WILLIAM B. BONDESON AND JAMES W. JONES

INTRODUCTION: THE ETHICS OF MANAGED CARE

Managed care has revolutionized the organization and distribution of medical services during the last decade and it continues to reside at the center of our national debate about the rights and integrity of patients, the right to health care, the cost of health care, and the entitlements of capital investors.

Traditional fee-for-service medicine and its related insurance programs began to develop difficulties when advances in medical technology, the rising expense and duration of medical specialty training, the cost of government-compliant research, and the complexity of full-service hospitals threatened to push the price of clinical care beyond the insurance industry's ability to pay and still retain a level of profitability.

Physicians with an ever-growing array of evaluation and treatment options used them liberally, sometimes to diagnose and cure, sometimes to protect themselves against future claims of inadequate effort, but always certain in the knowledge that medical insurers would honor their invoices. A culture raised on the philosophy that every human life was beyond price agreed that the only satisfactory medical care was the most extensive medical care, and that no expense was too great in the effort to prolong life and restore the afflicted to health. These generous thoughts were not difficult to maintain when anonymous third parties actually paid the medical bills. When those third parties, the medical insurance companies, sagged beneath the load, they responded by raising premiums to the large and small employers who offered subsidized health insurance in their benefit packages. Employees in turn were asked to accept higher premium shares, higher deductibles, and higher co-pays. As costs rose without a ceiling in sight, dissatisfaction with those costs rose as well.

Managed care, whether in health maintenance organizations or in other organizational configurations, offered a solution that seemed acceptable to many. The HMOs would accept an advance of a flat rate per capita for all the people in a covered group, offer preventive medicine programs which would control the incidence, suffering, and cost of major illnesses, and rein in the extravagances of physicians who prescribe unneeded tests and unproven therapies. These measures were believed to save American medicine and at least stem the rate of increase of medical costs.

But the goal of managed care was management, not care. Managed care organizations were run by people trained in the culture of the insurance industry, not

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in the culture of medicine, and they saw their mission as a generation of profit for stockholders, not necessarily medical care for clients. Cost-effective medicine was the goal in the context of a profit-making enterprise. Although preventive health care programs were promised, very few were realized and they were not nearly comprehensive. The definition of unnecessary testing slowly expanded to mean virtually any high-cost test requiring the service of a medical specialist, and low-priced generalist physicians with limited diagnostic and therapeutic skills were made available to patients with the instruction they should limit their access to high-cost specialists. Managed care organizations tended to reward primary care physicians who avoided specialty referrals, and severed contracts with those who persisted in sending their patients to outside consultants. Most notoriously, managed care organizations maintained veto authority over the provision of complex and expensive care, and that veto was often wielded in defiance of a physician's recommendation by managed care employees without medical training or experience.

Managed care did indeed slow the rate in increase of medical costs, but not without limitations on the care provided to patients and the professional integrity of physicians. Managed care organizations were so successful that they could provide extremely high salaries to their executives even in the context of limiting cost and care.

It is these developments that the papers of this symposium addressed. The most fundamental ethical issue is posed in the first paper by Dr. Edmund Pellegrino: Is medical care a commodity like any other commodity, and are the transactions between patient and physician like those between buyer and seller in any other area? Or, as Dr. Pellegrino argues, is medical care a different kind of service provided by professionals who, using their professional judgement, direct themselves toward the interest of patients who come to them facing the challenges of their medical needs? In other words, how much of medicine can, or ought to be, a business subject to the usual restrictions of the marketplace?

The papers which follow begin from considerations of this important question and elaborate upon other ethical dimensions which the complexities of managed care have brought to prominence.

Managed care is also about a new physician role, very different from the traditionally benevolent caretaker and patient advocate. The gatekeeper physician is the entry point to the managed care system and controls patient access to other resources within the system. The physician-gatekeeper is usually a primary care physician with an organizational responsibility to keep care at that level rather than refer complex problems to more expensive specialist care. In this role the physician becomes a representative of the managed care organization's fiscal goals rather than an advocate for his patients' health.

In the older fee-for-service system physicians were paid more for doing more. Some claim that this model led to excessive use of laboratory tests and procedural therapy with excessive treatment increasing iatrogenic illness and even mortality. In a managed care system, the physician is often paid more for doing less, and the

physician is asked by his employer to practice cost-effective, efficient, parsimonious medicine, sometimes reducing service at the expense of necessary care. When a physician's income is dependent on conservation of resources to the benefit of the HMO's profit margin, and patient care is considered a debit on the books, the quality of care is very likely to suffer.

Physicians have long prided themselves on their ability to exercise their judgement independently for their patients' benefit. Fee-for-service models value this right and the individual patients' integrity with the understanding that profit-driven excesses will occur as aberrations. In HMOs, decisions about patient care practices are often made by groups and/or clerks following a cost manual. There may not be enough money in the managed care system for more CT-Scans, or physician groups may have decided that such scans are not indicated and won't be compensated for headache patients. Physicians may be required to obtain second opinions before hospitalizing a patient, and be subject to additional "quality assurance" controls, or have their procedures reviewed by non-medical personnel.

The practices of HMOs raise questions of patient privacy and confidentiality. Patient records are regularly reviewed by others for purposes of quality assurance, the documentation of practice for incentive payment purposes, or for use in building larger databases. In the HMO model, employers who pay for enrollees' care, and who may even have a management role in the health maintenance organization, can obtain access to the patient's medical record even though they have no professional role in treatment and may use confidential patient information in personnel decisions without the patient's knowledge.

At a more personal level of competition, the physician may lack confidence in the specialists in the health maintenance organization and want to refer a patient to an expert outside of the plan. In some places there can be no alternative but to refer the patient to specialists in the plan even when their expertise is questionable. This forces the physician to decide whether to serve individual patient or the health maintenance organization.

The intellectual discipline of medical ethics presumes that medicine acknowledges an ethical responsibility. That ethical responsibility has been well developed since the time of Hippocrates, and continues to evolve in its particulars. It has been consistently characterized by compassion for the suffering of the infirm, the physician's agreement to place the needs of his patient above his own, and a sense that the therapeutic relationship includes, but somehow transcends, the simple exchange of goods and services for money typical of other transactions within the culture. Ethical considerations do not often merge easily with corporate goals.

Managed care appears, then, to be based in a value system directly contrary to the foundations of medical ethics. Having been forced to live together, can these two cultures reach accommodation? Many of the nation's leading medical ethicists gathered to explore this question and the papers in this volume represent their attempt to deal with these very difficult questions. Has managed care performed the over-arching ethical act of saving American medicine, and does it deserve our gratitude and our respect for its methods? Do the traditional concepts of medical

ethics become obsolete when the bills have to be paid? Does the physician who receives his daily bread from the corporate budget of a managed care organization owe his first loyalty to its stockholders or to the afflicted patient before him, whose illness threatens to diminish corporate resources? Can patients continue to trust their physicians with the knowledge that this question remains unresolved?

As our government, our citizenry, and our corporate centers debate and work through these issues, each on behalf of its own advantage, the writers whose work appears in this volume offer some most helpful guidance. They have our deepest gratitude for grappling with these very difficult issues.

CHAPTER 1

EDMUND D. PELLEGRINO

RATIONING HEALTH CARE: INHERENT CONFLICTS WITHIN THE CONCEPT OF JUSTICE

1. INTRODUCTION

There is an almost universal conviction today that no society, even one as affluent as ours, can afford to provide all its citizens with the benefits modern medicine makes possible. There is every prospect that this disparity will become even greater in the foreseeable future. As a result some form of rationing is deemed necessary for both the good of individual and the common good.

Any scheme of rationing, de facto or planned, involves an unavoidable tension between what is owed to each person in a society and what is owed to the common good of all the members of society. These are precisely the two beneficiaries rationing is designed to serve. Rationing therefore necessarily brings commutative and distributive justice into conflict. Satisfying one form of justice unavoidably compromises the other.

In this essay I wish to examine this conflict, as well as other conflicts within the concept of justice when it is considered within the context of rationing. I will use managed care as it exists today in America as a paradigm case. But in doing so, I recognize that even if managed care as it is today were to implode, the problem would remain. The conflict within the several dimensions of justice is inherent in any rationing scheme.

Is it possible to reconcile commutative and distributive justice? Or, is the conflict irresolvable without compromising one or both? What are the respective obligations of health care professionals whose traditional focus has been the individual, and the obligations of policy makers whose focus has been the body politic? Can a balance be struck that itself meets the test of justice? How do commutative, distributive, and general justice relate to each other? What is their proper relationship when rationing is necessary?

I will approach these questions in the following sequence: First by an inquiry into the concept of justice and its kinds, second by an application of the most relevant of these concepts to health and health care, third by outlining the conflicts in the obligations of justice arising out of rationing and lastly, by placing the preceding discussion within the context of social justice and the good society.

I shall argue that any system of conscious rationing places the justice owed to individual patients and that owed to the common good in conflict, that the conflict is

W.B. Bondeson and J.W. Jones (Eds.), The Ethics of Managed Care: Professional Integrity and Patient Rights , p. 1-18.

reflected most acutely in the clinical encounter and in professional ethics, that there is a proper ordering of individual to the common good which enables health professionals to balance the conflicting obligations of justice and that, finally, accountability for the proper ordering of justice within health care lies as much with society as it does with individual health professionals.

2. THE CONCEPT OF JUSTICE

The history of philosophy is replete with attempts to clarify the notion of justice (Berry, 1989). Different conceptions have been tied to virtue ethics, political philosophy or ideology, and determined by empirical, rational, or socially constructed conventions. No attempt is made here to unravel these sometimes-conflicting ideas of justice. Rather I will use major elements of the classical medieval conception of justice as a virtue as best exemplified in Plato (*Republic* and *Gorgias*), Aristotle (*Nicomachean Ethics*), and Aquinas (so-called *Treatise on Law*). I will use justice also as a principle of bioethics as adumbrated by Tom Beauchamp and James Childress (Beauchamp and Childress, 2001).

Plato's notion of justice is perhaps the least immediately applicable to our problem but its elements are fundamental for any of the others. Plato's *Republic* is a detailed argument for education in the ideal state, intertwined with the idea of justice. In it Plato sets out to say what justice is, and why it is essential to the well being of the individual and the state. Indeed, Plato uses the state as an analogy to make clear what he means by justice in the individual soul. In the state justice means that every member of the community fulfills that function for which he is naturally most fit (*Republic*, 433a-d). But justice in the exact sense can only be found in the soul of man, in that quality through which every part of the soul performs its function and does so in unison with other parts.

Justice is therefore for Plato a virtue, i.e., an habitual disposition to unite the conflicting forces within the soul, which is necessary for happiness. Justice as a virtue is independent of external shifts of politics, power, or government, quite the opposite of the distorted notion of justice as power advanced by Thrasymachus in the *Republic* or Callicles in the *Gorgias*. Justice thus was for Plato a key member of the quartet of the cardinal virtues along with courage, temperance, and practical wisdom.

Aristotle, like Plato, saw justice as a virtue in some ways essential to and underlying all other cardinal virtues. Justice is an internal disposition like the other virtues but it is also externally oriented since it disposes us to act well in our relations with others. It also carries a sense of duty - of obligation, i.e., to render unto others what is their due. This sense of duty is stronger in justice than it is in the three other cardinal virtues, which are more interiorly focused.

In Book V of his *Ethics* Aristotle distinguishes several kinds of justice or more properly several contexts of human relationships within which the virtue of justice may be manifest. One is general justice, which embraces the whole range of obligations each member of society owes to the common good and the community.

It consists in giving the community its due. Distributive justice is for Aristotle a more particular justice in which society or the community renders to each of its constitutive members what is his or her due usually in accord with merit. Or put another way, distributive justice renders equally to equals and unequally to unequals.

A third variety of justice, particularly for Aristotle, is commutative justice that which governs relationships and transactions between and among individuals. Here the obligation is to render to each his due. The community becomes involved here if contracts are broken, harm is done or transactions are unfair. The community then renders justice which is retaliatory, or punitive, or retributive, or compensatory, depending upon the nature of the infraction. When justice becomes the subject of positive law, it is legal justice. Too often today the whole of justice is mistakenly reduced to its legal expression.

In addition, Aristotle speaks of equity or *epikeia* - that is, a correction of law where it might be defective because of its generality (NE 1137-31, 1138, and Rh 1374a-26, b22). This is a correction of legal justice in circumstances wherein it is not possible to make a correct universal statement (NE 1137b10-12). It is expressed in legal systems of the western world as the law of equity.

Aquinas follows Aristotle and defines justice as a habit which makes a man "... capable of doing just actions in accordance with choice" that is to say it is done knowingly, and "... resolutely for a good intention" (ST Q.58, Art1). Aquinas also more definitively, like Cicero, relates justice to the natural law. Along with Aristotle (NE 1130a12), Cicero (De Officis, I, 7) makes justice in some way essential to every virtue (ST Q5J, Art. 6). "Therefore the proper end of justice is nothing else than to render to each is own" (Q 58, Art. 11). Like Aristotle, Aquinas distinguishes kinds of justice: commutative justice directed to private and individual transactions, distributive justice directed to proportioning common good and among the members of a community (ST Q. 61, Art. 1).

3. PARTICULAR JUSTICE AND MEDICAL AND HEALTH CARE

Each of these divisions of justice has a particular relevance to the question of rationing health care. Of particular interest for this enquiry will be commutative justice, distributive justice, general justice, and *epikeia.*

Commutative justice pertains to what is owed in the relations within clinical medicine, between the health professional and the patient. Distributive justice pertains to what is owed by society to its members in the allocation of health care resources. General justice pertains to what individuals owe to the common good in their uses of health care resources, and *epikeia* or modulated justice pertains to the preservation of equity in each of the other three forms of justice. Retributive justice pertains in the three foregoing as well to the recompense owed those who have suffered injustice in either commutative or distributive justice in the past.

CHAPTER 2

EUGENE V. BOISAUBIN

ETHICAL DILEMMAS IN MANAGED CARE FOR THE PRACTITIONER

1. INTRODUCTION

Those who believe in the cycles of history must be struck by the dramatic upheavals at both the beginning and end of this concluding century that have characterized American medicine. Some particular historical analogies are also in order. The beginning of the twentieth century saw the evolution from the Dark Ages of American medicine as the Flexner Report set needed standards for education and training. By the 1950s, the age of technology, like the Renaissance and later Age of Faith, led to an exuberance of discoveries, treatments and hope that seemed unbounded. But now, as a new century dawns, the Reformation is with us in the form of cost awareness and containment and shows no hope of abating now, or in the near future (Boisaubin, 1994, pp. 1-2).

Driven now by rising public expectations of excellent, available, comprehensive and affordable care, and yet bridled by the current unwillingness of American industry, government, and probably the populace, to pay for the requisite changes, the practice of medicine is being restructured in ways unimaginable only ten years ago (Inglehart, 1994, pp. 1167-1171). Although many realized that important changes were coming, the magnitude and speed of the changes has been almost inconceivable and has been likened to the restructuring of Eastern Europe after the fall of Communism, or the hypothetical rebuilding of the entire American automotive industry from the ground up.

But often lost in the high-level debates and machinations of the corporations, organizations and populations served, is the elemental dyad of patient and physician, which makes up the ultimate nucleus of the whole endeavor. Every overriding administrative or governmental dictum for change ultimately results in an impact upon a solitary patient and physician in a particular health care encounter. And often these higher-level decisions and policies, multiplied and modified countless times over as they descend to the practice level, bring about these changes in unique and sometimes wholly unanticipated ways. These changes are not only in the mechanistic and business aspects of medical care, but impact some of the core issues of professionalism and morality that typify the patient-physician relationship.

This paper will focus upon the ethical issues and changes that impact primarily the practicing physician, but also the patient, through the individuality and

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uniqueness of their relationship. This analysis will start at the very beginning of the endeavor, with the physician's decision to join a managed care enterprise, and then analyze the evolution of patient-physician decision making in both fee-for-service and managed care examples, ultimately recommending an optimal medical care model. Next, important psychological issues that impact moral decision-making will be addressed, and finally, some guidelines and recommendations will be made for both individual and group undertakings with the goal of benefiting both patient and physician.

2. JOINING THE NEW ORDER: CHOICE VERSUS COERCION

For virtually all practitioners, the first set of moral, professional and economic challenges encountered is the decision whether to participate at all in managed care practice. In an ideal world of physicians acting in both the best interests of their patients, and their own professional standards and ideals, this would be a reflective, carefully analyzed decision, balancing the strengths and weaknesses of the proposed practice plans. However, a large part of this deliberation is now concretely manifested in the written practice contract which contains a myriad of definitions and terms, and an entirely new lexicon, including "designated provider" and "medical necessity", among countless others. These contracts contain detailed descriptions of requirements for entry, exit, or termination from the practice plan. There are elaborate descriptions of how consultants might, or more likely might not, be utilized, and the related roles of primary versus secondary or tertiary care. There are careful explanations of the financial structure and systems of billing and payment, and whether a capitated system exists. The point is that this detailed legalistic, administrative and economic jargon of the arrangements dominates and often overwhelms the analysis and thinking of the practitioner. And in fact, any references to professional standards, much less moral or philosophic ones rarely, if ever, exist. This dominance largely excludes the more fundamental issues, such as whether this plan of care is in agreement with, or conflicts with, the physician's own moral and professional standards of care. It also never raises issues such as whether this business arrangement is a conflict of interest in terms of offering financial incentives (for example, selective cost containment) that might benefit, or more likely potentially harm the patient (Rodwin, 1995, pp. 604-607). In fact, the entire document is purely a business agreement, with the unwritten but tacit assumption that other professional, or even moral standards that might be held to by the physician are subservient, or at the least, should not conflict with the business plan. And for appropriate questions that the physician might have concerning, for example, how to question or challenge an administrative decision, he or she is referred only to the "appeals section" which usually describes how this might be undertaken, only by the truly courageous, with Byzantine clarity. In totality, the dominance of the business and restrictive aspects of the document cloud and blur the physician's basic concerns about professionalism and morality, including autonomy, trust and altruism, by totally changing the language of communication about these

issues. And if in fact the physician wants to understand more about what the document truly says, he or she is encouraged to speak with an attorney -- not another physician, and certainly not a moral philosopher.

Since most physicians, until recently, have been quite naïve in dealing with these kinds of contracts, their very real ignorance of the content is substantial. Much like any American purchasing a new home when faced with the intimidating legal documents that accompany this endeavor, physicians do not like to admit that they do not really understand what this transaction is all about. Therefore they take the proverbial "leap of faith" in signing the contract, and merely hope for the best. Nor is it possible for the practitioner to anticipate how and in what form this contract will truly impact the daily relationship between that physician and any given patient. In addition, this arrangement creates a new and unique facet in the relationship between physician and patient, as both are now subject to many of the same organizational requirements and restrictions, although they may view the guidelines in fundamentally different ways.

Last, and not inconsequential, are the increasingly indirect but economically coercive aspects of these contracts for the practitioner. As managed care has increasingly dominated health markets, the individual practitioner finds herself realizing that she cannot practice profitable medicine without joining local, regional or national managed care enterprises. Very real conflicts of interest can evolve as the physician finds the need for personal success and income potentially pitted against the best interests of the patient (Shortal, 1998, pp. 1102-1108). Personal conscience and professional standards are severely tested by the pragmatic needs of making a daily living. In sum, as a beginning, the business contract usually trumps the moral covenant of the new patient care system.

3. THE EVOLVING PATIENT-PHYSICIAN RELATIONSHIP

There is almost universal agreement that many aspects of the patient- physician relationship are being changed by the introduction of managed care, and often in a deleterious manner. A recent survey of over 1000 primary care practitioners in managed care revealed that two-thirds of them believed that the overall impact upon their relationships with patients was negative, particularly in terms of ethics (Feldman, 1998, pp. 1626-1632). A majority of them believed that managed care diminished their ability to place the interest of the patient first, and to avoid conflicts of interest. The same number perceived that the continuity of the relationship was being undermined. Almost half believed that their ability to respect patients' autonomy was reduced and one third believed that confidentiality was harder to respect. It is also significant that when these and other physician surveys comment upon the positive aspects of managed care, they emphasize preventive medicine and cost containment, but virtually no published study has showed a perceived positive impact upon the patient-physician relationship or the related ethical issues. Other surveys and articles that have focused upon the relationship from the patient's viewpoint have noted the negative aspects of real or potential loss of trust in the

CHAPTER 3

CHRISTOPHER TOLLEFSEN

MANAGED CARE AND THE PRACTICE OF THE PROFESSIONS

We owe Professor Pellegrino (2002) and Professor Boisaubin (2002) a debt of gratitude for bringing to light a number of difficulties faced by the medical profession in addressing the new framework of managed care. I have a great deal of sympathy for much of what they say. In this paper, however, I plan to focus not so much on the specifics they address, as on a more general issue. Managed care introduces new moral quandaries into the profession of medicine -- so much so as to put the profession itself in jeopardy, on Dr. Pellegrino's account. In this paper I plan to focus primarily on providing a framework for understanding the professions and professional ethics at a high level of generality. I think the framework I will provide helps us to give conceptual shape to the work of Pellegrino and Boisaubin, and also to raise some critical questions about the relationship between the profession of medicine and its institutional structures. These are questions I will raise at the conclusion of the paper.

A number of ethical theories compete for the favor of professional ethicists, including utilitarianism, Kantianism, and principlism. It would be foolhardy to suggest that such theories have nothing to offer professional ethics. Nevertheless, it is possible to consider an approach that differs in a fundamental way from these. The difference is sometimes characterized as that of an internal, versus an external, approach. Dr. Pellegrino himself has characterized the shifts in medical ethics as moving away from what I would call an internal approach (Pellegrino, 1979).

One way of drawing this distinction would be to say that an internal understanding of a profession must say something about the *point* of the external behaviors, expectations, and roles associated with a profession. And further, that point would have to be, at least normatively, integrated into the *self*-understanding of professionals as a way of making sense, to themselves and others, of why they were engaged in these various forms of behavior, expectations, and roles. Finally, a professional ethics would be developed out of this internal understanding, rather than being imposed on it, as it were, top-down.

I intend to supplement the internal/external distinction with the notion of a *practice*, a notion articulated by Alasdair MacIntyre (1984), and a distinction between goods *internal*, and goods *external*, to a practice. In the end, professional ethics will be understood in terms of the *practice of the professions*.

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This approach, beyond articulating the nature of the professions, and the ethical dilemmas peculiar to their domain, will also help to restore a hope once placed in the professions.[1] In the 19th century, as a result of the industrial revolution, philosophers, sociologists, and social reformers all became increasingly concerned for the conditions of the worker. These conditions seemed less and less able to provide workers with the possibility for fulfilling work, and more and more to instrumentalize laborers as mere cogs in a machine. Indeed, Marx argued, the conditions of the modern industrial age encouraged workers to view *themselves* in this merely instrumental way. To some, it was just this instrumentalization of work that the developing professions were equipped to escape. Louis Brandeis, in a graduation speech in 1912, wrote that in a true profession, "the amount of financial return is not the accepted measure of success" (1914, p. 2). He exhorted the graduates to view "excellence of performance in the broadest sense," including service to the community, as constitutive of a meaningful and successful professional life.

Both the notions of excellence in performance, and service to the community are modes of satisfaction in work that are unavailable under the Marxist paradigm of alienation. Moreover, both notions may be situated within an internal understanding of the professions. For excellence of performance, as we will see in more depth later, is excellence of performance in the service of those goods that constitute the practical point of a profession. And if service to the community bears some intrinsic relation to that practical point, then the goods of service that a professional might offer to the community will themselves be internal to the profession, and hence a constitutive aspect of what makes that profession's work meaningful.

Unfortunately, Brandeis's optimism seems undercut by the actual progress of the professions in the past 100 years. Brandeis himself, in an address delivered to the Harvard Ethical Society in 1905, quotes the chairman of that society as suggesting that "'People have the impression today that the lawyer has become mercenary" (Brandeis, 1914, p. 317). Instances of the same sentiment may be found in contemporary discourse about lawyers, journalists, and, of course, doctors.

Members of these professions have come to be viewed as motivated solely by the pursuit of what is external to their profession, and thus as mercenaries. A mercenary sells himself to the highest bidder, interested only in what he can get out of what he does. Not only does excellence in performance become diminishingly important; so, we can see, is service to the community marginalized.

But why is it that the professions should lend themselves both to the promise of meaningful work, and to the threat of crisis, of mercenary motives, of "any means to an end" types of thinking? To answer these questions I turn to the work of Alasdair MacIntyre.

After Virtue (1984) is MacIntyre's story of how the intellectual framework within which the moral discourse of the West makes sense became corrupted, and of the consequences which ensued for our use of moral language. MacIntyre is struck by the "interminable character" of moral argument. In our pluralistic world, all have their moral positions, and arguments, but each such argument goes back to premises

that are both incommensurable with an opponent's premises and rationally undefended by their own proponents. Under such conditions, the use of moral language can be no more than a rhetorically impressive way of emoting, and of attempting to change our opponents' minds non-rationally.

MacIntyre attributes this state of affairs to the Enlightenment's overthrow of the Aristotelian moral paradigm, which possessed a threefold structure. First, there was the natural condition of human persons; second, the telos of persons, which constitutes the conditions of human flourishing; and third, the moral precepts intended to bridge the gap between man-as-he-is-now and man-as-he-would-be-if-he-fulfilled-his-telos. Upon the rejection of all notions of teleology by the Enlightenment, the moral precepts ceased to be intelligible – what role could they play in relation only to man-as-he-is-now? Moreover, the emphasis placed by the earlier tradition on the virtues likewise ceased to make sense, except as dispositions to follow rules – rules that, as we have seen, MacIntyre no longer thinks play an intelligible role in our moral life.

The question, suggests MacIntyre, is whether the Enlightenment really was justified in its overthrow of Aristotle, and, correspondingly, whether Aristotle might not be rehabilitated without those aspects of Aristotle's views that are most repugnant, especially his metaphysical biology and easy expectation that human life would not be marked by conflict.

It is in his working out of this project of return and rehabilitation that MacIntyre proposes that an understanding of both precepts and virtues must be situated in relation to a threefold conceptual framework. The framework includes the notion of practices, of a narrative structure of human life, and finally the notion of moral tradition. Here, I will be primarily concerned with the notion of a practice, and its relationship to professional life.

For MacIntyre, 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, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended" (1984, p. 187).

An everyday example of a practice would be basketball. In the absence of a certain social setting, and certain social decisions and understandings, there would be no basketball. But, once such a context has been established, the game of basketball creates the possibility for persons to realize a certain kind of good – play – in an entirely new way, a way that to some extent can only be fully understood by those who play (or, perhaps, watch) basketball. Further, the good internal to basketball is sufficiently complex that players come to achieve the good more and more through increased excellence in the play of the game. Moreover, and again because of the complexity of the good, excellence at achieving the good typically opens up new avenues for pursuing the good of basketball, and hence new ways of being excellent. Thus it is that a player's excellence at basketball – the excellence of