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THE AIM OF MEDICINE. SANOCENTRICITY AND THE AUTONOMY THESIS

BY

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Abstract: Recent criticisms of medicine converge on fundamental questions about the aim of medicine. The main task of this paper is to propose an account of the aim of medicine. Discussing and rejecting the initially plausible proposal according to which medicine is pathocentric, the paper presents and defends the Autonomy Thesis, which holds that medicine is not pathocentric, but sanocentric, aiming to promote health with the final aim to enhance autonomy. The paper closes by considering the objection that the Autonomy Thesis is overly permissive and allows many highly controversial procedures as legitimate parts of medicine.

Prominent physicians maintain that we have entered an age characterized by growing criticism of medicine (see, e.g., O'Mahony, 2020), and two criticisms stand out claiming that medicine has diverted from its course. First, some critics maintain that medicine contributes to overmedicalization (i.e., the improper expansion of the category of what demands medical intervention), which leads to overtreatment and an explosion of the costs of medical treatment (Conrad, 2007; Parens, 2013). Second, critics charge that medicine fails to be driven by patient need, reflected in patient complaints that the care they receive is 'objectifying' and discounts the psychological and social dimensions of illness (Cassell, 2004; Marcum, 2012).

This situation provides fertile ground for addressing fundamental, philosophical questions about medicine. In particular, the different strands of criticism seem to converge on fundamental questions about the aim of medicine. Whether the charge of overmedicalization is warranted will

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depend on what the aim of medicine is. If medicine is not aimed at merely fighting disease but has some broader aim, then the charge might not be warranted. In a similar way, whether the charge of objectification is vindicated will also depend on what the aim is. If it is merely the removal and prevention of disease, then the charge might not be justified. In light of these and other current challenges to medicine (e.g., increasing economic pressures, ageing societies), attaining clarity on this matter is more pressing than ever. To assist progress, the main task of this paper is to evaluate several options and to propose an account of the aim of medicine.

The paper starts by examining an initially plausible proposal according to which medicine is pathocentric, aiming to restore the health of individuals by curing disease. Discussing and rejecting this opening proposal as well as competing ideas, the paper presents and defends the Autonomy Thesis, which holds that medicine is not pathocentric, but *aims to promote health with the final aim to enhance human autonomy*. The paper adopts a 'positive' notion of health, clarifies its relations to other concepts such as well-being and autonomy, and offers a pluralist perspective on some difficulties surrounding the concept. It closes by considering and defusing the objection that the Autonomy Thesis is overly permissive and allows many highly controversial procedures as legitimate parts of medicine.

Four methodological considerations guide the paper. First, with respect to the aim of medicine, the claim is not that every single action performed in the context of medicine is directed at this aim. That said, even complex institutions are held together only if most of their activities share a methodical effort to achieve some constitutive aim (or a limited set of constitutive aims) that they could not fail to pursue without losing their identity and that governs what counts as progress in that activity (for a discussion, see Bird, 2019).

Second, our inquiry is limited in two ways. It is limited to 'mainstream medicine' (i.e., scientific Western medicine caring for the human population) that – at least on some level of abstraction – is sufficiently universal in spite of variation in the cultural meaning of crucial concepts (i.e., disease, health, sickness, illness, and disability), in local features of institutions and practices, and in its societal role across societies and cultures (for a discussion, see Broadbent, 2019, ch. 1).[1] In this regard, the paper differs from recent work on the aim of medicine by Alex Broadbent (2019), which provides an account that is not confined to mainstream medicine. Instead of trying to provide some universal aim, the choice of such a limited scope is linked to the hope that our analysis could provide a more fine-grained aim that could make sense of the criticism of contemporary medicine.

[1]Also, due to this focus, the view offered here has no direct implications for thinking about other areas, for example, veterinary medicine.

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In addition, the inquiry is limited to medicine in a specific, narrow sense. In the medical literature, medicine is defined broadly as dealing with 'the diagnosis, treatment, and prevention of disease and the maintenance of health' (*Stedman's Medical Dictionary,* 2006, p. 1074),[2] clinical medicine as focusing on 'diagnosis, treatment, and prevention of disease in the individual patient' (Ibid. p. 351), and public health as dedicated to 'preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities, and individuals' (Ibid. p. 1299). Using these distinctions, this paper focuses on clinical medicine, but I note that clinical medicine is also the focus of the majority of the philosophical work on the permissible goals of medicine (see, e.g., Boorse, 2016; Brody and Miller, 1998; Schramme, 2017).[3]

Third, the question about the aim of medicine is unearthed in tandem with a closely connected matter that concerns the 'internal morality of medicine', that is, the moral norms and values that govern the practice of medicine (for recent discussions, see, e.g., Hershenov, 2020; Symons, 2019). While there is significant disagreement in literature on a number of its aspects (e.g., to what extent it is fixed, to what extent it is autonomous from general morality), what is common to the different accounts is that they trace the moral norms and values that govern the practice of medicine and aim to distinguish legitimate practices from those that violate the internal morality of medicine. Clinical medicine is comprehended as a practice, a social activity that has a teleological structure defined by an aim and particular goods.[4] For example, education is a practice aimed at developing the rational and affective capacities of human beings, and this gives rise to a set of professional norms that determines how 'excellence' is understood within the framework of education. Clinical medicine displays a similar teleological structure with the aim, most commonly assumed, to combat pathology and enable patients

[2]Closely similar definitions are found in, for example, *Mosby's Medical Dictionary* and *The Gale Encyclopedia of Medicine* (2015).

[3]While some have attempted to catalogues a number of goals that medicine permissibly pursues (see, e.g., Boorse, 2016; Brody and Miller, 1998; Schramme, 2017), this paper will attempt to provide a single, overarching goal. In this respect, the approach in this paper is similar to Alex Broadbent's (2019) work, even if Broadbent's perspective is broader and his thesis is not restricted to mainstream medicine. For these reasons, my account does not claim to falsify Broadbent's thesis, but merely shows that mainstream medicine is an *exception* to Broadbent's thesis that the goal of medicine is cure and prevention of disease, while understanding and predicting disease constitute its 'core business'. I am indebted to an anonymous reviewer for pressing me on this issue.

[4]According to a popular view, a practice is 'any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity' (MacIntyre, 2007, p. 187).

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to engage in activities and to increase their quality of life.[5] Excellence in the context of clinical medicine is tied to providing effective treatment options for patients, and participants in the practice are subject to norms that jointly constitute an internal morality of the practice. These norms generate prima facie moral obligations on medical professionals independent of general morality and offer a normative backdrop against which inappropriate use of medical understanding can be identified.[6]

Fourth, the question about the aim of medicine is approximated by deploying a sequential approach that proceeds by articulating increasingly more nuanced theses. The paper starts with common assumptions, identifies problems, and suggests a more complex iteration, which is introduced in response to the problems. Instead of simply describing and defending the final iteration, using such a sequential approach helps articulate ideas, putting us in a better position to identify different conceptions of health and disease and to clarify their relations to other concepts such as well-being and autonomy. Outlining an intelligible route in which the steps build appropriately on their antecedents will make it easier to achieve reflective equilibrium.

1. Cure and treatment

We start with the commonly held view that medicine is pathocentric, in the sense that it aims to promote health by curing disease. To grasp what this view involves, we need to add some clarification about what 'health', 'disease', and 'cure' mean in this context.

Health is typically comprehended as the absence of disease, where disease not only encompasses what are usually considered as prototypical diseases (e.g., infectious and chronic diseases) but also conditions that are roughly

[5]Perhaps one could question whether medicine has an aim at all, and hold that it is a social practice that is entirely culturally and historically relative. While I cannot deal with this objection in full, I note that if medicine is a *social practice* that meets MacIntyre's well-known definition, then it has an aim, a teleological structure, and is defined by particular goods. My thesis is restricted to mainstream, clinical medicine and it leaves open to what extent this aim is culturally and historically relative. I thank an anonymous referee for highlighting this matter. But we may add that there is much disagreement on these matters in the literature. For example, proponents of 'essentialism' (e.g., Pellegrino) hold that the telos and the good which medicine aims (the health of the patient) is fixed and so are the duties that they generate. Proponents of 'evolutionism' (e.g., Miller and Brody, 2001) hold that aim of medicine can be subject to change along with the duties they give rise to (see Ng and Saad, 2021).

[6]Importantly, internal morality cannot be reduced to general morality (i.e., the collection of moral norms in a given society) (Veatch, 2001). First, internal morality can *suspend the restrictions* of general morality. For example, general morality dictates that we maintain confidentiality but allows a number of reasons for breaking confidentiality. In clinical medicine, even when general morality would dictate breaking confidentiality, the internal morality of medicine might suspend this norm, permitting physicians to maintain confidentiality. Second, the norms of internal morality can *add to the restrictions* of general morality. While the latter may allow participation in certain activities (e.g., torture, execution, forced sterilization, using pharmaceuticals to render prisoners passive, use of human subjects for research without informed consent), there is widespread agreement that the participation of medical doctors in these practices would represent a violation of the internal morality of the profession.

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comprehended as deviations from some range of normal functioning (e.g., injuries, poisonings, growth disorders, and functional impairments) (see, e.g., Boorse, 2016).

Cure is standardly comprehended as an intervention that leads to the full elimination of the disease but does not require that the patient returns to a state she would have been in had she not been afflicted by the disease. Clearly, curative interventions may count as successful even if psychological or bodily injuries suffered from a disease remain unaddressed, and even if the marks of the intervention have a lasting impact on the patient's life. For example, a successful curative intervention by surgery may be accompanied by the formation of scar tissue, and curing an infection with antibiotics may cause an irritated stomach lining.

Having added these clarifications, we may now return to the view that medicine is pathocentric, in the sense that it aims to promote health by curing disease. An obvious objection to this initial proposal is that there are a large number of medical interventions that do not offer a cure. And yet, if somebody consults a physician with a bad case of the flu, hepatitis B infection, or asthma, some kind of intervention of a properly medical nature will take place. But the purpose of the intervention in such cases cannot be a cure, because there is none. Instead, the purpose is treatment, which, in general, encompasses both the cure and the management of conditions.[7] A treatment can amount to a cure if it eliminates the disease causing the symptoms, like antifungal ointments cure athlete's foot by killing the fungus that causes it. Many treatments like insulin injections for diabetes mitigate harm caused by disease and might even keep the patient completely symptom free for her entire life, but they do not amount to a cure as they do not remove the underlying cause.

The distinction between cure and treatment notwithstanding, one could insist that the final aim of medicine is still cure, while treatment or management that reduces symptoms, and alleviates suffering or harm caused by disease is what clinical medicine does if cure is not possible.[8] But this is not entirely correct. While a detailed argument would lead us off path, it is perhaps enough to call attention to commonly occurring cases in which there is no cure, but a treatment is offered that effectively reduces the risk of developing sequelae (other diseases, such as liver disease in the case of hepatitis B). Such a treatment is still regarded as successful and as progress toward the aim of medicine, even though no pathological condition has been cured. If the aim

[7]In the medical literature, the relationship between cure and treatment is not always clear. One encounters both sentences like 'there is no true cure for x, but it can be treated' (which implies a distinction between cure and treatment) and sentences like 'minor infection x can be treated' (which seem to collapse the distinction between cure and treatment).

[8]A similar general view is defended in Broadbent (2019). I will not provide a detailed treatment of Broadbent's position in this paper, but again, the scope of Broadbent's is much broader than what is proposed in this paper.

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were cure simpliciter, then we would reach a counterintuitive result: Treating a condition to thereby prevent other diseases from emerging would not count as making an advance toward the aim of medicine.

2. *Treatment and care*

Avoiding the challenges with 'cure' outlined earlier, we may adopt as our working proposal that the primary aim of medical understanding is to promote health by treating disease.[9] Still, one might argue that the example of prevention, especially with respect to diseases that are very unlikely to ever occur, spells trouble for this proposal, because describing prevention as a medical treatment appears forced. The trouble is that while prevention cannot be readily incorporated into the concept of treatment, there is still a sense in which it is an instance of medicine being practiced, and successful prevention counts as making progress toward the aim of medicine. To resolve this issue, we start by exploring two possibilities.

The first possibility is to argue that because such preventive interventions occur before diseases are actually manifest, prevention is not a part of medicine like treatment is. It merely uses medical understanding, in a somewhat similar fashion as medical understanding can be used to construct ergonomic chairs and computer keyboards. However, this possibility fails to withstand scrutiny, because there are many forms of risk management that are structurally isomorphic with interventions standardly regarded as a part of medicine (e.g., vaccination, the treatment of risk conditions like hypertension, and surgical removal of precancerous tissue). Maintaining that prevention is not a genuine part of medicine like treatment is would thus result in a highly implausible view.

The second and more appealing possibility is to deny that prevention is an instance of medical understanding serving some nonmedical aim, and – acknowledging the difficulties with incorporating prevention into the concept of treatment – to replace 'treatment' with 'care' in our working proposal, which allows us to effortlessly incorporate prevention along with other cases that we more readily describe as treatment (including cure and management). In this manner, we can think of medical care as including treatment and prevention as subordinate goals to the same end, namely, eliminating disease or rendering its occurrence much less probable. If treatment and prevention are part of a larger goal of promoting health, then we may propose that the aim of medicine is to offer care that promotes health by treating and preventing disease.

[9]An account of what constitutes understanding in medicine is beyond the scope of this paper. For a detailed discussion, see Varga (2023).

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This line of reasoning has perhaps convinced our interlocutor that prevention can be accommodated into our current proposal, but she can still point to difficulties in accounting for common medical interventions like pain relief, which by all accounts constitutes a central medical activity. Yet our interlocutor might argue that pain relief does not fit the current proposal, because it simply does not promote health by treating and preventing disease. Instead, pain relief exemplifies an important use of medical understanding to pursue another aim, but not an aim of medicine, even if it is performed by medical professionals using medical techniques in regular hospitals or medical facilities. Alex Broadbent (2019, p. 51) has recently proposed a similar view, stressing, for example, that palliative care only enters the picture when cure and treatment had been given up. As he puts it, 'palliative care is consistent with my assertion that pain relief is a use of medical skills and tools, but not a goal of medicine' (Broadbent, 2019, p. 50).

In reply to such a position, we have at least two strategies at our disposal. The first starts by distinguishing between pain as a symptom of injury or disease and chronic pain. The latter may be considered as a disease in its own right, because it has developed into a destructive force that no longer has a beneficial function (see Raffaeli and Arnaudo, 2017). If we accept that chronic and recurrent pain is a disease, then palliative care is still covered by our proposal, as it promotes health by confronting disease. Nonchronic pain is, of course, a different matter, but perhaps relieving nonchronic pain could be understood as a preventive measure, as pain leads to mental and bodily stress reactions (e.g., increase in blood pressure and heart rate) that weaken the immune system and increase the risk for conditions such as heart disease. If these considerations are on the right track, then the relief of both chronic and nonchronic pain would still fit the proposed account that the aim of medicine is to provide care, which promotes health by treating and preventing disease.

The second strategy contends that even if pain could not be considered as a disease in its own right, it is not clear that palliative care is a use of medical understanding for nonmedical purposes. To see why, consider cases of terminal conditions where palliative care is not pursued in tandem with potentially life-extending treatment, but, after weighing the risks and benefits of treatment, instead of it. These are typically cases in which treatment options offer little chance of extending life, and when the prospect of returning home and remaining pain-free for the remaining time seems more attractive than the prospect of gaining some time but suffering the side effects (e.g., post-surgery pain and chemotherapy-induced nausea). An implication of the position that Broadbent proposes is that in such cases, if physicians advise palliative care over the attempt to pursue life-extension, they would be advising a course of action that entails using medical understanding to pursue a nonmedical aim instead of pursuing the aim of medicine. But in that case, we run into a problem. While the course of action that the physician advises is

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permissible and relatively standard, it counts on Broadbent's view as the pursuit of a nonmedical aim over the pursuit of the aim of medicine – an act that would normally be considered inconsistent with the internal morality of medicine.

Importantly, these complications dissipate if we adopt the suggestion to use 'care' to capture the aim of medicine. Doing so not only offers a resolution to the problem with accommodating palliative care but also allows us to comprehend palliative care not merely as a nonmedical aim that physicians can legitimately pursue but as something that actively promotes the aim of medicine.

3. *Medicine is sanocentric, but not necessarily pathocentric*

One could object that instead of introducing the notion of 'care', one could also accommodate everything that has been mentioned so far, including palliative care, by acknowledging that medicine has several aims: curing disease (when possible), treating disease (including its consequences), and preventing disease. However, as we shall see, further reflection raises reservations about the idea that this necessarily involves treating and preventing disease. There are many cases of what appear to be genuinely medical activities that do not tackle disease but are still hard to comprehend as pursuing nonmedical goals. Consider the following two examples:

Age-related sarcopenia. A patient in her 80s consults her physician with concerns about loss of muscle strength. Having excluded potential underlying diseases, the physician explains to her that her condition is known as sarcopenia, which is not a considered a disease, but a common condition associated with old age, caused by a process that gradually reduces muscle tissue and increasingly replaces muscle fibers with fat tissue. The physician informs her that the most effective method to moderate this process is regular strength training combined with protein-enriched nutrition.

Pregnancy nausea. A 32-year-old woman in the first trimester of her pregnancy consults her physician with nausea and occasional vomiting. Having excluded potential diseases (e.g., hyperemesis gravidum), the physician explains that especially during the first trimester of a pregnancy, nausea and occasional vomiting are perfectly normal and impact approximately two-thirds of pregnant women. She advises eating small meals, limiting spicy and acidic foods, and prescribes an antihistamine (promethazine) in case the condition does not improve.

In each of these cases, the consultation involves two phases. In the first phase, biomedical understanding is deployed to specific or nonspecific symptoms in order to assess and exclude the possibility of underlying disease. In this phase, there is little doubt that medical understanding is being used for genuinely medical purposes: The likelihood of a number of diseases

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based on a set of symptoms is evaluated, which is a form of risk reduction that belongs to the same category as prevention.

In the second phase of the consultation, one might argue that something else ensues. Disease drops out of the picture as age-related sarcopenia and pregnancy nausea qualify neither as diseases nor as genuine risk factors. Instead, the activity of the physician during the second phase of the consultation seems to pursue nonmedical aims, perhaps best described as furthering the well-being of the patient in some broad sense. If we were to hold on to the previous thesis that links the aims of medicine to promoting health by treating and preventing disease, then we would be forced to accept that medical understanding is used for nonmedical purposes. The relevant premises and conclusions can be laid out as follows:

> (P1) The aim of medicine is to promote health by treating and preventing disease
> (P2) Health is the absence of disease
> (P3) Age-related sarcopenia and pregnancy nausea do not involve disease
> ___
> (C1) Thus, in the second phase of the encounter, the physician's use of medical understanding does not promote health
> (C2) Then, in the second phase of the encounter, the physician uses medical understanding for nonmedical purposes

While the argument is valid, the conclusions put us into an awkward position for at least two reasons. First, there are many similar cases in which medical attention is directed at typical conditions of old age (e.g., frequent urge to urinate due to reduced bladder capacity, weak hand grip, thinning of the epidermis and dermis, xerosis, and refractive errors) that are not considered diseases. These are so numerous that accepting (C2) would force us to accept the somewhat strange consequence that a significant percentage of medical interventions do not pursue the aim of medicine.

Second, a weightier reason for being alarmed about the conclusion is that accepting (C2) would lead to a clash with intuitive judgments about some of the norms in medicine that make up part of its internal morality. Under normal circumstances, as long as a physician operates within her area of expertise and has the required resources, the internal morality only permits limited leeway to refuse to provide treatment to a patient that she has formed a therapeutic relationship with. There are cases, however, in which physicians can refuse without penalty interventions that do not serve medical aims.[10] In such cases, the physician can legitimately opt out by appealing

[10]For a helpful discussion of such cases in reply to Boose's account, see Hershenkov (2019).

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to the nature of the profession even if refusing the requested intervention might violate external moral (or perhaps legal) norms. Such cases are unlike those in which internal morality forbids participation (e.g., torture), and more like cases in which refusal can legitimately ensue on grounds such as medical futility or patient noncompliance impeding the physician's ability to provide proper care.

The important point is thus that in cases in which no medical aim is involved, the internal morality of medicine does not place the physician under obligation to help. Put in slightly more precise terms, a reflection of the internal morality of medicine lets us conclude that.

> (T) There is no professional obligation to use medical understanding for interventions that serve nonmedical aims.

This line of reasoning is not restricted to medicine. Although it does not apply for all types of professional activity, for certain types of professional activity we can say that if X is the goal of the activity or practice that one has 'signed up for', then one may opt out of doing something with the goal Y, even if Y is not inconsistent with X. For example, consider a teacher who has formally adopted the profession, the aim of which is presumably something close to expanding the cognitive capacities of school children such that they can become competent citizens. Imagine that he is asked by the school administration to transport children to school, which is not forbidden by the internal morality of the profession and is not inconsistent with expanding the cognitive capacities of school children. But while not prohibited, it is not mandatory either. The teacher could choose to help without violating the internal morality of the profession, but he could also stress that it is not required by the norms of the profession, and he could decline the request by saying 'this is not what I have signed up for' without deserving reproach for violating the internal morality of the profession. Moreover, he could also stress that fulfilling the request would actually take time away from teaching and mentoring activities that do constitute professional duties. In any case, upon declining, the administration could perhaps complain that this teacher is violating external morality (e.g., he refuses to 'take one for the team'), but they would not be justified in blaming the teacher for violating professional norms.

We may now revisit (C2) in light of (T). Accepting (C2) means accepting that in the cases of age-related sarcopenia and pregnancy nausea, the physician uses medical understanding for the benefit of the patient, but does so while pursuing a nonmedical aim. This, however, has significant consequences if we simultaneously accept (T): Helping to alleviate the discomfort caused by nausea and providing information about the most effective approach to moderate sarcopenia are now neither prohibited nor mandatory.

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This means that the physician could choose to help without violating the internal morality of medicine, but she could also refuse treatment without violating the internal morality of medicine. Alleviating the discomfort and informing the patient would then be something like a charity-based or supererogatory action, which is optional, beyond any professional duty, and the omission of which would not deserve criticism.

Consequently, if we accept (C2) and (T), we obtain a result that is hard to accept: By appealing to the norms of the profession, the physician could have refused without penalty to provide information about the most effective approach to moderate the loss of muscle tissue or to treat the nausea. However, when assessing such a course of action, the expected reaction would be that there is something amiss with this physician's comprehension of the norms of the profession. But if we do not accept (C2), then we have to reject at least one of the premises. But which one(s)?

4. *Sanocentricity and positive health*

The suggestion here is to accept (P3), modify (P1), and replace (P2). (P3) stands firms because cases like age-related sarcopenia and pregnancy nausea do not involve disease by either lay or professional standards. However, holding on to the view that medicine is sanocetric, we may modify the first two theses as follows:

(P1*) The aim of medicine is to promote health
(P2*) Health is more than the absence of disease (positive health)

Accepting these theses would allow us to acknowledge that in the cases under consideration, the activity of the physician during the second phase of the consultation can be adequately described as using medical understanding to further the aim of medicine, namely, the promotion of health of the patients by increasing their robustness or resilience. Medicine would then qualify as sanocentric on some broad, positive sense of 'health', and we could maintain that while medicine often proceeds by treating and preventing disease, it is not restricted to it. But are the modifications introduced acceptable?

The modification in (P1*) is relatively uncontroversial, as it only introduces changes as to how the promotion of health is achieved. It is also a better fit with the treatment of pain and smaller injuries in cases that cannot be readily apprehended as involving disease or preventive measures. The second modification might be more difficult to agree to. Some might think that accepting (P2*), thus adopting a positive notion of health and giving up a negative notion on which health is merely the absence of disease, is

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implausible: It is quite natural to say that when a person has a disease then she is not healthy, and when a person is healthy then she does not have a disease. But there are at least three reasons for thinking that the notion of health is not entirely coupled to the absence or presence of disease.

The first reason is that health as the absence of disease is not consistent with how the general enterprise of health enhancement is understood in modern societies. Following Lennart Nordenfelt (1998), we may distinguish between two types of health-enhancement activities in modern societies: *health care* (medical care, nursing, rehabilitation, and social care) and *health promotion* (health education, medical prevention, environmental care, and legal health protection). This brief outline of the general enterprise of health-enhancement supports the view that health-enhancement activities in modern societies operate with a positive notion of health (i.e., health is more than the absence of disease). For example, if rehabilitation efforts designed to optimize functioning in everyday life after the pathological condition is cured count as health care, then health must be more than the absence of disease.

The second reason for thinking that (P2*) is correct is that using a conception of health in which health is simply the absence of disease has problematic implications. If health is merely the absence of disease, then it is difficult to make sense of comparisons between degrees of health that both lay people and medical professionals regularly make. For example, it is possible to say of two individuals with disease that one is unhealthier than the other, and we can also compare the health of people across generations, maintaining, for instance, that despite longer life expectancy, presently living adults are actually less healthy than were adults in previous generations. Some think that such comparisons indicate that 'health' may be a fundamentally comparative concept (Schroeder, 2013), but the important point here is a different one: If health were merely the absence of disease, then we would lack adequate resources to compare two healthy people. We can say that A and B are healthy because they do not have a disease, but we cannot say that A is healthier than B, which seems insufficient, as being healthy can involve a spectrum of states of healthiness. So if we deem A healthier than B, then we are attributing to A something that B has less of, but whatever it is, it cannot be disease. The following section looks closer at puzzles generated by comparisons of this kind. Perhaps one could say that such health comparisons do not necessitate positive health, but only some standard of being in perfect health, characterized by a complete absence of disease. Whether one is more or less healthy would then simply depend on one's distance from that standard. However, if being in perfect health is characterized as a complete absence of disease, then relatively large groups of individuals would qualify (e.g., a sizable part of first-year university students would probably qualify). But then, we would encounter problems with explaining on what basis we compare the health of individuals in these groups.

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The third reason is that debates on chronic disease and disabilities also seem to indicate a conception of health that is more than the absence of disease or disability. It is now increasingly common to think that it is possible to be healthy while having impairments that count as disabilities. Moreover, it is increasingly accepted that it is unsatisfactory to indefinitely classify persons with a successfully managed common chronic disease as unhealthy (Venkatapuram, 2013). But even if the condition can only be successfully managed, neither lay people nor medical professionals would claim that it excludes being healthy.

These reasons offer support for (P2*), and thus, the thesis that health is more than the lack of disease. But if this is true, then it opens up the possibility for thinking that medicine is not limited to promoting health (in the sense of the absence of disease). With respect to cases like age-related sarcopenia and pregnancy nausea, (P2*) would allow understanding the second phase of the respective clinical encounters as aiming to promote health, although without confronting disease. For this, however, we need to say more about health beyond adopting a positive notion.

5. *Health: Two puzzles*

We start by taking a closer look at what appear to be two puzzles about health. The first puzzle is that the analysis of health generates very different intuitions (for a discussion, see Kingma, 2019). Some think that health being the absence of disease is clearly intuitive, while others think that it is clearly not. One might suspect a prima facie problem if rigorously trained professional philosophers eliciting properly directed intuitions about a circumscribed subject fail to reach at least some consensus (Sosa, 2007). Such conflicts should make us cautious in our applications of the relevant concepts (see Schroer and Schroer, 2013; Williamson, 2004). If the intuitions elicited are themselves not systematically biased in some sense, the conflict can be taken to indicate that there is something irregular with the concept under analysis.

The second puzzle arises upon examining ‘health’ as a gradable and comparative adjective (see Schroeder, 2013). Gradable adjectives admit comparative (taller) and superlative forms (tallest) and can be modified by an intensifying adverb (e.g., fairly, rather, less, and very). ‘Healthy’ is a gradable adjective that admits both comparative and superlative forms (healthier and healthiest) and can be modified (less healthy, very healthy, etc.), whereas none of this is true for nongradable adjectives (e.g., wooden). Not all gradable adjectives are gradable in the same way, but if we hold onto the idea that health is merely the absence of disease, then using comparative forms generate contradictions. Consider the following comparison in health:

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(a) A is unhealthy. He has celiac disease, an immune reaction to eating gluten, which can damage intestinal linings, prevent absorbing some nutrients, and causes diarrhea, fatigue, weight loss, and anemia. Fortunately, A never eats gluten.
(b) B is healthy. Many of B's vitals (e.g., blood pressure, cholesterol, triglycerides, and BMI) are, however, very close to being abnormal.
(c) A is healthier than B.[11]

While (a) and (b) follow from the view that health is the absence of disease, (c) is intuitively appealing. And yet, together they generate a contradiction. How could somebody who is healthy turn out to be less healthy than someone who is unhealthy? It is exceedingly counterintuitive that somebody who lacks health due to the presence of a disease should be less healthy than someone who is healthy.

In light of the two puzzles surrounding 'health', we may suspect that they are generated at least in part because there is something amiss with the concept itself. In that case, 'health' would be less illuminating in explanations and generalizations. To make progress here, the guiding idea is that the puzzles indicate that 'health' admits of multiple incompatible analyses and that interlocutors might take 'health' to express closely related, but different properties. The suggestion is to endorse a form of conceptual pluralism (see Chalmers, 2020), which acknowledges that different things deserve to be called 'health' and holds that the puzzle is most likely generated by the activation of two slightly different concepts of 'health'.

The idea is that 'health' is stretched out between two concepts, and the prefixes 'negative' and 'positive' will be used to help express the concepts while allowing a degree of continuity. One important difference is that negative health refers to a *state* characterized by the absence of disease, and positive health refers to the presence of a *capacity*. The latter can be conceptualized in a number of different ways, for example, as some resilience or robustness of organisms or systems dealing with stressors and internal disturbances, as the ability of the organism to live through a range of likely future environments (Kingma, 2012), or as Lennart Nordenfelt (1998, 2007, 2017; see also Venkatapuram, 2013) has suggested, as the second-order ability to achieve vital goals. While such a broad characterization is satisfactory for our purposes, the capacities or abilities linked to positive health can be rendered more precise in a number of ways. For example, resilience and robustness can in general terms be comprehended as linked to maintaining set ranges of functioning (e.g., homeostasis) at low cost, or being able to rapidly return

[11]The example draws on structurally similar cases from the work of Schroeder (2013) that deal with intergenerational assessments of health. Schroeder argues that 'health' may be a fundamentally comparative concept: 'healthier than' is a conceptually more fundamental judgment than 'healthy'. The aim here is a different one, limited to a discussion about a negative versus positive concept of health.

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to a previous functional level following perturbation (Ananth, 2008; Sholl and Rattan, 2020).[12]

With this in mind, let us return to our puzzles. The first puzzle is relatively easy to deal with if we accept that 'health' is stretched out between two concepts. As already indicated, the analysis of 'health' generates clashing intuitions, because in some cases, it activates the negative concept, while in others, it activates the positive concept. The second puzzle can be dissolved along similar lines. Returning to our comparison of A and B with respect to their health, it is uncontroversial that the negative concept of health is active in (a) and perhaps also (b). However, when we get to (c), there is a shift to positive health, which allows that in spite of A's celiac disease, A may well be much more resilient or robust when dealing with stressors and internal disturbances. A may be healthier than B given the aggregate costs of healthy functioning and successfully adapting to disturbances throughout a long lifespan.

Overall, unlike negative health, positive health does not exclude deficiencies due to well-controlled diseases. Positive health is not necessarily inconsistent with disease or disability, because the relevant capacities are not necessarily significantly reduced by the presence of disease.

6. *Sanocentricity: Health and autonomy*

Opting for the positive concept allows us to both uphold the thesis that medicine is sanocentric (i.e., its aim is to promote health) and to accommodate cases like age-related sarcopenia and pregnancy nausea. But our opponent might argue that the introduction of a positive concept leads to a potentially devastating problem: Because health is comprehended as a capacity, like resilience or robustness, it can always be enhanced, which means that on our account, medicine has no upper limit to permissible health promotion.[13] This, however, would render our account overly

[12]While a detailed treatment of this issue is not our current focus, it seems beneficial to separate robustness (ability to resist deviation from the original state) from resilience (ability to recover after a deviation from the original state) for a more thorough theory of health (Ukraintseva *et al.*, 2016).

[13]One may add that without further argument, sanocentricity as a sufficient condition could lead to a number of problems. First, it could mean that *any* health-promoting intervention by medical professionals (e.g., taking people on a walk, bringing them a cup of hot tea, telling them to drive slower, convincing them not to become professional soldiers) qualifies as a *medical* intervention. However, we should bear in mind that the internal morality of medicine does not dictate performing such actions even if they might promote health. Medical professionals can opt out without violating medicine's internal morality, which also means that such matters are not directly relevant for the aim of medicine. Second, a related, potential worry is that if we take sanocentricity to be a sufficient condition, then even health-promoting interventions by nonmedical personnel (e.g., friends and family) might qualify as a *medical* interventions. However, as the account presented here is restricted to the aim of medicine as a social practice, it is focused on the permissible activities of people who participate in the practice. Of course, nonparticipators could engage in similar activities (e.g., a friend could advise you to take an Advil, avoid stress, and clean a wound), but that would still not count as medicine.

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permissive and invite the charge that it cannot exclude cases of overmedicalization. In other words, we would reach an overly liberal comprehension of the aim of medicine on which virtually any intervention that promotes health is permitted.

This objection is serious and reveals that our hitherto thesis that medicine is sanocentric needs to be adjusted. As a first step toward such adjustment, the next sections present four observations on the relationship between health and autonomy in the context of clinical medicine. Based on these observations, we will implement a final modification to the thesis that the aim of medicine is to promote health and introduce the Autonomy Thesis. It will be argued that the objection can be defused, because the promotion of health, according to the Autonomy Thesis, is guided and limited by considerations about autonomy. Promoting health is the proximal aim of medicine, pursued to the extent that it serves or is at least consistent with the final aim of promoting autonomy.

(a) *Autonomy guides considerations about health promotion.*

Considerations about what is best in terms of health are sometimes unable to solve conflicts between different options (e.g., in cases in which a treatment for one disease, like type 2 diabetes, can raise the likelihood of another, like heart failure). Here is a case to illustrate this point.

Elective amputation. A patient with Body Integrity Identity Disorder (BIID) complains that despite repeated efforts to reconcile himself to living with his body, there is a profound mismatch between his phenomenal experience of his body (i.e., body schema) and the actual structure of his body. In particular, he stresses that his left leg has always felt intensely 'alien' to him, which is why he requests that the leg be amputated. He has been evaluated by a psychiatrist who confirms the he is not suffering from delusions (e.g., believing that the leg was artificially added to his body) and exhibits full decision-making capacity.

Whatever the appropriate course of action is in such a complicated case, making decisions only by reflecting on which option would result in the maximal increase of health is unlikely to provide sufficient guidance without considering what the respective health gains would mean for the autonomy of the individual. Assuming that the amputation would cure the BIID, is living with an amputated leg healthier than living with BIID? Instead, it is much more plausible to suppose that decision-making hinges on a reflection on the motive for seeking amputation and how the 'alien' leg is impeding his autonomy. Such reflection could reveal that surgery could, all things considered, indeed augment his autonomy and relieve psychological suffering by enabling him to finally be who he feels he is supposed to be.

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While there is fundamental disagreement in the literature with respect to such cases,[14] the main point with this brief discussion is merely to show that a reflection on what is healthier is insufficient without comprehending what it means for the autonomy of the individual. The course of action that will best promote the aim of medicine will in such cases depend on reflection not on health, but autonomy, which, according to a very rough, but generally accepted account, refers to the capacity to direct and determine one's actions in light of principles of one's own.[15] Simply put, how to best increase health becomes a question of how to increase autonomy, which suggests that the thesis that medicine is sanocentric needs to be adjusted. Of course, one might object that considerations about autonomy in such cases are just like other considerations about aspects other than health (e.g., cost–benefit ratio and the fair distribution of resources) that regularly play a role in decision-making. However, these types of considerations, unlike those about health and autonomy, are not internal to medicine.

(b) *The promotion of health is not permissible at the cost of autonomy.*

There is relatively broad agreement in contemporary medical ethics that competent patients who have the required capacities for self-government, are free from external constraints, and are sufficiently well-informed should always be allowed to refuse treatment aiming to improve their health, even if leaving the condition untreated will lead to certain death. The promotion of health is constrained by considerations about autonomy: If a patient who fulfils these criteria decides against accepting the treatment, then respecting her autonomy dictates that she should not be treated against her will. Some might object that disobeying her decision can in fact amount to respecting her autonomy because treatment is the only way in which she will be able to continue living as an autonomous agent (see, e.g., Varelius, 2005). This is, of course, an oversimplified depiction of a complex debate, but fortunately it is neither required to add more detail nor to take sides. What matters for our context is that on both views autonomy outweighs health, but does so without this somehow violating the aim of medicine or its internal norms. This also seems to indicate that the thesis that medicine is sanocentric needs to be amended.

[14]Some argue that with nonpsychotic and well-informed patients, the principle of respect for the patient's autonomy renders elective amputations permissible (Bayne and Levy, 2005), while others think that it involves a violation of the integrity of the (healthy) human body that renders it inconsistent with the aim of medicine, at least to a degree that allows physicians to refuse surgery without violating the internal morality of medicine.

[15]A person is autonomous just in case she demonstrates self-governance, guiding her life from her own perspective instead of being manipulated or forced into a specific course of action by external forces (Christman, 2009). There is not much agreement, however, as to how self-government is to be comprehended, and accounts vary depending on the theoretical and practical context in which the self-government occurs.

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(c) *Autonomy is a legitimate aim when the promotion of health is no longer possible.*

In some cases, health promotion is no longer possible, and biomedical understanding is deployed to explain and prognosticate the progression of a disease.

Ruptured aneurysm. An older person whose life has been plagued by anxiety presents with an acute headache. Tests reveal that he has developed a type of ruptured aneurysm that cannot be treated. The physician in charge is able to completely relieve the pain, carefully explains the nature of the condition, and predicts that without any significant pain or discomfort, the person will fall into a coma in 2–4 days and die after another 3–4. The physician also educates the partner about the condition and gives advice that might help cope with the situation, including about socioeconomic support.

In such cases, informing the patient about the condition and offering a prognosis is clearly crucial, yet it does not have import for the health of the patient. Moreover, given the overall psychological vulnerabilities of the patient, most accounts of well-being would deny that the prognosis actually increases the well-being of this person for the time he has left. Instead, medical understanding is used to predict the course of the disease and to promote the autonomy of the patient by offering him a chance to be in control over whatever is left of his life. When supporting autonomy via prediction in such cases, the physician is not pursuing some nonmedical aim. Correspondingly, choosing not to provide this information is not something that the physician could opt to do without violating the internal norms in medicine.

(d) *Autonomy is in exceptional cases permissibly pursued at the cost of health.*

Finally, a yet different sort of case involves the promotion of autonomy at the expense of health. In this regard, we may use a much discussed case in the literature involving sterilization.

Surgical sterilization. A woman in her early 40s contacts her obstetrician- gynecologist and requests surgical sterilization (tubal ligation) after having considered but declined other options for contraception due to possible side effects. She informs the physician that she does not want more children, and that her partner is in agreement with the decision. The physician has no reason for thinking that there is a risk for regret and helps her obtain the procedure.

In the literature, assuming a negative concept of health, there is broad agreement that this medical intervention does not target disease but reduces health, as it renders the reproductive system inoperative and, less notably, exposes the patient to (low) risks generally associated with surgeries. On a

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positive concept of health, it is easier to see that sterilization can improve health, especially when considering that unwanted pregnancies can lead to an overall decrease in health, most typically in the form of short- and long-term mental health problems, including maternal depression (see McCrory and McNally, 2013; Yanikk *et al.*, 2013). Although not explicitly noted, this may be one of the reasons why the American College of Obstetricians and Gynecologists sees sterilization as a legitimate medical intervention that is consistent with the internal norms of medicine (ACOG, 2017). If this is true, then such cases of surgical sterilization might be similar to cases in which reflections on health are insufficient and considerations about autonomy enter the picture.

This line of reasoning also applies to contraception. Some accounts that operate with a narrower notion of health maintain that because fertility is not a disease, contraception and sterilization are 'borderline' or 'peripheral' medical practices: They are neither within the appropriate domain of medicine nor unambiguously supported by its aims (Brody and Miller, 1998; Miller *et al.*, 2000). These accounts accept that giving individuals control over their reproductive capacities may be a legitimate aim of significance to autonomy, but stress that it is not the aim of medicine. In contrast, on the positive concept, contraception is effortlessly accommodated and consistent with the currently accepted practice that decision-competent women may legitimately expect that their request for contraception will be met unless there are suitably powerful countervailing reasons.

A much less discussed but poignant case in which increasing autonomy is achieved at the price of decreasing health is the medical procedure in which a healthy organ is removed from the body of a healthy donor.

Removing an organ for donation. A 27-year-old male signed up to donate a kidney to a stranger (nondirected or altruistic donation) through a nonprofit organization. He reports that as soon as he learned about the pros of kidney donation and the low impact on the donor, he immediately knew what to do. He has always been deeply committed to the idea that if it is possible to alleviate suffering at a low cost for oneself, one should take action. Shortly after, specialists at a local transplant center removed the kidney and the donor returned to normal activities after 4 weeks.

In this case, there can be no doubt that whatever benefit is achieved by this medical procedure, it is achieved at the price of decreasing the health of the donor while entirely consistent with the internal morality of medicine. Apart from the pain and (minimal) risks associated with the procedure, the donor faces a higher risk of developing certain conditions (e.g., high blood pressure and proteinuria). But note that here the anticipated effect on autonomy is very high: Besides the autonomy of the recipient, the medical procedure also supports the autonomy of the donor. After all, it is consistent with his deeply

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held moral conviction and helps foster certain values that he takes to define who he is.

7. The Autonomy Thesis, well-being, and the overinclusiveness objection

Considered together, these observations help implement a final modification to the thesis that the aim of medicine is to promote health and to introduce the Autonomy Thesis. The first observation (a) helps shed light on the importance of autonomy in cases in which the aim of promoting health does not offer clear guidance for decision-making. In such cases, which health goal ought to be pursued will depend on how the expected increase in health linked to a particular course of medical action would serve the autonomy of the individual. The other three observations carry a stronger weight in our argument, as they illustrate that (b) autonomy sets the limits of health promotion, and that (c) autonomy can be a legitimate medical aim, at least in cases in which health promotion is not an option. Thus, (b) and (c) suggest mutual restrictions: Medicine can only pursue health as long as it does not undermine autonomy, and autonomy can only be directly pursued by medical means if health is no longer an option.

We should note that (c) also provides some ammunition against a competing thesis, namely, that the final aim is not autonomy, but well-being. Discussing Pellegrino and Thomasma's influential work, Kyle E. Karches (2019) points out that while these authors limit medicine to the pursuit of an intermediate good (health), they are forced to acknowledge that in some cases (e.g., the management of chronic pain), some notion of a good – a final end beyond health – becomes relevant for medicine. However, this final end is defined by Pellegrino and Thomasma as some kind of well-being and sense of 'wholeness' that even includes a spiritual dimension, which leaves open whether their account is able to place any limitations on what medicine can permissibly promote (see Varga, 2022). Of course, one could argue that there are more narrow notions of well-being that would not face such challenges. Nonetheless, our examination of (c) suggests that whether well-being is comprehended as a matter of the greatest balance of pleasure over pain (hedonism), fulfilment of desires (desire-fulfilment theory), or developing and exercising one's natural capacities (perfectionism), the thesis that well-being is the final aim of medicine would make it difficult to make sense of the fact that thoroughly informing the patient about the condition and offering a prognosis have such an import. While the limited space available precludes me from exploring this topic in greater depth, it suffices to point out that – at least with respect to cases as the one considered in our discussion of (c) – on most accounts of well-

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being, it is hard to see how providing a devastating diagnosis and prognosis could increase the well-being of this patient for the time he has left. And yet, physicians cannot opt not to provide this information without violating the internal norms in medicine, which indicates that well-being is not the best candidate for the final aim of medicine. Of course, this is not to say that well-being cannot be some secondary goal that may permissibly be pursued. For example, in a recent paper, Roger Crisp adopts the view the primary aim of healthcare is to 'advance human well-being through promoting health' (Crisp, 2023, p. 6) and highlights the possibility that healthcare may have 'secondary or further goals, one of these being the well-being of staff'. While the Autonomy Thesis is not consistent with Crisp's take on the primary aim, it can accommodate the point that the well-being of staff can be factored in, as long as it does not affect the health or autonomy of the patient.[16]

However, adding (d) to the mix poses an additional challenge: If cases like that discussed in (d), that is, the removal of an organ for donation, are legitimate medical interventions and consistent with the internal norms of medicine, then this generates a problem for the thesis that the aim of medicine is to promote health. If autonomy can be permissibly pursued at the cost of health, even if only in exceptional cases, then it cannot be true that the aim of medicine is to promote health.

To solve this problem, we implement a final modification to the thesis that the aim of medicine is to promote health. With this, we arrive at the Autonomy Thesis, according to which promoting health is the proximal aim of medicine, pursued to the extent that it serves or is at least consistent with the final aim of promoting autonomy. It is only in exceptional cases (e.g., the surgical removal of organs for donation) that biomedical understanding can be deployed to increase autonomy in a way that does not proceed via the proximal aim of promoting health. Having added this final modification, our thesis is now consistent with observations (a), (b), and (c), and the problems raised by observations in (d) disappear. At the same time, the

[16]I should highlight that I take Crisp's (2023) helpful points to apply to medicine, although the article speaks of the aims of health care, which is usually taken to be a broader term than medicine, encompassing a wide range of activities and services that promote health and well-being. Crisp presents a discussion of religious preferences in health care and notes that 'it may even be that in some cases (e.g., where the cost to the patient is negligible, such as the painless delay of a procedure by a very short period of time) staff religious preferences can outweigh the preferences or health of patients' (Crisp, 2023, p. 10). On the view about the aim of medicine proposed here, staff religious preferences can perhaps outweigh some preferences of patients, but not their health, as that would constitute a violation of the internal morality of medicine. Of course, in a broader perspective discussing 'the aims of a healthcare system' (Crisp, 2023, p. 10) it may still be possible that under certain (extreme) circumstances, religious preferences can be sufficiently weighty to defeat competing considerations. However, in the optic of the Autonomy Thesis, this would still violate the internal morality of medicine. While this issue deserves further consideration elsewhere, perhaps the aims of a health care system do not always align with the aim of medicine.

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overinclusiveness objection loses its bite, because autonomy sets the limits of health promotion.

8. *The Autonomy Thesis and the second overinclusiveness objection*

Our opponent may point out that a similar problem may resurface with the notion of autonomy. Our opponent could argue that because the Autonomy Thesis allows that autonomy can in exceptional cases permissibly be pursued at the cost of health, this opens the door for highly controversial medical interventions to qualify as legitimate parts of medicine.[17] Two such cases often discussed in the literature are prescribing anabolic-androgenic steroids for athletes to increase performance and performing cosmetic surgical breast augmentation in women. The opponent may stress that there is widespread agreement in the literature that such interventions would not serve the aim of medicine, and argue that because the interventions would promote autonomy, proponents on the Autonomy Thesis need to clarify why these cases should not be classified as exceptional cases. If not, another version of the overinclusiveness objection threatens.

To deal with this objection, we may start by noting that what characterizes exceptional cases discussed in Section 6 was the combination of (a) a significant increase in terms of autonomy and (b) a minor reduction in health. But there are reasons for thinking that in the controversial cases under discussion, (a) or (b) are not sufficiently met.

In the case of anabolic-androgenic steroids for athletes, it may be argued that (b) is not met to qualify as an exceptional case. The health risks of nontherapeutic steroid consumption in athletes are substantial and include increased risk of cardiomyopathy, atherosclerotic vascular disease, hypomanic or manic syndromes, decreased sperm motility, erectile dysfunction, menstrual dysfunction, and substance use disorder (for a review, see Kersey *et al.*, 2012). Consequently, the health risks are considerably higher than in the exceptional cases discussed in Section 6.

In the case of cosmetic surgical breast augmentation, we may assume that the health risks are minor (although surgery requires lifelong further operations), but there are at least two reasons for thinking that (a) may not be met to a degree that renders the intervention admissible as an exceptional case. First, while the majority are satisfied with the outcome of the augmentation surgery (Coriddi *et al.*, 2013), there is little empirical evidence of long-term

[17]Our opponent could draw on the work of authors who have contended that medicine's aim cannot be autonomy, because medicine would then become 'merely an instrument to maximize individual choice and desire'.

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improvement in psychosocial functioning, self-esteem, or body image. With a lack of compelling evidence, it is not obvious that the relevant complaints are best approached with surgery instead of some other intervention (Sandman and Hansson, 2020). But in that case, it is not clear that breast augmentation in such cases would lead to a significant increase in terms of autonomy.

Second, simply assuming that the requested medical intervention would promote autonomy would rely on an overly crude notion of autonomy, which basically boils down to desire satisfaction. But such a notion would be unable to take into account that desires and intentions might be deeply held and yet still heteronomous, for instance, if they are unreflected impulses, resulting from compulsion or from internalized social oppression. In this regard, feminist scholars have argued that the desire to seek surgical transformation to approach an idealized body type can be formed by oppressive gender norms. But in that case, pursuing their realization may in some cases not only fail to promote autonomy, but may even be detrimental to it (for a discussion, see Chambers, 2008; Davis, 1991). To be clear, this is not to deny that some elective cosmetic surgeries can improve self-image and strengthen self-confidence in a way that increases autonomy. The point is merely that it cannot be readily assumed that meeting the request of persons seeking cosmetic breast augmentation will promote their autonomy to a degree that characterizes exceptional cases.

Overall, the objection revealed the need for clarifying why such controversial cases do not belong in the class of exceptional cases that the Autonomy Thesis would allow. We found that while exceptional cases meet two specific criteria, the controversial cases under discussion fail to meet at least one of them. For this reason, they fail to produce serious challenges to the Autonomy Thesis. This helps show that the Autonomy Thesis does not result in an overly liberal comprehension of the aim of medicine. The conclusion is consistent with the majority position in the literature that these controversial interventions would not serve the aim of medicine. While the Autonomy Thesis is shielded from such objections, it can neither be reduced the thesis that the aim of medicine is (a) to promote health, as long as this is in line with the autonomous will of the patient, nor (b) that the aim of medicine is to enable people to achieve their autonomously formulated goals.

9. *Concluding remarks*

Debates about medicine often proceed under the assumption that medicine has a well-established aim and what really demands attention are questions about determining the most suitable approach toward its realization. However, the deliberations in this paper indicate that the aim of medicine is far from clear, and there are a host of reasons why attaining more clarity on this

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issue would be productive. In order to help improve this situation, the main task in this paper was to propose and defend an account of the constitutive aim of medicine. Acknowledging the dangers of unreasonably simplifying a diverse enterprise, it was maintained that on some level of abstraction, medicine is a coherent enough enterprise to have a constitutive aim, which patients and medical professionals can appeal to when they fear that medicine is used to serve 'alien' purposes, be it due to economic, political, or other reasons.

Starting from the opening proposal that medicine is pathocentric, the paper proposed and defended the Autonomy Thesis, according to which medical understanding aims to promote health, with autonomy being the final aim of health promotion. Shifting to a positive concept of health helped articulate the thesis and accommodate controversial cases. At the same time, it was argued that the positive concept does not render the account overly unrestrictive and does not allow highly controversial procedures as legitimate parts of medicine.[18]

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