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MEDICINE AND THE CALL FOR A MORAL EPISTEMOLOGY, PART II

constructing a synthesis of values

ALFRED I. TAUBER

ABSTRACT The demands and needs of an individual patient require diverse value judgments to interpret and apply clinical data. Indeed, objective assessment takes on particular meaning in the context of the social and existential status of the patient, and thereby a complex calculus of values determines therapeutic goals. I have previously formulated how this moral thread of care becomes woven into the epistemological project as a “moral epistemology.” Having argued its ethical justification elsewhere, I offer another perspective here: clinical choices employ diverse values directed at an array of goals, some of which are derived from a universal clinical science and others from the particular physiological, psychological, and social needs of the patient. Integrating these diverse elements that determine clinical care requires a complex synthesis of facts and judgments from several domains. This constructivist process relies on clinical facts, as well as on personal judgments and subjective assessments in an ongoing negotiation between patient and doctor. A philosophy of medicine must account for the conceptual basis of this process by identifying and addressing the judgments that govern the complex synthesis of these various elements.

Center for Philosophy and History of Science, 745 Commonwealth Avenue, Boston University, Boston, MA 02215.

E-mail: ait@bu.edu.

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TO ASK ABOUT THE FUTURE of philosophy of medicine already assumes that there is a philosophy of medicine. Much dispute has swirled around this matter (Stempsey, this issue, Wildes 2001), and I align myself with those who maintain that medicine does indeed have a philosophy, and that that philosophy may be characterized. When developing a philosophy of medicine, we ask what binds medicine's various elements and approaches together. I submit that the answer is not to be found in medicine's epistemology, its forms of knowledge and manner of understanding, when conceived narrowly. Instead, I suggest the idea of knowledge be expanded to join two branches of philosophical discourse: the moral and the epistemological.

I wish to argue for a *moral epistemology*, whose meaning here differs from the common understanding of this terminology. I am not using "moral epistemology" to address the epistemic status and relations of moral judgments and principles—for example, the justification of statements or beliefs, in epistemology, or validation of judgments of actions, in ethics. Instead, I am using the term to capture the active dynamics that govern the application of scientific facts in the context of the interpersonal relations of doctors and their patients. On this view, the values framing the ethical encounter directly influence the application of scientific knowledge, for no neat division exists between the objective and subjective domains in the care of the patient, and further, the imposition of such a stark separation between "science" and "ethics" subverts best practices of clinical care. "Moral epistemology" thus designates the view that ethics and epistemology cannot coexist as separate domains, but must be understood as fully integrated in the care of the patient. Accordingly, medical ethics moves from a sub-specialty to assume its rightful place at the fulcrum of medical decision-making.

On this view, "medical ethics" is too narrow in focus, and in many ways follows the partition of medicine established by the scientific dissection of disease. If illness frames the physician's philosophy, and that philosophy is ethical care broadly understood, then a moral epistemology more effectively captures what doctors do and to what they should aspire. This position has been outlined, detailed, and generalized elsewhere (Tauber 2001, 2005a, 2005b). Further, I have claimed that clinical medicine is fundamentally a technical enterprise in the service of a moral mandate, the care of the ill (Tauber 1999). Medicine's foundational ethics frame the character of the field, and the science and technology applied to serving the patient are in the service of that mandate. Below I summarize these views and then explore the process by which the synthesis of values might be characterized.

**RECALIBRATING THE RELATIONSHIP
OF FACTS AND VALUES**

Describing clinical medicine as embracing a moral epistemology highlights how knowledge is structured by, defined through, and embedded in diverse values, and more to the point, that these values are those established by lived experience

and ordered by a personal ethic (Tauber 2001). Because of its dual character of scientific practice and ethics of care, the distinction between facts and values in clinical medicine collapses in a particularly interesting way. Values presuppose judgment, and in this sense ethics is based on values—such as autonomy, justice, empathy—and of course objective science is also ordered by another array of values—such as objectivity, coherence, predictability, comprehensiveness, simplicity (Putnam 1990, 2002). The values supporting objective science, at least for the past 150 years or so, have conferred a particular cast to scientific knowledge, a form of positivism that restricts the kind of value allowed to participate in the scientific endeavor. Flexnerian medicine, based on a laboratory research ideal, sought to follow positivist precepts, for better and for worse.

Objectivity divorced from personal value is embraced precisely because such knowledge is regarded as making facts universal. Indeed, it is the universality of scientific knowledge that affords its authority. Who could quarrel with the triumphs of such an approach, which has served medicine so well? However, I claim that in the care of the ill, the limitations of biomedical objectivity require a recasting of medicine's scientific aspirations. For the view from nowhere, the absent perspective, is not only inappropriate for medicine, it is unattainable as well. Medicine's epistemology is thoroughly embedded in non-positivist values, and these constitute a moral structure that ultimately orders and defines clinical science (Tauber 2005b).

Moral epistemology dispenses with the positivist distinction of "fact" and "value," because facts *become* facts as a result of values that make them so. In the post-Kuhnian understanding of scientific practice, critics have persuasively argued that a vast array of "non-objective" values comes into play during the discovery of facts and their interpretation. Most generally, the neat division of facts and values only admits the separation of certain kinds of facts from certain kinds of value, and conversely, the intermingling of facts with other families of value. Putting aside science proper, clinical medicine demonstrates this description in a compelling way.

I have made the argument for a more integrated appreciation of how facts and diverse values intertwine, and more to the point, how humane values participate in the scientific scenario (Tauber 2005a, 2005b). My position grows from a commitment to holism, whose ontological commitments differ radically from reductionism, and from there the epistemology "precipitates" (Tauber 2002). I have previously discussed the contextualization of clinical facts and how their meaning is derived from their particular placement within the pathology of complex systems (Tauber 2005a, 2005b), and suffice it to simply note here that the "system" of concern is not only a circumscribed physiological entity, for example, the cardiovascular or endocrine system—but the entirety of the person called a patient. Facts attain their meaning in that larger universe, one that extends from the psychosocial domain to the laboratory data sheet. On that spectrum, the ethics of medicine are inseparable from medicine's forms of knowledge.

At least four dimensions of this relationship may be described. First, and most importantly, in the clinical context the interpretation and application of scientific knowledge occurs in a framework oriented by human need and physician's obligations. Indeed, the science of medicine is cast in a *moral* framework, one that antecedes the epistemology proper. It is moral in the sense of human-valued, human-centered, human-derived, human-constructed, and human-intended. Accordingly, values directed by human need place investigative findings in the context of seeking a means to benefit the patient. So a foundational epistemology has been replaced with a functional one, by which I mean the pragmatics of establishing a clinical strategy for each individual patient must be based on the needs of that patient.

Second, this alliance of the moral and the epistemological goes all the way down, because medicine as a clinical science follows the same moral precepts operative in science more generally: open discussion of findings, comparison of data, free inquiry about interpretation, and transparency of experimental reports. These parameters of discourse are assumed as a simple epistemological requirement: private experience cannot become a public fact until scrutinized by a community of observers, inasmuch as shared experience is crucial for conferring the final criteria of objectivity, or in other words, diverse perspectives converging on a common assessment. This social appraisal is, by definition, ethical, inasmuch as the social is ethically constituted by particular rules, practices, and definitions.

The third moral dimension pertains to the values embedded in knowledge. I am not referring to how knowledge is valued, but rather how values are embedded in knowledge itself. This aspect is most evident in the normative sciences—the life sciences—where functions are evaluated as fulfilling certain teleological criteria. Here, a normative continuum is inseparable from scientific descriptions. The implications for the medical sciences are self-evident, from clinical trials to the bedside (Tauber 2005b; Worrall, this issue).

Finally, some of medicine's values are most directly derived from social practices, others from a system of metaphysics, and yet others from particular legal, political, and moral philosophies. Recognizing this complexity has provided a heightened awareness of how even the clinical science of medicine is not only impacted by politics and ideologies but is more subtly influenced by its cultural milieu and moral environment. On this view, medicine never stood alone in an objective cultural chamber insulated from the social pressures surrounding research and theory. To show how clinical science is so embedded does not diminish its accomplishments, or even its aspirations, so much as highlight how isolating its science from its broader context radically misrepresents the larger moral universe in which physicians function. Discerning and then establishing medicine's philosophical position on the coordinates of fact and value must ground a philosophy of medicine. How that might be conceived, follows.

CONSTRUCTIVISM IN MEDICINE

The amalgam I am calling moral epistemology begins by acknowledging that the doctor-patient encounter is, by its very nature, a negotiated attempt to coordinate, if not combine, different frames of reference. Treating disease (medical science applied to biological dysfunction) does not necessarily coincide with effectively dealing with illness (the patient's psychological and social experience of disease). Thus the recurrent ethical question plaguing a reductionist, positivistic clinical medicine is to what extent the disease may be separated from the person, and the person reduced to a medical object of scrutiny.

I have approached this issue by arguing that all values governing care—both epistemological and ethical—are in flux and configured by each individual case. In a trivial sense, values direct knowing. For instance, we constantly choose to pay attention to certain elements of our experienced world and ignore the vast majority. Values determine what is studied and how data are interpreted (Putnam 1990; 2002). In medicine, this view is overwhelmingly self-evident and hardly needs recitation: from the socially based policy decisions of health-care administrators to the attention paid to the individual patient, the care delivered is allocated by a distillation of value choices. Medicine is embedded in a value system, and patients are subject to complex moral choices, whether declared or not.

Clinical medicine cannot attain radical objectivity in its applications or in its practices, and doctors must engage the psychological and social worlds of the sufferer as much as the biophysical and genetic domains of the body. With poorly demarcated boundaries, the positivist attitude simply will not suffice in the care of the patient. But more, it is an encumbrance. Patients are social creatures as well as organic ones, and they thus require multidimensional interpretations and judgments. But more, the doctor must appreciate how disease manifests itself not only in a strict, circumscribed organic realm, but also as an experience defined in some measure by the person—psychologically, socially, culturally, historically (Marcum, this issue). At times, this understanding dominates and organizes the therapeutic options.

From this point of view, each case must be constructed from a complex intermingling of psychological, cultural, social, and physiological elements. Such a construction tilts more heavily in one direction or another depending on the peculiarities of the individual affliction, the social context of the illness, and the clinical options available. *Construction* is used deliberately, because the narrative that presents the illness and the consequent “disease” designation exhibits plasticity. Physician A may understand a patient's disease and social context in one way, resulting in strategy A, whereas physician B may have an entirely different view and follow strategy B. Each has access to the same information, but the scenario may be interpreted differently as a result of the experience and knowledge of the doctor. Configuring the case differently, even radically so, is commonplace, and such differences are usually attributed to the hermeneutical flexibility

of the “art of medicine.” Instead of *art*, I think *construction* more accurately reflects this process of interpretation. Invoking a constructivist approach, I am not arguing about the metaphysical basis of disease, but rather I am using a weak form of constructivism to capture the highly complicated nexus of factors that may be configured in one way or another given the particularity of an individual case.

A definition of constructivism begins with “X is said to be constructed if its produced by intentional human activity” (Kukla 2000, p. 3), and thus human artifacts or social activities are easily recognized as products of human invention. But are scientific *concepts* constructed? Not according to the doctrine of natural kinds, whereby conceptual schemes just carve nature at its preexisting joints and these are then regarded as discovered, not invented. But this simply gainsays the success of the conceptual structure erected, the success of the construction called a theory, fact, or concept. At least that is the argument, which should be understood with certain distinctions, at times conflated: constructivists may argue a metaphysical thesis about the facts describing the world in which humans live, an epistemological thesis concerning what can be known about the world, and a semantic thesis regarding what can be said about the world (p. 4). Some confusion exists in the literature as to what these various positions maintain, and more pointedly on whether constructivism is invariably associated with relativism, whether ontological or epistemological (pp. 4–6).

The second aspect of the debate concerns the “extent” to which a constructivist argument can be made in science. In some sense, constructivism in a social and political context is self-evident: certainly, science is pursued and supported for social reasons and technological gain. But the question looms as to what extent these forces determine scientific findings and theory construction. While neutrality is betrayed, is objectivity compromised as well (Proctor 1991; Megill 1994)? Science is, in a trivial sense, “social”—it is a human activity that draws upon all those elements of culture that support its enterprise. This is hardly contentious in itself, but while describing the inter-contextualization of science and its supporting culture seems innocent enough, such descriptions have generated heated debate when the arguments have followed a theoretical continuum that appears to conclude in radical deconstruction, whose endpoint leaves science reduced to politics and where an insidious relativism reigns. The academic debate erupted into polemics during the so-called “science wars” of the 1990s. Measured assessment may be found in Labinger and Collins (2001) and a more opinionated version in Brown (2001).

In the context of our discussion, the constructivist argument, in its broadest interpretation, claims that science and, perhaps more obviously, medicine can be segregated neither from the complex cognitive and linguistic structures nor from the economic and political forces that support their activities, but are, in fact, heavily indebted to them. Accordingly, “what is” (the reality as described by science) cannot be understood independently from *how* that reality is examined.

Consequently, facts are laden with both declared and unannounced values, and scientific methods are pragmatic and resistant to formalization, so that no “system” could comprehensively (or fairly) describe theory development (Kuhn 1970) or scientific method (Feyerabend 1975).

Building upon the constructivist notion of knowledge acquisition and application explicitly acknowledges the role of competing and contested values in the process of assessing, judging, and choosing clinical options. This use of *construction* differs from simply factoring in the social dimension of both philosophy and medicine (Wildes 2001), because in my view the construction applies to the assembly of all the pieces that constitute the evaluation and care of the patient. The facts and judgments must be sorted and assembled into a mosaic, one that is unique to each individual patient. The social configuration is a major influence, but only one of several modes of construction. How this formulation takes shape is the subject of my concern here.

Whatever positivist aspirations clinicians may still hold, they collapse in the face of the social constructive character of illness and disease, which I will refer to as the “social” definition of the pathological. George Canguilhem (1989), in observing that “there is no fact which is normal or pathological *in itself*” (p. 144, emphasis added), showed the ever-changing shifts of the normal and the pathological as constructs. He was concerned not only with the distributive, numeric scientific context in which the pathological was defined, but also with the context of personal experience of illness as determined by the social mores of suffering and the very definition of dysfunction. In brief, illness, determined by several misaligned factors, was described as a construction of these various elements, and their realignment, the therapeutic process, became a reconstruction.

The experience of the ill is not solely “physiological” in some essentialist sense, but it is deeply embedded in a rich cultural and personal context. When Canguilhem asked, “What is a symptom without context or background?” (p. 88), he sharply drew in the reins of a scientist medicine, or some might say, freed physicians from a false scientism. Medicine both creates and functions within the categories of disease and illness, which are defined and treated as part of a complex web of human values. Recent scholarship has confirmed Canguilhem’s general lesson by emphasizing how social values play into the understanding of disease, whether viewed from the perspective of psychic influences, by the formulation of gender identity, as determined by cultural standards, and as supported by implicit metaphysical assumptions (Brook 1999; Ehrenreich and English 1979; Fadiman 1997; Good 1994; Kirmayer 1988; Kleinman 1980; Shorter 1988). Each of these literatures highlights an anthropological and philosophical truism: disease is defined within a complex of epistemological, social, and metaphysical claims that differ between cultures (macro-level), and illness manifests amongst a given culture’s individuals (micro-level) with variables difficult to predict or quantify with any accuracy. This means, simply, that while disease has certain characteristics within contemporary positivist observations and supporting

theories, other systems of understanding may determine a patient's experience of illness and even the effectiveness of therapy (Callahan 2002). Indeed, the very nosography within biomedicine itself varies within Western societies (Payer 1988), and when we regard the controversies within orthodox allopathic practice in the United States, we clearly see that interpretation is basic to the clinical arts.

Clinical medicine, in its myriad dimensions, functions as a hermeneutical discipline, inasmuch as all clinical facts must be interpreted from several points of view. As already discussed, a finding must be understood within the encompassing context of one or more physiological systems, as well as in relation to the general condition of the patient taken as a whole. This is an interpretative process that in itself may be reduced to algorithms and formulas, but more often requires application of general heuristics rather than any prescribed strategy. In the best case, judgment requires the application of some general finding to a particular case (a deduction that may not be easily achieved); perhaps more frequently, the data are simply not available or the diagnosis remains problematic.

Further, once clinical definition has been reached, it must be subjected to interpretative decision making that includes various psychosocial factors, local concerns of health care, and a host of other determinants beyond the bedside. In short, clinical facts must be interpreted at several levels of analysis and within various frames of reference; at each stage an assortment of values vie for dominance in prescribing the course of action for an individual patient. Objectivity alone hardly suffices; formulaic rules seldom fulfill their billing; prescribed regulations fail to mediate humane health care. So, given the multidimensional nature of medical reasoning, how might we characterize the clinician's hermeneutics?

To begin, let us break out of an archaic mindset: rather than encumber 21st-century medicine with 19th-century standards, we must formulate a philosophy of medicine that still incorporates scientific ideals and yet distances itself from inapplicable positivist conceits. Clinical medicine *is* scientific, but it possesses a character that distinguishes it from physics or chemistry. The key differentiating factor is the need to balance choices within the particular context of an individual patient. While general scientific laws apply, the individuality of disease and the constraints of the personal setting undermine the application of a positivist ideal that operates only within the universal. These differences may be formalized.

Scientific theories generally fall into two camps: some are simply descriptive with no judgments as to optimal or suboptimal states. Such theories, which characterize the natural sciences—for example, Newtonian mechanics or general relativity—are value-neutral (relative to human or subjective values). Of course, they are *not* value-free, as they follow their own hierarchy of values. Other kinds of theories embed different social or personal values in their descriptive structure that are necessarily derived from human experience and accordingly account for conditions on a normative spectrum of values. Physicians use heavily normative theories of health, and they do so by defining the *normal* and the

pathological in a human context. Thus, simply by necessity, their descriptions are subject to relative and subjective factors: standards of *function*—again, a normative idea—must be established, and within these standards normative evaluations are operative.

Because function is so overdetermined by human evaluations and judgments about those functions, the criterion of “normal” must remain flexible. So as a normative science, medicine must acknowledge that its scientific standards are fundamentally different from those of physics precisely because the clinician embraces *different* kinds of value as a governing element of her pursuits. And more to the point, no neutrality at the bedside exists (Tauber 2005a, 2005b). The clinician is always oriented by the patient, and she thus operates with a complex amalgam of objective and subjective judgments determined by the needs and goals of that patient—or, in other words, a normative structure. Because each clinical case determines the meaning of the facts, meaning is conferred within a specific context, not a universal one. Thus the difference between physician and physicist resides not only in the criteria of standards, but more fundamentally in the context in which those standards are obtained.

Care is governed by goals, namely restoring, optimizing, or maintaining health, which is itself a value relative to some goal or function (Richman 2004, p. 13–17). The physicist sees no teleological basis to the phenomena she investigates, but the physician’s science is employed for a *human goal*. With this agenda, how can a value-neutral evaluation be achieved? Medicine cannot attain the status of a natural science, nor should it. Instead, biomedicine must establish its own scientific ethos. That should, and must, suffice. But a dilemma remains: If medicine is not scientific by positivist criteria, what are its standards? What are its veridical claims to rationality and validity? Accepting its own pragmatic achievements for achieving the *best* outcomes (and settling for approximations to some objective ideal and positivist aspirations for evidence), represents a deviation from the “ideal” of a physics-based science by acknowledging the nature of a more complex epistemology. In short, a pragmatist philosophy captures what physicians *do*. And they do their work by *constructing* unique interpretations and practices for each case.

DEBTS TO JOHN DEWEY

As described, moral epistemology—in various forms—embraces the melding of facts and values to produce an epistemology that better accounts for the value structure of all knowledge and experience. Indeed, this orientation points to a philosophy of medicine that again brings investigation of illness and disease into the domain of a pluralistic reason, where various cognitive faculties receive their just deserts. I am building here on John Dewey’s (1922) moral philosophy, according to which all sciences: “are a part of disciplined moral knowledge so far as they enable us to understand the conditions and agencies through which man

lives. . . . Moral science is not something with a separate province. It is physical, biological and historic knowledge placed in a human context where it will illuminate and guide the activities of men” (p. 296). For Dewey, no firm demarcation between moral judgments and other kinds is possible, for “every and any act is within the scope of morals, being a candidate for possible judgment with respect to its better-or-worse quality” (p. 279).

Dewey effectively widened the scope of “morals” to include value judgments writ large: “morals has to do with all activity into which alternative possibilities enter. For wherever they enter a difference between better and worse arises” (p. 278). For Dewey, morals are “objective” in the sense that consensus and considered judgment deliberate the better choice of dealing with the world or drawing inferences from it. A Platonic ideal of “objective” or “real” or “true” is then replaced with a pragmatic assessment adjudicated by the rules of human flourishing. Indeed, as Alasdair MacIntyre (1978) cogently confirms: “To be objective, then, is to understand oneself as part of a community and one’s work as part of a project and part of a history. The authority of this history and this project derives from the goods internal to the practice. Objectivity is a moral concept before it is a methodological concept, and the activities of natural science turn out to be a species of moral activity” (p. 37; see also MacIntyre 1984). I have extended this philosophical approach in previous studies (Tauber 2001, 2005b), and here I place a Dewey-inspired understanding of medicine in its contemporary context. To summarize that schema, I offer no formulas or rules. Each case demands its own descriptive analysis of how facts are construed and built from wide and diverse resources. Yet, three characteristics deserve mention.

First, following Dewey and later pragmatists, the only reality is “ordinary reality” (Shook 2000), and in that service, moral epistemology becomes a philosophical approach to the full panoply of experience. This attitude seeks to envelop all experience, from esoteric front-line science to the full application of science’s harvest. This final distillation of thought draws from diverse cognitive and emotional faculties and requires harnessing them into some integrated coherence. In short, moral epistemology becomes an *integrative description* of the world and one’s experience of it.

Second, moral epistemology presents the world as an ongoing dialectical exploration in which meaning, not truth, becomes the focus of interest (Dewey 1931, p. 4). This configuration places truth in the employ of meaning, which in the context of medicine, pertains to the restoration of health or the maintenance of personal dignity in the context of suffering. Truth-claims then constitute a stage on the way towards some final synthesis, towards meaning. On this view, truth functions in the service of meaning-seeking behaviors, which, of course, coincides with the integrative requirements of thought. Reality is thus experienced in an ongoing test of personal knowledge against the world that demands responses that invoke one kind of reason or another. This manner of constructing reality represents a synthesis of experience in the employ of meaning.

Indeed, meaning becomes the endpoint of knowledge, as the individual interprets the world as a product of the present moment within the context of prior experience.

In this fashion, meaning becomes the cognitive glue in which experience coheres. This attitude, developed by pragmatists and contemporary cognitive scientists, serves to capture human intention, because without the search for meaning, the motivation for integration and coherence would have no basis. Further, experience would have no structure. Accordingly, a “foundational” epistemology has been replaced with a functional one, by which I mean the pragmatics of situating meaning-seeking ventures of ordinary experience. (For discussion, see Tauber 2005b.)

Finally, moral epistemology embraces a self-reflective attitude about experience. Comprehension of an integrated world, created by the search for meaning in a dialectical exchange with the world, emerges as epistemology’s object of inquiry. In the final analysis, meaning serves to focus judgment’s function, an arbitration of experience to create human reality. The play of facts and values, interacting with varying valences assigned to each, serves as the *métier* of life experience, ordinary and otherwise. Following flexible rules of navigation, moral epistemology acknowledges that reality ultimately places humans within the reality *they* experience. The facts of the world—or more simply, the world—only become factual with the values assigned by human evaluation. And thus reality becomes a product of mind and nature, as Kant first proposed—not constructed by a universal reason as he thought, but composed with varying rules, historical and culturally developed and thus contingent to time and place. Some cognitive rules may present themselves precisely, while others less so, and some remain seemingly nonspecific, their full character shrouded as the faculties of human explanation and understanding weave the threads of experience into whole cloth, all the while oblivious to analytic attempts to discern them. In the most general sense, the world so construed is fundamentally moral, inasmuch as values direct and order cognitive processes. On this view then, values serve as a cognitive “glue.”

Moral epistemology’s tools for insight and integration directly confront the ethical dilemma provoked by a medicine dominated by technoscience. An epistemology which does not account for human value is laden with an unresolved irony, partly attributed to its historical development and partially due to its embedded precepts: that which masters also enslaves; that which provides also expends; that which enlightens also disenchant. Science, however, is a human invention developed for human use. The fruits of scientific labor may be harvested in many ways, and while the Faustian pact seems firmly entrenched, critical attempts to revise that contract remain possible, and, indeed, necessary. Medicine shows us this lesson at every bedside and in every clinic. From this point of view, moral epistemology offers a response to Dewey’s (1929) acute diagnosis: “The problem of restoring integration and cooperation between man’s beliefs about the world in which he lives and his beliefs about the values and purposes that

should direct his conduct is the deepest problem of modern life. It is the problem of any philosophy that is not isolated from that life” (p. 204).

CONCLUSION

While many have offered responses to the challenge of formulating a philosophy of medicine based in its clinical science, an inner tension remains as physicians are stretched to accommodate the demands of a normative posture (Boorse 1977; Nordenfelt 1995; Richman 2004). Indeed, I would go further: this conflict over medicine’s basic character demands a dual allegiance that remains too often out of balance. Ultimately, because of vast historical and social forces, physicians by and large remain oriented towards an unattainable and inappropriate positivist ideal, and thereby severely compromise the deeper values of their own moral agenda. This choice—encouraged by the professionalization process—largely explains why medical ethics serves such a minor role in medical education; why complaints of medicine’s dehumanization are rampant; and why myriad studies, surveys, and testimonies attest to the lack of physician empathy (Tauber 2005b). Indeed, if medicine aspires to an objective ideal at the expense of its unique value-laden agenda, the profession will be hounded by complaints that it has forsaken its ancient calling for a Faustian pact.

A self-conscious moral epistemology—an epistemology that remains aware of its ongoing negotiation of competing values and construction of its interpretative knowledge—provides a philosophy of medicine for the doctor’s diverse roles and activities. On this view, a philosophy for medicine must acknowledge the multidimensional character of medical thinking that utilizes values spanning the ideals of laboratory science to the empathetic response of humane care. But more, this philosophy must recognize a fundamental difference between the scientist’s search for the real and the physician’s pursuit of the therapeutic.

Medicine requires more than “true” outcomes (as in scientific truth-seeking); physicians embrace “best” results for the care of their patients. While seeking the “true,” patients and their caregivers are often satisfied with something else (for example, the effective intervention may be a sham treatment or a placebo). “Truth” directs clinical science, and clinical science directs itself to good outcomes, but in the hierarchy of medicine’s philosophy, it is ethics of care that directs the physician’s science and ultimately determines clinical choices.

In closing, two points must be emphasized: first, medicine’s epistemology must incorporate values that have no standing in science; and second, how those values are integrated into the clinical encounter depends on an effective construction that addresses individual goals and needs. Although “true” may be construed from a constructivist vantage, “best” is *always* made through personal interpretations and judgments. The notion of “best” relies on the pragmatic utility of a selected course that is designed for the individual based on her personal needs, values, and expectations. In the most general sense, this commitment to the

particular person signifies that the meaning of the illness must be understood in its particulars as placed on both epistemological and moral coordinates. With this perspective, albeit in a different context, John Dewey (1931) would proclaim, "Meaning is wider in scope as well as more precious in value than is truth" (p. 4).

Once the discussion shifts from "true" and "real" to "best" and "interpreted," building a philosophy of medicine suited for the 21st century might proceed. After all, we now live at the *end* of positivism's demise, so isn't it time to move on? What epistemological precepts should take the place of positivism's discarded dictums? If pragmatism has become our default resting place, what are its philosophical limits, and to what end does the pragmatist venture? That answer must be found at the bedside—we just have to ask, search, ponder, and wonder.

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