body, and vice versa.

5 Aristotle, *Nicomachean Ethics*, §1153b, 21–24, p. 1823.

6 See Azevedo, Paula S., et al. “Cardiac Remodeling: Concepts, Clinical Impact, Pathophysiological Mechanisms and Pharmacologic Treatment.” *Arquivos brasileiros de cardiologia*, vol. 106, no. 1, 2016, pp. 62–69. <https://doi.org/10.5935/abc.20160005>.