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The aristotelian ethics of collaborative care

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A B S T R A C T

Collaborative care is common among health care practitioners, serving multiple benefits for the patients. Clinical procedures are in place to serve as a checklist, ensuring that the proper means of treatment is provided. This essay details an Aristotelian ethics that defines teleology, that which achieves the final good. In the sense of the patient's *telos*, the rehabilitation clinician should be viewed as a co-laborer in working towards this end, rather than a means showing that a process was followed. This distinction is important when determining the optimal care for the patient. The works of Aristotelian ethicists Edmund Pellegrino and Alysdair MacIntyre are introduced in describing teleology, science, art, virtue, and practice. Two cases are presented that show how, in current practice, collaborative care is used differently in achieving the final good as defined by the patient. Finally, the model of International Classification of Functioning, Disease, and Disability (ICF) distinguishes how the viewpoint of physicians can differ from that of rehabilitation clinicians.

1. Introduction

Health care practitioners are taught, as part of their school training, the concept of interprofessional practice. This training includes values and ethics, roles and responsibilities of all providers, interprofessional communication, and the composition of health care teams.[1] The preparation is designed to improve the quality of the delivery of health care to the patient when implemented in both inpatient and outpatient settings. The thought process behind such a delivery of health care is to introduce various experts and points of view in treatment of patients. While introducing other disciplines to collaborate on the plan of care for a patient seems intuitive, it is not practiced in all clinical settings as students in health care would expect it to be based on the stress it is given in academia.

With the intention of treating the impairment, the practitioner (whether it is the physician, pharmacist, or physical therapist) has the patient's overall health and function in mind. However, the mode of treatment in the United States generally aims towards following the proper means in treatment. This rationalist approach to treatment emphasizes what should be done with a population of patients with a particular diagnosis or clinical presentation. This is similar to the scientific process the physician reads in medical journals. What is a reasonable treatment for a patient with a specific diagnosis? This methodology is evident in the way many physicians manage, for instance, the care of a patient with mechanical pain. The approach typically follows a methodical pattern where the treatment options begin with the least invasive option (e.g., oral medication or a referral to physical therapy). Gradually, the patient will receive more aggressive treatments (injections or surgery) if the previous ones are unsuccessful.

Conversely, an empirical approach focuses on the patient as an individual with a particular set of values and characteristics that influence decision-making. It is the goal of this paper to argue for the inclusion of rehabilitation clinicians in treatment of patients not simply as a means, but rather as a collaborator in attaining the good of the patient. In doing so, I will be referring to Aristotle's teleology with the patient as the one to define the good life, drawing on Edmund Pellegrino's explanation of medicine and Alysdair MacIntyre's definition of practice. This will help the reader understand how the patient's understanding of the good life should enter the conversation in treating a patient, and how a clinician whose specialty is rehabilitation of the body can be used efficiently in restoring the patient to that good life. In addition, I will be referring to several cases throughout the paper to introduce scenarios of where collaborative care currently works well and seems to address this *telos*, as well as instances where opportunities exist. This change in the mindset of how rehabilitation professionals should be consulted will assist the physician, and the patient, in moving closer to the patient's *telos*.

2. Background

Collaborative care, also termed interprofessional or interdisciplinary practice, is not new to the medical community. It involves health care providers working collectively as a team to provide care to the patient. Benefits are believed to include, among others, increased efficiency, improved patient satisfaction, and better outcomes.[2] In discussing a case regarding a medical student placed with a midwife as part of his educational training, Burcher points to the issue raised by the student that he was trained to be a physician and not a midwife. Burcher argues that it is an obligation of the medical educators to incorporate interdisciplinary training into the educational setting.[3] In doing so, each clinician learns what

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foundational knowledge other practitioners can bring to the table.

Health care organizations (e.g., hospitals and clinics) implement policies and procedures that incorporate the use of collaborative care in treatment for patients. Clinical pathways are sometimes implemented as guidelines to standardize care with the hope of improving overall outcomes for an organization. Such protocols, when implemented from the outset, involve other disciplines as a sort of checklist to ensure a thorough approach. For example, when a patient is admitted to a hospital with generalized weakness, the protocol for the admitting physician may entail a referral to physical therapy to address this weakness. In doing so, the therapist and physician will exchange clinical opinions regarding the patient.

This process of referring according to previously set clinical guidelines lends itself to a procedure where the rehabilitation clinician is seen as a means rather than an end. To use the generalized weakness example, the referral to physical therapy is similar to that of a referral for imaging studies or for oral medication, where the physician follows a rational approach by following a set of rules for what is typically done with a particular presentation. I will now present Aristotle's version of the good and its relation not only to the patient, but to the health care provider and to the relationships that result.

3. Telos

In describing his ethics, Aristotle details what leads to a good and virtuous life by man. The final end, he says, is a state of perfect happiness and this happiness is part of the intellect. This happiness and intellect not only separate us from animals, but it is also what we share with the divine. Achieving this *telos* of happiness involves intrinsic virtues that Aristotle lists extensively, emphasizing the mean between excess and deficiency.[4]

Applied to health care, the *telos* of the patient is something that is intrinsic and unique to each patient. The health of the patient contributes to this final end. The patient recognizes this *telos* in everyday function. When a patient seeks medical care, it is frequently because he[a] notices a decline in function, or a loss in his health status. Upon seeking medical care, the physician will evaluate the patient in order to determine a diagnosis. This evaluation partly includes a subjective examination where the physician gathers relevant information to determine symptoms that relate to the person's problem. However, in this conversation, the physician must also determine what is good for the patient. The remainder of the evaluation involves a more objective assessment, where data is collected then correlated to the patient's subjective report. This correlation results in a plan for the patient that involves restoring the patient's health, at least to some degree. Since the patient is the instigator of this conversation, and the primary focus, the patient must be the one involved not just in consenting to treat, but also in the conversation of how his function should be restored. It is with the purpose of achieving the aforementioned *telos* through the intellect that the patient and physician must be focused. The expertise of the physician can help the patient in ascertaining whether or not function can be fully restored and to what extent.

Understanding a patient's view of the good is arguably challenging for a practitioner to achieve in the course of one office visit. Emanuel and Emanuel detail four models in the physician-patient relationship: paternalistic, informative, interpretive, and deliberative. While allowing for certain scenarios where each model may be appropriate (e.g., a patient unable to give consent would enter into a paternalistic relationship with the physician), the authors explain that the deliberative model is the optimal relationship insofar as it allows the physician to help the patient choose the appropriate treatment based on his health-related values. In this model, the "physician must delineate information on the patient's clinical situation and then help elucidate the types of values embodied in the available options".[5] The relevance of the relationship is important to mention at this point since the physician's understanding of the patient's values will allow the physician to recommend the treatment most aligned with the patient's original goal for seeking treatment.

This article has two shortcomings that should be mentioned here. Emanuel and Emanuel note that specialization is a threat to the deliberative model. They see that some physicians, only seeing a patient once, may choose an informative relationship with the patient. In this model, the physician gives facts pertaining to the patient's medical condition. He, in turn, must choose the best treatment option according to his value system, regardless of the physician's set of values. Where the authors fall short is in the inclusion of other professions in the patient's care at this point that can better understand the patient's values and move him closer to his *telos*. It must be noted, though, that the nature of health care, specifically the rehabilitation sciences, is vastly different in the current system than it was at the time of publication. Diversity of professions and specialization has changed the context in which these relationships occur.

Second, Emanuel and Emanuel do not mention whether the patient and physician agree on the relationship. Without consent as to which relationship is optimal given a particular situation, the two parties may understand differing models of the relationship. For instance, an older patient who sees a physician as the sage may take the relationship as a paternalistic one; whereas, the physician who is more of a learned bioethicist may choose to enter a conversation with the patient regarding his health related values. This conflict will likely hinder the construal of the health care provider as she moves closer to understanding the patient's version of the good.

Similarly, the patient may have a perspective of a virtue that is unlike the perspective of that same virtue by the physician. The authors do mention that patients frequently select physicians based on virtues that are similar. Yet, those virtues, as they shape the *telos* of the patient, may change based on the patient's condition (e.g., a patient who suffers a serious injury and has unrealistic expectations of his outcome). The deliberative model mitigates this in a provider who "integrates the information and relevant values to make a recommendation and, through discussion, attempts to persuade the patient to accept this recommendation as the intervention that best promotes his or her overall well-being".[5] Taken out of context, this citation seems like coercion; however, it includes an understanding of the patient's values and allows the provider to incorporate not only the scientific knowledge, but the skill of diagnosing and establishing a prognosis. This "art" of medicine will now be discussed.

In defining the form of medicine, Pellegrino focuses on the end when it comes to the physician-patient relationship. An interruption in function of the patient results in "a deviation of one's concept of well-being, a value-laden concept including social function, identity, and interpersonal relationship".[6] The goal of treatment is to move towards the end as defined by the patient and understood by the physician. This treatment not only involves treatment of the biological problem with a physical remedy, but also includes the personal restoration of the patient to an

[a] For consistency to the paper, the patient will be referred to as male, and the health care practitioner as female.