

Virtual Mentor

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Medicine and society

Achieving a shared view of treatment goals

by Kenneth A. Richman, PhD

To address this issue's theme, I want to consider the goals of particular encounters with particular patients. How these are set and pursued is central to the ethics of the clinical encounter. It is an ethical matter because being thoughtful about the goals of care helps physicians satisfy their obligation to provide medical benefit to the patient. It is an ethical matter also because of the physician's duty of respect for patients. Pursuing goals without patient buy-in is not just likely to fail, but is, generally speaking, contrary to the physician's duty to respect patients as persons. Respecting patients as persons requires, at a minimum, allowing them to veto the pursuit of certain goals, even those that seem to the physician to be clearly in the patients' interest. Like beneficence, respect for patients can help physicians identify appropriate goals, and it can also be a goal in itself. But it would be a mistake to overlook the fact that patients are not the only persons involved in the medical encounter who deserve respect. The physician can also have relevant goals for the encounter that may not fall under the categories described so far. Ignoring any one of these categories of goals can lead to miscommunication and unethical decisions.

The thoughtful reader will have noted that these goals can conflict with one another. That's one factor that makes the clinical encounter interesting. These potential conflicts will remain in the background for most everyday encounters. When communication seems to break down, however, or when physicians begin to feel frustrated with patient questions or noncompliance, making these goals explicit and setting them out for examination can help to clarify and address or resolve the issue.

Goals relating to medical benefit are often the simplest to manage. The patient might articulate her treatment goals as feeling better and returning to work; for the physician the goal of treatment might be to eliminate an infection. "Fill this prescription, take the pills as directed and come back if your fever persists." Patient complies. Mission accomplished for all parties. Does it matter that the patient and physician think differently about the goals? Not as long as the physician successfully communicates her medical goals for treatment to the patient.

Physician's duty to explain goals

Assuming that nothing is interfering with communication, the physician has the responsibility to explain the goals of treatment as she conceives them. She is, after all, the active party, acting on the patient, on the patient's behalf and as the patient's agent. Given that the nature of an action is determined by the intention of the agent

(whether a student is stretching his arm or signaling that he wants to ask a question depends on what's going on in his head—on his intention [1]), a patient cannot fully consent to a clinician's action or adopt her recommendation without understanding her goal for that action—what's in her head.

It is important to note here that our actions and goals are defined by how we think of them, even if our thinking fails to account for relevant facts about the world. (Students of philosophy may recognize the *de re/de dicto* distinction here.) For instance, the goal of visiting the gravesite of Mark Twain is not necessarily the same as the goal of visiting the gravesite of Samuel Clemens. Someone who held the first goal could truthfully say that she did not hold the second one, even though the gravesite of Mark Twain is precisely the same gravesite as that of Samuel Clemens. Similarly, a reasonable patient who knows that he has a fractured shoulder blade might be surprised to hear that he has a fractured scapula. Like actions, what goals a person has depends on what is in that person's head.

The features of actions and goals just discussed—that we cannot know what action is being performed without knowing what is in the agent's head and that actions and goals are what a given individual thinks they are—support the transparency model of informed consent, according to which "...disclosure is adequate when the physician's basic thinking has been rendered transparent to the patient" [2]. These features of goals also show how difficult transparency can be and how easy it can be for a patient to miss or misunderstand what a physician is doing or trying to do.

Patients generally have no reciprocal duty to make their goals transparent to the clinician, although one could imagine such a duty arising from specific patient-physician relationships. Such a duty might arise, for example, in a psychotherapeutic relationship or when the patient requests a treatment (such as a medication she read about on the Internet) and is initiating an encounter in which the physician is asked to act on the patient's intentions rather than vice versa.

The goals that patients have for the medical encounter often can be described in more simple terms than can those of their physicians, even though the patient's role in therapeutic relationships and decision making can be much more complicated. To give a personal example, I recently dislocated my right shoulder. As a patient, my short-term goals for treatment are to restore my ability to pick up my twin infant sons, to write on chalkboards with my right hand (as my students will attest, my left-handed writing is nearly illegible) and to avoid pain. My orthopedist's goals for my treatment probably have more to do with tendons, nerves, cartilage, etc. Obviously, this is not a case of conflicting goals. In principle (and, I dearly hope, in fact) both sets of goals can be satisfied. In this case I am likely to appreciate many of the implications of the physician's goals as he attempts to make the reasons behind his recommendations clear. But if I can't see how they relate to *my* recovery goals under the descriptions *I* give them, I will be confused, dissatisfied with the physician and much less likely to comply with treatment.

Getting patients to do what's good for them is an important goal of doctor-patient communication and a good reason to listen carefully to how patients describe their goals. Aside from diagnosis, compliance seems to be the primary reason given to medical students for listening to patients [3]. But listening to patients in this way for this reason is insufficient for respecting patients or for patient-centered care.

Defining health by disclosing goals

This is where things get even more interesting. I have argued elsewhere that an important aspect of what we mean when we talk of health refers to the ability to do the things we reasonably want to do [4]. What makes my shoulder injury unhealthy for me is that I became suddenly unable to do certain things that I want to do—for example, to reach into my sons' cribs when they wake up crying. This is not to deny the underlying physiological causes of this inability. But if the changes in ability occurred without the physiological changes, I would still be unhealthy simply because doing these things is a reasonable goal I have for my life. This perspective on the nature of health suggests that we cannot assess what would count as contributing to medical benefit (health of the patient) without understanding the patient's goals.

Of course, patient goals can be unrealistic, based on fears or false beliefs. They can be immoral, as when a patient wants treatment for his trigger finger in order to commit murder. They can be just odd, as when a patient wants to treat his arthritis in order to carve pencils into miniature totem poles. Patients can also have goals that are not directly related to a present illness, as when a patient mostly needs reassurance or a few minutes of conversation. When patient goals for an encounter seem a bit off, a lot can be gained simply by asking about the patient's hopes and expectations. Where the expectations are very different from yours, ask the patient why she has those goals or why she thinks they can be achieved. In some cases, the most effective part of the encounter can be some goal therapy, achieved by gently addressing false assumptions or faulty reasoning.

Even if we think of goals as inscrutable preferences (there's no accounting for taste, as they say), simple belief-desire psychology reminds us that a change in belief can effect a change in desires. For instance, if I come to believe that chocolate causes warts, my desire for chocolate will wane. Goal therapy can be thought of as a species of cognitive behavioral therapy (CBT). Some professional philosophers have developed related techniques based explicitly on the traditions and tools of their field and practice what is called philosophical counseling. Both of these traditions involve working with patients to identify false beliefs or bad reasoning. For instance, patients can have false beliefs about the efficacy or side effects of a treatment; they can also make mistakes of logic such as overgeneralization or failing to recognize patterns in symptoms. Of course, this type of therapy is done best by the pros, but they don't have a monopoly on truth and logic. As one experienced philosophical counselor puts it, "Reason is drug-free, internal medicine" [5].

Clinicians might have goals for interactions with their patients that are outside the categories discussed so far. For instance, it is legitimate for physicians to aim for efficiency in order to leave time for other responsibilities. They might also want to limit the number of times a patient comes to the clinic in order to keep costs down for everyone involved. My main point is that the goals of medicine are not a simple matter. When a clinical encounter isn't going well, making these goals explicit may be just what is needed. Where necessary, a little goal therapy can go a long way.

Notes and references

1. This example is used to excellent effect by Stanley Fish in *Is There a Text in This Class? The Authority of Interpretive Communities*. Cambridge, MA: Harvard University Press; 1982.
2. Brody H. Transparency: informed consent in primary care. *Hastings Cent Rep*. 1989;19(5):5-9, 142.
3. See Richman KA. *Ethics and the Metaphysics of Medicine: Reflections on Health and Beneficence*. Cambridge, MA: MIT Press; 2004:165-173.
4. See, for example, Richman KA, Budson AE. Health of organisms and health of persons: an embedded instrumentalist approach. *Theor Med Bioeth*. 2000;21(4):339-352. Several other writers have adopted this general line with respect to understanding health, e.g.: Nordenfelt L. *On the Nature of Health: An Action-Theoretic Approach*. Boston, MA: D. Reidel; 1987; Porn I. An equilibrium model of health. In: Nordenfelt L, Lindahl BIB, eds. *Health, Disease, and Causal Explanations in Medicine*. Boston, MA: D. Reidel; 1984:3-9.
5. Cohen ED. *What Would Aristotle Do? Self Control Through the Power of Reason*. Amherst, NY: Prometheus Books; 2003:7.

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