VALUE PROMOTION AS A GOAL OF MEDICINE

ABSTRACT

In this paper, we argue that promoting patient values is a legitimate goal of medicine. Our view offers a justification for certain current practices, including birth control and living organ donation, that are widely accepted but do not fit neatly within the most common extant accounts of the goals of medicine (i.e., those that focus on healing or best interests). Moreover, we argue that recognizing value promotion as a goal of medicine will expand the scope of medical practice by including some procedures that are sometimes rejected as being outside the scope of acceptable medical practice, such as certain forms of physician-assisted death. We then rebut some common and possible objections to this view. Our aim is not to argue that other accounts are mistaken—except when they argue for a single goal that does not include patient values—but rather to show that value promotion should play a more central role in discussions about the goals of medicine.

INTRODUCTION

In May 2019, lawmakers in Delaware introduced a bill that would legalize physician-assisted death under certain circumstances. This move faced opposition from several groups, including The Medical Society of Delaware, who wrote that "Control over the manner and timing of a person's death has not been and should not be a goal of medicine."[1] An appeal to the goals of medicine was also made in an American College of Physicians position paper arguing against physician participation in assisted dying.[2] Similar arguments have been made in other jurisdictions that have considered legalizing physician-assisted death, as well as in debates surrounding other proposed shifts in medical practice. For example, in response to the idea that physicians aid in performing executions, Robert Truog and colleagues argue that "Execution is, intrinsically, the involuntary taking of the life of another human being, an act that can never be aligned with the goals of medicine."[3] Others have appealed to the goals of medicine for each of these issues.[4-6] Notice that in neither case do those quoted claim that the act in question is itself morally wrong—though perhaps some of them would endorse this stronger position as

well. Rather, the claim is that participating in these procedures is not a legitimate application of one's role as a physician.

As these examples illustrate, physicians and bioethicists often reference the goals of medicine in debates at the frontiers of medicine. The idea, roughly, is that there is a circumscribed set of ends that physicians and other medical professionals, in their distinctive capacities, are permitted to pursue in treating their patients. Put differently, pursuing any treatment that does not align with these goals of medicine is morally wrong because it contradicts the goals of medicine.

There are many different accounts of what the goals of medicine are, though two deserve particular mention. First, *the healing view* says that healing or promoting patient health is the only appropriate goal of medicine. Second, *the best interest view* holds that the goal of medicine is to promote the patient's best interests or to provide benefit. The best interest and healing views enjoy wide popularity in both philosophical and clinical discussions.[7-9] For instance, physicians often appeal to the healing view when objecting to procedures such as assisted dying, and appeals to the best interests of the patient often play a role when there is disagreement between the patient and the provider about the plan of care. (For other discussions, see [10-14].)

In this essay, we explore an alternative view, which we call the value promotion view. This view holds, roughly, that one goal of medicine is to promote the patient's autonomous values. Our ambition in this essay is relatively modest: we are not attempting to show that the value promotion view is the cardinal or even sole goal of medicine. Indeed, for reasons that are beyond the scope of this paper, we believe it has limits. Rather, we only aim to show that this relatively unexplored view has certain virtues that have been almost entirely unappreciated in the

goals-of-medicine literature, and that the limitations and objections that spring intuitively to mind against the view are not nearly as decisive as some might assume them to be.

As we hope to show in what follows, the goals of medicine question is not of merely theoretical interest. It also has important practical implications, such as which medical practices can be permissibly performed, on what basis physicians' duties and patients' rights can be delimited, and how we should conceive of the medical art in terms of research and practical education. While political battles surrounding issues like physician-assisted death will continue, a philosophical consensus is emerging: in a broad range of cases, medically assisting in a patient's death is a permissible application of the physician's role. The task, then, is to determine the basis for this consensus, as well as other proposed expansions of the medical art, and to explore how far-reaching its implications are.

THE GOALS OF MEDICINE

Before turning to the details of the value promotion view, it is important to clarify certain key features of the debate. First, there are important differences in the types of arguments on offer for the goals of medicine. Some argue in defense of the relevant goal—e.g., healing or best interest—as being *a* goal of medicine, while others argue that such a goal is *the* goal of medicine. The difference between these two approaches is significant: to argue that something is a goal of medicine is to claim only that it constitutes one permissible goal that physicians may pursue. There may be other distinct goals of medicine, and it would not necessarily be wrong for a physician to fail to promote *this* goal of medicine, provided her actions promote one of the other accepted goals of medicine. (The details of priority will depend on the specifics of the account.) By contrast, to argue that something is *the* goal of medicine is to hold that there are no other

permissible ends of medicine but this one; all legitimate medical practices must aim at this particular end.

Let us call views that defend some goal as *the* goal of medicine *monistic views.* Some popular accounts of the goals of medicine are explicitly monistic. For example, for defenders of the monistic healing view such as Leon Kass, healing is the only justified goal of medicine.[9] Only interventions aimed at healing are permissible, and those that do not, including, for Kass, abortion and assisted death, are impermissible. The monistic version of the best interest view proceeds in a similar fashion: it says that only those actions that promote the best interests of the patient are permissible, though other conditions can be placed in pursuit of this goal (the most obvious being a requirement for informed consent from patients with the capacity to provide it).

In contrast to monistic views, there are also *pluralistic views*, which allow for multiple goals of medicine. Some of these views are *exclusive*—that is, they offer a discrete and complete list of acceptable goals. An example of an exclusive pluralistic account is Daniel Callahan's four goals of medicine: preventing disease and promoting health, relieving pain and suffering, forestalling death and promotion of a peaceful death, and curing disease while caring for those who cannot be cured.[15-16] On this view, no goal has priority over the others in all circumstances. Rather, the goal that gets priority will depend on the situation. The same is true of Franklin Miller and Howard Brody's eight conditions, which are mostly aimed at the diagnosis and treatment of disease.[17-18] A complete pluralist theory will detail how the goals are ranked (if they are) and what their relative weights are.

But we can also imagine a pluralist view concerning the goals of medicine that is *inclusive*. Such a view takes no stand on the other acceptable goals of medicine, and instead only offers a detailed defense of a given goal as legitimate. For example, we can imagine a version of

the healing view that holds only that healing is *a* goal of medicine, perhaps among others. (Indeed, all the monistic and exclusive pluralist views just sketched can be weakened to allow that there are perhaps other goals of medicine in addition to those discussed.)

The existence of these different approaches—monistic and pluralistic; exclusive and inclusive—complicates any argument in favor of an alternative account. To argue that a proposed alternative is only *a* goal of medicine, the argument must only show that this is a plausible goal of medicine that does not reduce to the others on offer. If this argument is successful, then this goal warrants inclusion among the others. This is our approach. It is not our goal here to argue in favor of value promotion as *the* goal of medicine. As such, we offer no criticism of the other accounts of the goals of medicine here, except to show that value promotion sometimes offers better justification for acts we believe ought to be permissible. Our aim is only to show that value promotion is one goal, perhaps among many others.

There are certain other features of arguments about the goals of medicine that it is important to clarify. First, while the fact that a given practice aligns with a goal of medicine is a *necessary* condition of permissibility, it is not *sufficient*. The idea of the goals of medicine therefore gives us a conditional: a physician may treat her patient in some particular way *only if* she does so in a way that is consistent with the goals of medicine. This is because there are constraints on the pursuit of medical interventions. One type of constraint is theoretical. Tom Beauchamp and James Childress's [19] principles of bioethics—autonomy, beneficence, nonmaleficence, and justice—can be viewed as this type of constraint (though this is not how they describe them). On this interpretation, the principles provide limits, or conditions, to acceptable medical practices. For example, the current practices of 'withdrawal of care' and Do-Not-Resuscitate orders demonstrate the importance of patient autonomy: even if the physician

could promote a goal of medicine—e.g., healing—by treating the patient in some way, the patient's request not to be treated constrains what the physician may do. (But the healing view claims that physicians can only offer interventions that aim at healing, which is why autonomy in this case is a constraint instead of a goal.)

There are also practical constraints. The intervention could fall outside the physician's expertise, or require a degree of expertise that she lacks; some other physician might be considerably better suited to provide the treatment; the patient might prefer to wait a few weeks, etc. Note that there is no sharp line between theoretical and practical constraints; many practical constraints will have ethical implications. In any case, these constraints do not bear directly on the question of whether or not the physician's intervention aims at the proper goals of medicine.

Some philosophers have understood the goals of medicine as the basis for physicians' duties. Edmund Pellegrino writes that "The ends of medicine thus define the moral obligations, the virtues, duties, and principles that constitute medical ethics."[1420][1] Understood as a broad claim about all duties, however, this is clearly false: the fact that some practice aligns with the goals of medicine does not itself give the physician an *obligation* to perform it. Consider conscientious objection, which is not a constraint on permissible practice but rather a claim *against* obligation. If conscientious objection is ever permissible, then there are at least some cases in which promoting the goals of medicine is not obligatory. There are other, more mundane examples: a physician is not obligated to treat patients who request medical advice when they see each other at the grocery store, nor is she required to treat patients while she is on vacation or maternity leave. Here we are concerned with how the goals articulate some of the physician's negative duties. This is just what it means when we say that a physician may not pursue

[1] Pellegrino attempts to distinguish between 'goals' and 'ends', claiming that goals are fleeting while ends are more constitutive of the practice itself. We use the term 'goal' in a sense closer to how Pellegrino uses 'end', so the quote above aligns with our present discussion, despite the terminological difference.

treatments that do not align with the goals of medicine. But again, the goals of medicine only provide part of the answer; other components include the constraints listed above. It is possible that the goals produce some positive duties. For example, on the healing view, perhaps physicians have some positive duty to heal. We grant that this might be so but will not explore this point in what follows.

This all leads to a further point, which is that settling the goals of medicine will not on its own produce a theory of distributive justice or general morality. Sometimes, acts that might promote the goal do not occur. This could be because the patient is unable to pay and her insurance does not cover the procedure, or because she needs a scarce resource (blood or an organ or a hospital bed) but the system has prioritized others over her. Whether this is acceptable or not does not depend on the goals of medicine; there are many other variables that must be considered. However, the goals of medicine are an important component. The goal of medicine question is central because it features in a basic part of the argument for so many other ethical questions. So, at least in that respect, it is different from just ordinary morality. It is also partly because we tend to view physicians and other healthcare professionals as having a distinct set of duties specific to their roles, which requires an understanding of the parameters and bases of these duties. This is not true of just anyone; it is a distinctive feature of their role. (And we need not be adherents to a 'role morality' view to accept this.)

THE VALUE PROMOTION ACCOUNT

With these clarifications in hand, we will now turn to the details of the value promotion account. Let us begin with a simple formulation that we will refine throughout the rest of this section. Roughly put, the value promotion account holds that a goal of medicine is to promote patient

values. We understand values as the foundation on which an individual's identity and life are built. They consist in her deeply-held beliefs, desires, attitudes, preferences, and projects. It is important to note, however, that values are not merely desires. As Samuel Scheffler puts it, "the things we value are things that matter to us, or that we prize or cherish, or that have a certain importance for us. Not everything that we desire matters to us."[21] In ideal scenarios, one's values feature as fundamental reasons in one's self-justifications, and they are at the core of rational deliberation. Individual values reflect the basic idea that capacitated individuals are self-governing beings who have a unique power to determine how their lives will go and what may be done to their bodies.

Values are not fleeting or ephemeral, but they need not be unchanging, particularly when one is confronted with new ideas, perspectives, or experiences. Some values will be the result of such rational deliberation; others will be recalcitrant or deeply moored. In some cases, these values will be comparatively less significant, and so may be more easily jettisoned. In other cases, they are the foundation of an individual's self-conception.

While many of these values will be widely shared across all rational beings, they are fundamentally agent-relative. That is, whatever we might take to be the relevant objective values—health, natural ability, minimizing pain, etc.—may not feature among a given agent's own values, or may not be given much weight. This is clearest in cases where risks must be assessed, side-effects must be weighed against health promotion, and so on. In some cases, patients will make choices that align closely with how one might understand the objective values at stake concerning optimal health; but in other cases, patients will evaluate their options differently.

Physicians promote these values when they perform interventions that align with and are properly responsive to their patient's values, using the expertise they possess as physicians. To be clear, this does not mean that all patient *requests* should be fulfilled. This is because a patient's requests are not always reflective of his values: some requests will not be autonomous, suitably informed, or will be inconsistent with his other values. Consider a patient who, while experiencing intense but temporary pain, requests a lethal dose of morphine; or a patient who, owing to a severe misunderstanding of the procedure, requests a tonsillectomy to cure his astigmatism; and so on. These are extreme examples, of course, but they suffice to show that promoting patients' mere requests is not a goal of medicine. Rather, it is the patients' values that matter, which may be in conflict with her requests (or lack of requests, as the case may be).

One might wonder at this point what role 'promotion' plays on our view—that is, why we do not instead defend, e.g., a value-*respecting* view instead of a value-*promoting* one. These two views could come apart in certain cases, such as when a patient's refusal, if acceded to, could make pursuit of their values more difficult in the future. A value-respecting account might counsel non-interference, whereas our value-promotion account would seem to take a more paternalistic approach.[2]

This means that our view allows for a mild form of paternalism. To wit, it is consistent with value-promotion to refuse patient requests when there is sufficient reason to believe that the request is not in line with the patient's values—or, in a more difficult case, when the patient's values conflict, such that acceding to the request would be at the expense of the value the patient holds more strongly. And in the case of refusal, our view allows the physician to press the patient to consider that her refusal will frustrate further pursuit of her values.

[2] Thanks to an anonymous reviewer for pressing for clarification on this point.

Depending on the specifics, a value-respecting account may reject one or both of these conclusions. But these differences may not be that significant in practice. For one thing, the value-promotion account does not hold that it is *justified* for physicians to override patients' refusals. As we have already noted, the issue of justification is separate from what the proper goals of medicine are. These points raise important questions about how clinical practice will look according to our view, ones that we plan to explore in future work.

The physician aims at a proper goal of medicine only if the intervention aligns with her distinctive expertise as a physician. What exactly constitutes a physician's expertise is a difficult question that we do not have the space to treat fully here. Furthermore, we are skeptical that there are any conditions that capture just the expertise of physicians and no other profession. Rather, there is overlap, and the boundaries are vague. The differences are determined by a range of factors, such as education, experience, efficiency, and social practices and needs. These factors rule out in a principled way those cases that are clearly beyond the physician's expertise. For example, a physician who offers home decorating tips is hardly acting from his expertise as a physician, and thus does not promote the goals of medicine. This vagueness concerning the profession's expertise is not exclusive to doctors. For example, while lawyers have a clear central expertise, their role sometimes overlaps with other professions, such as when they act as mediators or do public relations for their clients.

In short, patients have values, many of which relate to physicians' expertise; patients seek out physicians precisely because physicians are exceptionally well (usually best) suited to promote those values; and physicians can promote some of those values by employing this expertise. According to the value promotion account, physicians act in accordance with the goals of medicine when they promote patient values that are draw upon their expertise as physicians.

The value promotion account differs in several ways from the other views on the goals of medicine we canvassed above. Naturally, the clearest contrast concerns the role of values: the healing and best interest views apply standards that exist independent of the patient's own values—that is, their focus is squarely on objective, agent-neutral concepts of health and interest that may or may not comport with the patient's own conception of these ideas.[3] By contrast, the value promotion account centers around patients' values and understands the concepts of health and best interest as merely widely—but not necessarily universally—shared values. All of these views can explain the justification for some types of care: e.g., putting a cast on a broken leg heals, can promote the best interest of the patient, and is done because the patient wants to be healed. Because we are not defending the monistic view that value promotion is the only goal of medicine, the rivalrousness of these explanations is no cause for concern. It just means that the justification in many types of care will be overdetermined.

One might think that our view is ultimately just one type of best interest view. Unfortunately, defenders of the best interest or benefit view rarely say what they mean by 'best interest'.[4] In many cases, context suggests that they take best interest to be distinct from patient values. This is also true of the way healthcare providers use 'best interest'. When physicians refuse to act on the stated preference of a patient, the objection is often rooted in the physician's belief that the patient's request is not in the patient's best interest, even if it is based on stable values. However, one could take a subjective view of best interest (i.e., where what is best for someone is wholly determined by their values). On this interpretation, our views align. Nevertheless, it is more direct to focus on values instead of best interest, and it avoids confusion

[3] This, anyway, is how we are defining the best interest account. We expand on this below.
[4] See Boorse [47] and Brülde [58], who both say that 'best interest' means 'well-being' but offer no further definition of well-being. 'Best interest' is a persistently under-theorized concept in bioethics.

with will non-subjective best interest views. Therefore, for the sake of clarity, we will treat our view as distinct from the best interest view.

DEFENDING THE VALUE PROMOTION ACCOUNT

To show that the value promotion account is a goal of medicine, we only need to demonstrate that there are some cases that are acceptable medical interventions for which the only or most plausible goal of medicine is value promotion. In this section, we discuss four categories where that applies. It is impossible to survey every alternative account, but the examples should suffice to show that values deserve to be on any plausible list.

Given that we are highlighting cases that are not adequately covered by the other goals of medicine, these cases tend to be situated closer to the margins than the mainstream of accepted medicine. As such, some might wish to deny that certain of these interventions are legitimate medical practice. Our argument is able to withstand selective disagreement: provided that at least *some* of the cases we discuss are taken to be legitimate medical practice that other accounts of the goals of medicine cannot capture, our view is sufficiently motivated.

These cases can be roughly organized into four categories: project-based interventions, optional function interventions, moral interventions, and aesthetic interventions.

Project-based interventions

Some interventions aim at supporting an individual's pursuit of a specific life project. One example is sports medicine, which often focuses on promoting high performance instead of healing. Consider, for example, the procedure known as "Tommy John Surgery," which is a common surgery performed on pitchers in Major League Baseball. The surgery reconstructs the

patient's torn ulnar collateral ligament (UCL) by replacing it with a ligament from elsewhere (either from their own body or a donor's). This procedure is considerably more invasive than alternatives to repairing the UCL; indeed, an alternative route to repairing a torn UCL is to modify one's activities—i.e., to cease using it in precisely the way pitchers do. Of course, this is unacceptable to most pitchers who tear their UCL, so Tommy John surgery, though not medically necessary in most cases, is nevertheless the preferred option. Another example is the widespread use of cortisone injections, which allow the athlete to play by returning her to her prior performance level, but do not promote healing.[22]

This suggests that it is neither healing per se (nor 'high performance') that are distinct goals of medicine, but the values that center around that project, that explain why the intervention is appropriate. This is also why none of Callahan's goals capture the justification for this type of intervention. Relieving pain comes closest, but it does not capture the purpose of the intervention, which is returning the player to optimal performance as soon as possible.

Furthermore, it is questionable whether many of these treatments are in the patient's best interest, understood objectively: perhaps the risks of the procedure to her health, or the possibility of enabling further pursuit of a risky project (e.g., stunt driving, football, mixed martial arts fighting), outweigh the benefits from an outsider's perspective. But it is the value of the project to the individual that overrides that fact.

In certain other cases, individuals opt for treatments that are otherwise not medically necessary, citing the benefits to the individual's pursuit of a particular project. To take one example, a patient who suffers from seizures might request a resective surgery to remove the affected portions of her brain, as opposed to simply remaining on medications, because doing so will better enable her to pursue a particular career path or hobby that is important to her (e.g., by

avoiding certain undesirable or prohibitive side-effects of the medications). It may be that this procedure would heal the patient, but it does not seem that the healing view gives a complete picture of the justification. After all, if such medically optional procedures come with significant risks, it is hard to see how we could understand this procedure entirely on the basis that it heals the patient. Both Callahan's and Miller and Brody's goal to treat the disease is relevant here, but it fails to sufficiently explain why the risks of the surgery could be justified over the status quo of medication. An appeal to the patient's values is a better explanation.

Optional function interventions

A related category concerns interventions that center on one's ability (or requested inability) to function in a biologically typical, though strictly speaking non-necessary way. The most common area for this type of intervention concerns sexual or reproductive functions. Some patients seek prescriptions to improve sexual performance, such as Viagra. Some seek vasectomies or tubal ligation, as well as other forms of birth control (intrauterine devices, the birth control pill, contraceptive patch, etc.), for reasons based in family planning rather than strict medical need.

None of these interventions promote the goal of healing. Vasectomies and tubal ligation help to prevent unwanted pregnancies, and do not serve to heal any underlying injury. One might perhaps claim that a prescription for Viagra aims to heal the patient. But this is true only if we assume that that which is to be healed is the unsatisfactory optional sexual function. This extends far beyond what defenders of the healing account typically mean when they speak of healing.

The same goes for the best interest account: it can hardly be said that these interventions are in the patient's best interest unless one has already accounted for the patient's own values.

For example, we might say that it is in the patient's best interest to obtain a vasectomy; but to the extent that the best interest account could make any such claim as this, it would be parasitic on the patient's values regarding procreation and his sex life. Finally, none of Callahan's goals are useful here.

Moral interventions

A moral intervention enables the patient to live according to her moral commitments (either obligations or supererogatory acts). Consider living kidney donation, which certainly does not heal the donor.[5] It also is clearly not in the patient's best interest: the risks are non-trivial, and the benefits to one's own well-being (in the sense assumed by the best interest view) is unclear. Other examples of this type of intervention include various forms of living donations (e.g., tissue donations), and perhaps certain cases of surrogacy. What makes these acts morally praiseworthy is that they are other-regarding, a feature which other goals of medicine have difficulty including.

Aesthetic interventions

Some interventions aim to change the appearance of an individual without any clear medical need. . Consider cases of elective surgery, such as breast enhancement, facial rejuvenation, or body contouring. Clearly, such surgeries are not in pursuit of healing, nor are they necessarily in the patient's best interest. This category is more controversial, as some people do object to physicians focusing on elective procedures when there is nothing medically wrong with the

[5] While it is true that healing does occur as a result of the donation, defenders of the healing view will want to avoid the implications of setting the healing standard in this way. It would mean, for example, that helping a patient die would align with the goal of medicine provided that he was an organ donor, a result that many healing proponents want to avoid.

body.[17,23] Nevertheless, cosmetic surgery is still widely accepted as legitimate medicine in many such cases, and it has been defended by appealing to social and cultural values.[24] Aesthetics can also play a role in the other direction. A routine procedure that most others would accept might be refused by someone whose values—being a model, say—make the procedure too risky because of his values.

Additional cases

In addition to the cases that fall relatively neatly into one of these four categories, there are also other examples that defy simple categorization. One such example is elective abortion. It is not hard to imagine certain cases of abortion fitting within many, or perhaps even all, of the above categories. And while some people object to the permissibility of elective abortion on general morality terms, few object to abortion falling within the scope of medicine.

But again, it is not clear that the other accounts of the goals of medicine apply here. While it may be that one of the many factors relevant to a decision to obtain an abortion might be concerns about one's health, the intervention is not centrally concerned with healing. (There are, of course, cases in which an abortion is medically necessary to protect the life or health of the pregnant person, hence our use of the qualification 'elective' here.) Moreover, it is not clear that an abortion aims at a proper goal of medicine only when doing so is in the best interest of the individual. Indeed, it is not clear how a physician would go about determining this. It is much clearer that abortions are legitimate medical practice because they are autonomously requested by the patient—that is, because they align with her values.

Another example is gender confirmation surgery, which can be very important to many transgender people for reasons ranging from having the body type and characteristics that best

align with their gender identity to their self-presentation and self-understanding—that is, reasons that fall under the categories of project-based, optional functioning, and aesthetic interventions, at least. Here again, healing and best interest do not seem to give an adequate account of why such procedures conform to the goals of medicine.

Gender confirmation surgery also demonstrates the role of values in assessing the risk of harm. Physicians, acting out of a concern for the welfare of their patients, can err by enforcing their own values about what constitutes appropriate risk. Trans writer Andrea Long Chu makes this point in a discussion of her then-upcoming gender confirmation surgery:

> The medical maxim 'First, do no harm' assumes that health care providers possess both the means and the authority to decide what counts as harm. When doctors and patients disagree, the exercise of this prerogative can, itself, be harmful. Nonmaleficence is a principle violated in its very observation. Its true purpose is not to shield patients from injury but to install the medical professional as a little king of someone else's body.[25]

Chu goes on to advocate for a version of a value promotion view in her discussion of gender confirmation surgery:

> I […] believe that a surgery's only prerequisite should be a simple demonstration of want. Beyond this, no amount of pain, anticipated or continuing, justifies its withholding.[25]

To be clear, on our view, it is not the patient's mere demonstration of want that justifies medical intervention. For one thing, as we have already noted, the all-things-considered judgment may require reference to other factors, such as justice. Furthermore, the justification question is distinct from the goals of medicine question. Nevertheless, Chu's general point still applies: by enforcing a standard of harm that is not sensitive to the patient's own understanding of what aligns with her values and what risks are acceptable to her, the principle to do no harm is self-effacing.

OBJECTIONS

The value promotion account invites a number of criticisms. In this section, we sketch and reply to several of the most pressing objections.

Too inclusive

One possible objection to our view is that it seems to allow for doctors to perform interventions in a range of cases that might seem intuitively impermissible. This objection is strongest when considering the most extreme examples. Consider a patient who requests that the physician surgically remove his legs for aesthetic reasons, or a patient who requests a prescription for a drug that might cause significant damage to his health. The value promotion account seems to say that the physician promotes a goal of medicine—and thus acts permissibly—by acceding to these requests. But is this right?

First, when considering extreme cases, we must be cautious not to inadvertently build in assumptions that run counter to the value promotion account's actual commitments. Recall that values are not simply requests; promoting requests per se does not aim at a goal of medicine.

Thus, if a patient undergoing a psychotic episode requests that her legs be amputated, the physician does not promote a goal of medicine by acceding to this request. (The same can be true when an incapacitated patient, such as someone in a delirium, is refusing treatment for which the benefits clearly outweigh the costs. In such cases, the mere refusal might not be sufficient to justify accepting it.) We must also be careful not to assume that the patient is properly informed about the intervention. If the patient is unaware that the prescription he requests will cause significant damage to his health, then the physician does not promote the patient's values by prescribing this medication.

It is also important to recall that the goals of medicine question does not settle the further question of what is permissible all things considered. For one thing, in both versions of the cases as presented in the previous paragraph, even if our view did allow that acceding to such requests aligned with the goals of medicine—which, to be clear, is not our view—one could still hold that performing these interventions would be impermissible by virtue of the lack of autonomy in the former case, and failure to properly inform the patient in the latter. As a general matter, however, our view is compatible with the possibility that there may arise cases in which a physician promotes the patient's values—and so acts in accordance with a goal of medicine—and yet acts impermissibly overall. Thus, it is important to identify the source of the implausibility in the objection. It does not follow from the fact that the intervention is impermissible that the source of the concern lies with the account of the goals of medicine.

Once these factors are fully accounted for, however, we see much less reason to be troubled. Some patients wish to promote values of theirs that many of us might struggle to understand. But our inability to understand certain values should not stand in the way of patients and willing physicians who seek to promote them. Patients with body integrity identity disorder

(BIID) may seek to have their appendages amputated in order for their physical body to conform to their self-image.[23] Many of us cannot begin to understand the value this has for patients with this condition. But when such requests are truly autonomous and reflective of one's sincerely held values, we see little difference from certain other widely accepted interventions, like gender confirmation surgery, vasectomies and tubal ligation, and various forms of elective plastic surgery.

Of course, given that such requests can be so unfamiliar, coupled with the significance and irreversibility of their effects, they might require additional support before performing them is morally justified. For example, perhaps patients who request elective amputation should consult with psychiatrists, and should be required to show that their request is stable over time. But again, these are constraints on what it is permissible to do, not on whether the intervention aligns with the goals of medicine. This point is not distinctive of the value promotion account; all other accounts of the goals of medicine allow for this possibility.

Perhaps some will remain skeptical. If the skepticism rests purely on differing intuitions on hard cases such as those just mentioned, then we are willing to bite the bullet. As we have argued, the importance of promoting patient values is clear. But one might object that values are already an important part of medicine, so there is no need for the account we are defending. We turn to this point now.

Defending the status quo

According to the previous objection, the value promotion view is flawed because it permits interventions that should actually be impermissible. In other words, it allows too much. According to an objection from the other side, a defense of the value promotion view is

unnecessary because patient values are already incorporated into current practice. A defender of this objection could appeal to the rise of person-centered care, which involves elucidating and acting on patient values. If this objection succeeds, there is no need for a defense of values because it is the world we already inhabit.

This objection has an element of truth. Patient values play a larger role in clinical practice than they used to, and this is for the best. There are far fewer physicians who will appeal—at least explicitly and in front of a clinical ethicist—to pure paternalism to justify their actions. In this sense, patient values are not new.

However, as the rest of our discussion has made clear, we favor a different and expanded role for value promotion. The sense in which value promotion will be different on our account is that some procedures, including controversial ones such as physician-assisted death, can be justified based on this goal of medicine, whereas they are often rejected through appeals to other goals. The sense in which the role of values will be expanded is by direct appeal to values in many clinical situations. It is more parsimonious to defend vasectomy, tubal ligation, or kidney donation on the grounds that the patient has a consistent, stable value that is promoted by the procedure.

Currently, values are given the following role: once the physician has decided the procedure that is most clinically indicated (usually based on healing), he recommends it (or perhaps a couple alternatives). The patient can then either choose the option that best promotes her values or she can refuse all care. The values only matter within the scope of what the physician deems acceptable based on other goals of medicine. To use the language we introduced above, on the current model, the patient's values are a constraint on permissible care. On our view, values influence the care more centrally.

The rise of person-centered care makes it all the more strange that no account of the goals of medicine directly appeals to value promotion. If our arguments are successful, value promotion does a better job than other views at justifying currently accepted care, and it also shows how medicine should adjust its approach to include other types of care frequently taken to fall outside its scope.

Physicians' value judgments

One might object that the value promotion account requires physicians to make value judgments about which lives are worth living, or which values are worth respecting. This point has been made most forcefully by Daniel Callahan in the context of expanding euthanasia:

> Apart from depression (the main statistical cause of suicide), people commit suicide because they find life empty, oppressive, or meaningless. Their judgment is a judgment about the value of continued life, not only about health (even if they are sick). Are doctors now to be given the right to make judgments about the kinds of life worth living and to give their blessing to suicide for those they judge wanting? What conceivable competence, technical or moral, could doctors claim to play such a role? Are we to medicalize suicide, turning judgments about its worth and value into one more clinical issue?[27]

He goes on to say that

> It is not medicine's place to determine when lives are not worth living or when the burden of life is too great to be borne. Doctors have no conceivable way of evaluating

such claims on the part of patients, and they should have no right to act in response to them.[27]

Applied to the value promotion view, the objection goes roughly like this: value promotion as a goal of medicine would allow physicians to promote patient values via their distinctive expertise, which would require that they are able to assess competently what these values are. But such assessments fall well outside the physician's realm of expertise: physicians either cannot or should not make such assessments. Thus, the value promotion account is mistaken.

Let us begin with the suggestion that physicians cannot determine what the patient's values are (or whether they are sincere, informed, etc.). It is of course true that this will sometimes be difficult for physicians to do, particularly when the patient's request is of an unfamiliar and uncommon sort (e.g., patients with BIID requesting limb removal). But it is surely false that physicians are wholly incapable of assessing patients' values—indeed, it is a frequent part of their job. Physicians are regularly tasked with assessing patient competence, whether their choices are autonomous, and whether they are fully informed. This occurs in both high- and low-stakes settings: consider the variety of procedures that patients opt in and out of in the course of a pregnancy, during palliative care, or in myriad other circumstances.

Furthermore, being a good physician requires aligning care with values. This is the lesson from person-centered care, which teaches that the constant pursuit of healing is often the wrong approach, especially in end-of-life care.[28] To be sure, certain physicians might question their ability to assess patients' values in some cases. But we should not conclude from this that the task is impossible, and thus that the value promotion account is mistaken. For one thing, in

certain unorthodox or high-stakes cases, physicians ought to supplement their judgments with those of other physicians. (Indeed, it is a common feature of legal physician-assisted death policy that multiple doctors are consulted prior to granting the request.) Moreover, it is important not to forget the role of the clinical ethicist, whose training and expertise in elucidating patients' values is a valuable supplement to the physician's own assessment.

One might still object that physicians ought not to make such judgments. This seems to be the heart of Callahan's worry. But here again, we reply by noting that physicians *do* commonly make such judgments in the course of their work, and few of us are deeply troubled by this fact. It is, perhaps, only troubling when one looks to marginal cases, such as euthanasia or other frontiers of accepted medical practice. But at this point, we have circled back to the question of what are the proper aims or goals of medicine. We are therefore skeptical that the objection that physicians ought not to make judgments concerning patients' values can avoid begging the question against our view.

Scalpels for hire

A related objection takes issue with the implications for the value promotion view on the medical profession. On this general worry, Leon Kass writes the following:

> At what should the medical art aim? What is the proper end—or the proper ends—of medicine? Continued confusion about this matter could bring about, more directly than any other cause, the demise of the profession [...] For without a clear view of its end, medicine is at risk of becoming merely a set of powerful means, and the doctor at risk of

> becoming merely a technician and engineer of the body, a scalpel for hire, selling his services upon demand.[9]

While Kass is concerned with a lack of specification of the goals of medicine, his point applies equally to a view like ours. That is, the value promotion account seems to make physicians into 'scalpels for hire' insofar as it views physicians as possessing a distinctive expertise that can be put to the service of patients' ends.

It is a bit unclear precisely what his concern is. If it is that physicians will be *obligated* to perform any procedures that patients request, then this is clearly not entailed by our view. If it is that physicians will be justified in doing anything for which their services are requested, then this too is false on our view, since our view does not center on requests as such but requests in line with values; and, furthermore, the question of the goals of medicine does not settle what it is all things considered permissible to do, since other concerns (e.g., justice) factor into that judgment. But if the concern is that the physicians' *role* will be reconceived in an unpalatable way, then this is either false or else a bullet worth biting. It is false for reasons canvassed above: there are already many interventions where physicians aim at the goal of promoting patient values. Thus, the professional role is not so much reconceived and expanded as better understood for what it already is. But if one still finds this perceived expansion to be problematic, then we are happy to bite the bullet. As we have stressed throughout this essay, there is significant value in respecting and promoting patients' values. When physicians have the tools and resources to do so, and they opt to provide this service, we should see this as a good, rather than troubling, expansion of their role. Instead of calling physicians 'scalpels for hire', which, on our view, risks oversimplifying

and obscuring the nature of their role, we might instead think of them as 'value-promoters for hire'. But this, we submit, is not an unwelcome title.

CONCLUSION

Our aim in this essay has been to show that value promotion, suitably qualified, is one of perhaps several goals of medicine, and that some of the most intuitive objections to this view are not as troubling as they might have initially appeared. The value promotion account, if correct, will have several important implications for the medical profession. For one thing, if this view is correct, then it offers qualified support for several controversial procedures, such as surgery for patients with BIID, various forms of enhancement, and physician-assisted death in a broader range of cases [29]. Furthermore, it will have implications for certain other significant questions in medical ethics, such as the extent of justified conscientious objection; the positive duties of healthcare providers; patients' rights to treatment, whether from insurance companies or state providers; and how we conceive of the medical art in general, which will impact research priorities, medical specialization, clinical education, and other related areas.

The arguments of this essay are intended only as a first step toward a more thorough treatment of the value promotion account. There is much more to be said concerning the distinctiveness of medicine, the relationship between the goals of medicine and the constraints on permissible action, and how the goals of medicine (if there are several) interact. These are tasks for another occasion. If nothing else, we hope to have shown here that the value promotion account warrants more serious consideration than it has received.

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