

**A DIALECTICAL INTERPRETATION OF THE HISTORY  
OF WESTERN MEDICINE: PERSPECTIVES, PROBLEMS  
AND POSSIBILITIES.**

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I, the undersigned, hereby declare that the work contained in this assignment is my own original work and that I have not previously in its entirety or in part submitted it to any university.

## **ABSTRACT**

The health of the medical profession hangs in the balance. Scepticism, mistrust and legal restraints have entered its hallowed corridors and are threatening its integrity and independence. There are myriad seemingly intractable moral dilemmas that doctors, ethicists and judges are trying to resolve with the aid of available principles and rules of ethical discourse; yet, the answers remain elusive. Hegel, the eighteenth century philosopher, postulated that perplexity only exists because we do not look at the world correctly: because we tend to think in an oppositional way, we abstract from the complex interrelation of things. He therefore suggested that one should step back and think reflectively about the problem and seek the one-sided assumptions that led to the impasse. My proposition is that at the heart of many of the current medical dilemmas lies the opposition between paternalism and autonomy. These two fundamental concepts arose out of two different traditions, and now, because they have been abstracted from the contexts and histories that inform them, seem to be diametrically opposed.

Paternalism arose out of the ethics of competence that originated in ancient Greece. The art of medicine was still in its infancy and physicians had to prove their ability and benevolence to a mistrustful public. Demonstration of competence became a necessary component of any successful practice. As the power of medicine grew with the scientific and technological advances of the Enlightenment, professionals' authority and competence were reinforced and systematically fostered a paternalistic attitude at the expense of adequate protection of the individual. In response to the power differential found in the political and social arena, individual human rights were promulgated in the eighteenth century. In the medical sphere, the culture of rights was translated into, among others, the fundamental right to autonomy. Patients now have the right to decide on interventions and treatment in accordance with their own conception of a good life. Paternalism thus developed out of a societal system that embraced the virtues and communal responsibility within the bounds of the *polis* of antiquity; autonomy arose out of the designs of the Enlightenment where the individual was hailed supreme. Remnants

of both traditions are evident in contemporary medicine, but they have been abstracted from their original purpose and meaning, leading to perplexity and antagonism.

Following the Hegelian method of dialectic, I postulate a *thesis* of paternalism, and in response to this, an *antithesis* of autonomy. I attempt to show that an intransigent insistence on one side or the other will only serve to strengthen the paradox and fail to lead to an acceptable solution. I aim to develop a *synthesis* where both concepts are embraced with the help of a better understanding of human nature and the inevitable limits of human knowledge. Influenced by the work of the psychoanalyst Carl Jung, I firstly argue for the existence of a biological human need for compassion and thus the importance of virtue ethics, which embraces this need. Secondly, focusing on the ethics of futurity developed by Hans Jonas, I delineate the altered nature of human action and the derivative need for an ethics of responsibility. I propose possibilities for the future based on the ideas of compassion, virtue and responsibility and argue that they can only be reconciled in a pluralistic ethic.

## **OPSOMMING**

Die mediese profesie het 'n dokter nodig. Een wat kan sin maak van die wantroue en vyandigheid wat te bespeur is in die pasient-dokter verhouding en wat toepaslike terapie kan voorskryf. Al die pogings tot behandeling deur middel van reëls, regulasies en etiese kodes het tot dusver misluk en het vele skynbaar-onoplosbare morele dilemmas agtergelaat. Die Duitse filosoof, Hegel, het in die agtiende eeu aangevoer dat verwarring ontstaan bloot omdat ons die wêreld op die verkeerde wyse beskou: die mens is geneig tot opposisionele denke en neem daarom nie die komplekse onderlinge verbintnisse van die onderskeie elemente in ag nie. Hegel het dus voorgestel dat wanneer ons met sulke hardnekkige situasies gekonfronteer word, ons 'n tree terug neem en die situasie reflektiewelik ondersoek vir eensydige veronderstellings. My hipotese is dat baie van die etiese dilemmas wat op die oomblik in medisyne voorkom, voortvloei uit die opposisie tussen paternalisme en outonमितiet. Hierdie twee fundamentele beginsels het uit twee verskillende tradisies ontstaan en nou, omdat hulle nie meer in hulle oorspronklike konteks voorkom nie, vertoon hulle skynbaar teenstellend.

Paternalisme het ontstaan vanuit die etiek van bevoegdheid wat teruggevoer kan word na die tyd van Hippocrates. Medisyne was 'n nuwe profesie wat nog sy eerbaarheid en welwillendheid aan 'n wantrouige publiek moes bewys. Bevoegdheid was dus 'n essensiële komponent van enige suksesvolle praktyk. Indrukwekkende vooruitgang in die dissiplines van wetenskap en tegnologie sedert die agtiende eeu het dokters se gesag en bevoegdheid bevorder en stelselmatig 'n paternalistiese houding gekweek ten koste van toepaslike beskerming van die individu. In respons tot die magsverskil in die politieke en sosiale sfeer het 'n beweging in hierdie tyd ontstaan om universêle menseregte te bewerkstellig. In medisyne het hierdie regsbevegung gekulmineer in, onder andere, die fundamentele reg tot self-beskikking – in ander woorde, outonमितeit. Die pasient is dus nou geregtig daarop om self te besluit oor ingrepe en behandeling op grond van sy/haar konsep van 'n goeie en sinvolle lewe. Paternalisme het dus ontstaan uit 'n samelewing waar die deugte en gemeenskapsverantwoordelikhede integraal was tot die funksionering

van die *polis*; outonomie aan die ander kant, het ontstaan uit die idees van Die Verligting waar die individu as belangriker as die gemeenskap geag is.

Volgens die Hegeliaanse dialektiese metode, postuleer ek dus 'n *tesis* van paternalisme en in respons daartoe, 'n *antitesis* van outonomie. Ek voer aan dat 'n eiewillige aandrang op een of die ander die dilemma net sal verdiep. Ek poog dus om 'n *sintese* te ontwikkel wat albei konsepte inkorporeer met behulp van 'n analise van die aard van die mens en die noodwendige beperkinge van sy kennis. Geskool op die werk van die psigo-analis Carl Jung, bespreek ek die mens se biologiese behoefte aan medelye en stel dus die saak vir die belang van 'n etiek van deugte wat hierdie behoefte onderskraag. Tweedens, beïnvloed deur die etiek van die toekoms, soos beskryf deur Hans Jonas, ontwikkel ek die idee van die gewysigde skaal van menslike dade en gevolglik die noodsaaklikheid van 'n etiek van verantwoordelikheid. Ek postuleer dus 'n benadering wat wentel om die konsepte van medelye, deug en verantwoordelikheid wat slegs in die vorm van 'n pluralistiese etiek tot uiting kan kom.

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## **1. INTRODUCTION:**

“Under fire from all sides, the doctor-patient relationship is battered, bruised and in need of repair. American physicians are teetering on their lofty pedestals. Never have doctors been able to do so much for their patients, and rarely have patients seemed so ungrateful. Today’s doctors must contend with ever changing technology, ever threatening lawsuits and a medical-industrial complex second-guessing their every decision. No wonder they feel as sick as their patients” (<http://www.time.com/archive>).

The once noble profession of Western Medicine finds itself in a critical condition. It is suffering from the diseases of our postmodern condition: ambiguity, contingency, and distrust of knowledge, scientific truth and progress. Its body is riddled with the cancer of scepticism. The profession is being impugned from all sides; patients, legislators, alternative healers and even doctors are questioning the technology, motives and benefits the profession purportedly has to offer. Disquietingly, these ails seem to stem from more than just a general disenchantment with technology and science, from more than the pervasive disillusionment with the promised breakthroughs of modernity. Patients feel alienated from the world of contemporary medicine, lost in the sterile corridors of its practices. Many a patient enters the doctor’s surgery reluctantly, either coaxed or coerced by concerned family members, and it is not unusual for them to begin the consultation with the words “I really do not like doctors, but...” How did a once respected profession fall into such disrepute? Where was the art of healing lost and how was it replaced by technocracy? How did suspicion and antagonism find a foothold in the fiduciary relationship between doctor and patient?

In July 1989 *Time* magazine sported a cover with a rattlesnake with bared fangs and a forked tongue, coiled around a staff. The snake, whose skin is shed and rejuvenated, had been adopted by Asklepios<sup>1</sup>, and later by Western medicine, to symbolise eternity and the restoration of life. In this representation however, the traditional healing symbol of

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<sup>1</sup> Asklepios, a Greek demigod, the son of the god Apollo by the human Koronis, was the patron of human healers. His name appears in the oldest version of the Hippocratic oath: “I swear by Apollo, by Asklepios, by Hygeia, Panacea, and all the gods and goddesses...” (Jonsen 1990:19).

medicine had been transformed into a venomous reptile, a deadly and fearsome creature. The cover story – “Doctors and Patients: Image vs. Reality” – described the “infected climate” in which the doctor-patient relationship now existed. “Lack of trust, generated by the cost of care, by the uncertainties of diagnosis and treatment, by dehumanising technologies, by malpractice threats, has made ‘doctor bashing a blood sport’” (Jonsen 1990:121). It continued: “The air of the operating room, where once the doctor was sovereign, is now so dense with the second guesses of insurers, regulators, lawyers, consultants and risk managers that the physician has little room to breathe, much less heal. Small wonder that the doctor-patient relationship, once something of a sacred covenant, has been infected by the climate in which it grows... Ambivalence and hostility divide doctors and patients” (Quoted by Jonsen 1990:75).

This hostility has found expression in the culture of litigation currently engulfing Western medicine. The process of litigation followed in the wake of the rights-based social and political reforms of the eighteenth century. Especially since the latter half of the twentieth century, individuals have been made aware of their rights and are no longer tolerant of perceived or actual violation of these. Although rights are valuable in that they serve to protect the individual against abuse and exploitation, a mere assertion and counter-assertion of rights, leading parties to frequently seek legal recourse, does not seem like a satisfactory cure with an acceptable long-term prognosis for the ills of medicine. Litigation is especially commonplace in the United States of America, and hardly a physician exists who has not been threatened with or affected by it. An American survey found that 22% of practitioners considered litigation to be the worst possible thing that could happen to them; worse even than death, dread disease, and divorce (Van der Spuy 2002). A recent survey in the Medical Journal of Australia found that 75% of obstetricians hoped to have stopped practising within ten years, with concerns of litigation being the predominant consideration (Hickey 2002). South African doctors have thus far not been greatly affected by litigation, but this situation is set to change according to the South African indemnity insurers, the Professional Protection Society.

Many reasons have been advanced for this 'infected', hostile atmosphere. The medical profession has many skeletons in the closet and in the 1960's, with the acknowledgement of press freedom, many of these were exhumed in public. Some of the most notorious were found in the hallowed annals of medical research: two of the most disquieting being the study of the natural history of hepatitis conducted at Willowbrook State Hospital in New York on retarded children, and the study of the natural progression of syphilis in a poor, rural, black population in Tuskegee, Alabama. These unethical research methods caused widespread disillusionment with the means and ways of Western medicine and created the perception that doctors were only interested in diseases, not patients, and were in fact willing to sacrifice human lives on the altar of knowledge. Medical personnel were increasingly perceived as coolly professional and emotionally distant. The intrusion of increasingly complicated and impersonal technology has of course only widened this gap between caregivers and patients.

Medical mishaps continue to make the headlines in the press and clearly afford popular reading. A recent informal two-week survey of South African newspapers, conducted by the attorneys acting for an indemnity association, revealed that when advertising is disregarded, matters concerning medical affairs occupy a staggering 50% of all the news (Van der Spuy 2002)! Furthermore, as Dr. Levin (2002b:52), a well-known commentator on medical affairs, recently noted in the *Medical Chronicle*, "when doctors transgress the law, or 'cross the line' it becomes front page news in the print media, while rape, murder and violence are relegated to the inside pages. This tells us something. Doctors' misbehaviours are newsworthy because of the public's perception of 'pedestal occupancy' by the medical fraternity. In essence, doctors cannot afford to be human. They have an image – or at least they used to have an image – to uphold and as such are regarded as different to other mere mortals. Thus their human errors are not readily understood, or accepted."

Another reason advanced for the growing hostility towards the profession is the perceived financial rewards inherent in medicine. There is a widespread perception that medicine is extremely lucrative and that all doctors live in mansions and drive expensive German

sedans. Although this might have been partly true a few decades ago, most doctors of today will testify that this is the exception rather than the rule. But, with the prices of medical expenses soaring, an increasing number of patients regard pharmaceutical companies and doctors as businessmen/-women in the guise, only interested in the profit margin of their businesses. In their eyes, the cold, impersonal association between contractor and client has usurped the intimate doctor-patient relationship of yesteryear. Gone is the care and compassion embodied in the 'old medicine'. Many patients also view medical interventions not only as exorbitantly expensive, but often as dangerous and frequently futile. They believe that the impressive technology often creates more problems than it solves, or extends suffering unnecessarily. One only has to recall one of the landmark cases of biomedical ethics, that of Karen Ann Quinlan<sup>2</sup>, to sympathise with these sentiments.

A growing number of patients deem medicine to be 'unnatural' and turn to the alternative homeopathic or naturalistic remedies instead. These unconventional practitioners are seen as more humane, patient-friendly and focused on the holistic picture: mind-body interactions, environment and life-style. So much so that by 1996, according to an article in *Time* magazine by John Langone (1996), a third of adult Americans spent an estimated \$13.7 billion a year out of their own pockets on "a bewildering array of breakaway treatments, including chiropractic, colonic irrigation, meditation, homeopathy, naturopathy, hypnotherapy, music therapy, folk medicine, guided imagery and Shiatsu massage." In Australia in the year 2000, patients spent on average four times more on alternative medicine than on orthodox medicine. More than a thousand homeopathic remedies are available over the counter, together with "a bewildering variety of vitamins, minerals, herbal remedies, fat burners, passion promoters and bee pollen." And all this despite the fact that these medicines are generally scorned by the traditional medical community, have no scientific data to back up their claims, no proper double-blind,

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<sup>2</sup> Karen Ann Quinlan was a twenty-two year old woman, in a persistent vegetative state after mixing barbiturate drugs with alcohol. Her father petitioned the court to appoint him as her guardian in order to allow him to disconnect her from the respirator, against the wishes of her doctors, allowing her to die (Poland 1997:195). After the respirator was disconnected, she lived for almost ten years, protected by antibiotics and sustained by nutrition and hydration provided through a naso-gastric tube. "Unable to communicate, she lay comatose in a fetal position, with increasing respiratory problems, bedsores, and weight loss" (Beauchamp & Childress 1994:203).

placebo-controlled clinical trials demonstrating benefit, and no regulating body ensuring quality control. It is ironic, or perhaps rather a sign of the diseased state of health care, that these remedies are embraced by patients, while orthodox, 'scientific' medicine is shunned and distrusted.

Doctors find it increasingly difficult to justify their decisions and practices not only to patients, but also to outside parties. The privacy of doctors' consulting rooms has been invaded by countless third parties, each with an interest in the details of the interaction: insurers, government regulators, utilization reviewers, malpractice lawyers. These third parties strive to limit, restrict, control, or dictate the course of clinical care. Robert Berenson lamented this fact in an article in the *New York Times* entitled "Meet Dr. Squeezed": "[p]racticing medicine today means being caught in the middle. Insurers, government agencies, hospitals, one's own patients, put the squeeze on the doctor as they all press for their own interests or rights. Most doctors accept the inevitable conflicts between cost and quality, patient wishes and clinical judgement, professional autonomy and consumer protection. Nevertheless, physicians feel increasingly beleaguered. Their recommendations and decisions are being questioned, constrained and overruled" (Quoted by Jonsen 1990:80).

This is no longer only an American phenomenon, as the disenchantment with medicine seems to know no regional or cultural boundaries. In the *Medical Chronicle* Dr. Levin (2002a:48) painted an equally dismal picture of the situation in South Africa: "The attitude of patients towards their medical practitioners is changing, and not for the better – it is becoming one of great concern." He was particularly concerned with the attitude of non-compliance in the taking of medication, lack of patient feedback, and apparent absence of loyalty as many patients had medical files in two or more different medical practices. The latter is a problem since patients often fail to inform the 'major service provider' of the services rendered by other health care practitioners, leading to mistakes because of a lack of information or a duplication of investigations. Furthermore, Dr. Levin was perturbed by the attitude of 'I will just pop into the lab and have a blood test, or let me visit my gynaecologist for a pap smear'. And what he called the *coup de grace*,

the patient's attitude towards the payment of fees for medical services given: doctors' debtors lists are notoriously long since many patients fail to declare that their medical scheme resources were exhausted, or that they had left the scheme months preceding that visit to the doctor in question. "It is an attitude of lies, stealth, deceit and corruption."

Unfortunately, the attitude of some medical practitioners towards their patients is equally worrying. Dr. Levin bemoaned the fact that many doctors failed to listen to the medical history of patients, failed to examine them adequately, and omitted to carefully explain the pathology and detail the long-term management of the condition. "The attitude of caring which was once the epitome of excellence within the medical profession, is gradually being expunged from medical practice, often at the expense of providing both physical and emotional support for the patient's kaleidoscope of illness" (Levin 2002:48).

It is clear that the condition of the profession of traditional Western medicine is indeed critical. Although I have advanced a few reasons for this, it has been merely a perfunctory exposition focusing on the symptoms of the disease; the root causes still remain to be unearthed. In order to accomplish this and discern the complexities of the current crisis, I propose that we examine the historical developments that led up to this predicament. Only through a better understanding of the history can we appreciate the ethical quandaries and responsibilities of the physicians, and the complaints, demands, and responsibilities of the patients. In the words of the contemporary essayist, William Pfaff: societies "need to connect with their past in order to deal with their present: to make moral sense of the past in order to possess moral confidence in the future" (Quoted by Jonsen 1990:157). Hegel was the first philosopher to systematically explore the importance of understanding the historical development of events in order to make sense of complex situations. Hegel, as the 'father of historical consciousness', is thus eminently well suited to guide us on our journey.

In this essay I therefore attempt to shed light on the origin of the particular problems faced by the medical profession, specifically the estrangement and mistrust often evident in the contemporary doctor-patient relationship, by tracing the footsteps of the historical

development of Western Medicine. By employing the Hegelian method of dialectic we commence our journey in the era of the great Greek physician, Hippocrates, travel through the Middle Ages and the dawn of Christianity, the revolution of the Enlightenment, the promise of the technological era, and finally arrive at the crisis of modernity and the postmodern condition. We make important stops at the door of John Locke who introduced us to the notion of individual human rights, and Friedrich Nietzsche who resolutely demonstrated the consequences of an unrestrained individualism. In order to overcome the aporia of the Nietzschean conclusion, we visit the twentieth century psychologist, Carl Jung, the expounder of the healer archetype in the collective unconscious, and lastly consider the words of contemporary philosophers championing a return to virtue ethics, specifically Alasdair MacIntyre and Edmund Pellegrino, and an ethics of responsibility, notably Hans Jonas.

I propose that the root cause of the apparently intractable dilemma faced by the health care profession can be found in the remnants of two separate traditions. Following the Hegelian method, I formulate the *thesis* as the tradition of paternalism stemming from the Hippocratic era and the ethics of competence, and the *antithesis* that developed in response to this, the tradition of individual human rights conceived during the Enlightenment, leading to the notion of patient autonomy. Once we understand the context of these two traditions that seem to stand diametrically opposed to one another, I endeavour to overcome the opposition and raise the hope for the possibility of a higher synthesis in which harmony and trust have been restored in doctor-patient relationship.

We live in a time when “[t]he great issues of ethics – like human rights, social justice, balance between peaceful co-operation and personal self-assertion, synchronization of individual conduct and collective welfare – have lost nothing of their topicality. They only need to be seen, and dealt with in a novel way” (Bauman 1993:4). I humbly propose that the method of dialectical interpretation of Western Medicine might be one such novel way.

## **2. HEGEL'S BASIC PHILOSOPHY AND DIALECTICAL INTERPRETATION OF HISTORY:**

Georg Wilhelm Friedrich Hegel was born in 1770, at the time when Germany entered its '*Sturm und Drang*' years. He belonged to the generation of thinkers that revolutionized German thought and literature at the turn of the eighteenth century: Herder, Schiller, Schelling, Schlegel, Schleiermacher, Fichte, Hölderlin, Goethe. These thinkers felt the full impact of the French Revolution and much of their writing can be analysed in terms of their need to come to terms with the initial elation, and eventual horror and moral conflict, following in the wake of the revolution (Taylor 1975:3). The cultural milieu similarly served as a catalyst for transformation as the ideas of Romanticism challenged the beliefs of the Enlightenment. There was a spirit of optimistic creativity in the air and the originality and significance of the philosophy of that time has been likened to that of classical Greece (Stern 2002:3).

Hegel's thought, as that of his contemporaries, centred on the question of the nature of human subjectivity and its relation to the world. This question developed in the wake of the main stream of radical Enlightenment thought in England and France. It originated as a theory of knowledge with the epistemological and scientific revolutions of the seventeenth century directed against Aristotelian science, and developed into a theory of man and society in the eighteenth century. This movement of ideas can thus best be interpreted as "primarily an epistemological revolution with anthropological consequences" (Taylor 1975:4). During the Enlightenment the notion of subjectivity introduced an objectification of the world: the world was no longer viewed as the reflection of a cosmic order, but as a neutral domain of contingent fact, to be utilized for the benefit of man. This objectification also extended to man and society in the form of utilitarian ethics, atomistic politics of social engineering, associationist psychology and a mechanistic science of man (Taylor 1975:539).

One of the central tenets of Hegel's philosophy was a rejection of the Cartesian dualistic stance: the body-soul dichotomy or the spirit-nature dichotomy. Hegel rejected any

notion of an immaterial spiritual reality and turned to categories of life that aimed at overcoming this bisection. He was inspired by the expressivist ideas of his time: human activity and human life seen as expressions. The model of subjective expression that underlies the expressivist theory held that life is the realization of an essence or form: life manifests this form in reality *and* also defines this form in a determinate way. Thus, “[i]n the course of living adequately I not only fulfil my humanity but clarify what my humanity is about” (Taylor 1975:17). The expression theory rejected the dichotomy between meaning and being characteristic of the Enlightenment, so that human life became both fact and meaningful expression. Although this theory fell back on the Aristotelian notion of final causes, it was modern in that it incorporated the notion of a self-defining subjectivity. “The realization of his essence is a subject’s self-realization; so that what he defines himself in relation to is not an ideal order beyond, but rather something which unfolds from himself...” (Taylor 1975:17).

Language and art are the forms through which human beings express themselves. The expressivist theory thus introduced three related transpositions: “a new theory of language, a new understanding of art, and a new understanding of their centrality” (Taylor 1975:18). Language was no longer seen as the expression of ideas, but rather the expression of self, and as such continuous with art as the characteristic human activity. “The human centre of gravity [was] on the point of shifting from *logos* to *poesis*” (Taylor 1975:18). This expressive activity is integral to achieving self-clarity and freedom, since man can only be free when he is able to express his full self. The expressivist theory not only enhanced the importance of freedom as a value of human life, but also changed its meaning: freedom was no longer seen as the Enlightenment idea of independence of the subject to external control (e.g. to the state or religious authorities), but rather as authentic self-expression. “Freedom takes on central importance because it is synonymous with self-realization which is the basic goal of men” (Taylor 1975:24).

The expressivists were passionate about unity and wholeness, as against the ‘dissected man’ of the Enlightenment. They rejected not only the body-soul dichotomy, but also the notion of an objectified nature, and strove to open themselves up to “the greater current

of life that flows across it” (Taylor 1975:25). They extended this communion with nature to a bond of unity with other men, where human concerns were shared and interwoven in community life, in contrast with the stark individualism of the Enlightenment. The expressivists subscribed to “[t]he image of a whole, integrated life in which man was at one with himself, and men were at one with each other in society...” (Taylor 1975:51). The expressivists thus harboured four principle aspirations: unity, freedom, communion with nature, and communion with man.

At the turn of the eighteenth century there was however a growing sense that the perfection of the expression model was not enough. The work of Immanuel Kant on moral freedom became exceedingly topical. Kant defined freedom in contrast to inclination. His famous dictum stated that the moral subject should not only act in the right manner, but also from the right motive. This motive cannot be determined by any external consideration e.g. inclination or authority (this would be heteronomy), but only by respect for the moral law that stems from rational will. The Romantics objected to this radical division between reason and sensibility and believed that a higher synthesis between the two ideals of “radical freedom and integral expression” (Taylor 1975:33) could be achieved through the imagination. Schelling, in his philosophy of nature, postulated a vision of nature as slumbering spirit and attempted to achieve the synthesis through a meeting of finite and cosmic spirit.<sup>3</sup> The self-consciousness of radical freedom found expression in nature and could achieve unity with this ‘great current of nature’ through art, and hence through something not transparent to reason.<sup>4</sup>

Hegel found Schelling’s synthesis to be inadequate. He similarly criticized the emptiness of Kant’s free self and pure rational will, but objected to the Romantics’ exclusion of reason since he saw the clarity of rational understanding as the basis of self-determining freedom. He believed that a union with nature that denied a place for reason was “not a synthesis between autonomy and expression, but a capitulation in which we give up

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<sup>3</sup> The spirit that expresses itself in the external reality of nature comes to conscious expression in man. The creative life of nature and the creative power of thought were one (Taylor 1975:43).

<sup>4</sup> Immanuel Kant said that the point about artistic creation was that we cannot give the formula (Taylor 1975:47).

autonomy” (Taylor 1975: 47-48. The essence of Hegel’s synthesis thus revolved around reason as conceptual clarity. “In everything that is supposed to be scientific, reason must be awake and reflection applied. To him who looks at the world rationally the world looks rationally back; the two exist in a reciprocal relationship” (Quoted by Stern 2002: 11). Hegel believed that the world was rational and that the goal of human enquiry was to become aware of this rationality and so achieve full comprehension of reality. But Hegel agreed with the Romantics that reason – or ‘understanding’ in his words – “divides, analyses, individuates, kills” (Taylor 1975:48), since rational understanding necessitates a distinction between subject and object. In the preface of his ‘Phenomenology of Spirit’ Hegel compared the power of understanding to that of death, but he maintained that the way to reconciliation with spirit was not to flee this death, but to “‘hold it fast’, to ‘bear it and maintain oneself in it’, to ‘sojourn’ with it” (Taylor 1975:48).

Hegel believed that whether man achieves absolute knowledge does not only depend on the nature of the world, but also on how man looks at the world. If man does not look at the world correctly, it will appear to contain incomprehensible, contradictory elements. He postulated that these mistaken conceptions arose because man tends to think in an oppositional way: man believes that things are *either* finite *or* infinite, one *or* many, free *or* necessitated, etc. But reason struggles to make sense of this because it will then “look at reality in a way that abstracts from the complex interrelation of these ‘moments’, when in fact to see itself in the world, reason must grasp that there is no genuine dichotomy here” (Stern 2002:13)<sup>5</sup>. When we are therefore faced with an apparently insoluble problem, on Hegel’s advice, we should step back and think reflectively about how the problem came to arise in the first place; once we understand that the problem arose from a set of one-sided assumptions, the problem would be dissolved. Consequently, we should ask whether there is something problematic about our starting point; the initial dichotomy must be broken down if the puzzle is to be solved.

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<sup>5</sup> For example: if we believe that to act freely means to act without any constraints, we are faced with the impossibility of only seeing arbitrary choices as autonomous actions, since only then is our behaviour free from any determining factors (Stern 2002:14).

On Hegel's view, consciousness will therefore follow through these characteristic movements: starting from one position (the thesis), it realises that that position leads to problems that are intractable from that standpoint. Consciousness, plunged into despair because it finds only frustration in the world, then moves to a fresh standpoint in order to recover a sense of being 'at home in the world'. It comes to the new standpoint by questioning the assumptions of its initial position, but because it does so in a one-sided (non-dialectical) manner, arrives at an equally problematic second position (the anti-thesis) and is once again plunged into despair. Only when consciousness is ready to reflect on the categorical assumptions that have led to this impasse, can the puzzle be solved and a higher synthesis be achieved (Stern 2002:28-29). Hegel aimed to provide man with a way of solving these puzzles by finding a new way of looking at the world; to show the world as it intrinsically is (Stern 2002:12). Thus, unlike the irrationalists and conservatives of the counter-Enlightenment who disputed the power of reason, and unlike the Romantics who turned to aesthetic experience, Hegel still saw philosophy as integral to a synthesis that could combine the opposition of freedom and integral expression.

Hegel's philosophy was anchored by three contrasting principles: the expressivist vision of the union of man with himself and other men (as in classical Greece), the moral aspirations of the Enlightenment for freedom of self-direction through reason, and theology in the form of Christian religion. Hegel gradually came to realise how incompatible these aspirations were: the view of the Greek polis (founded on mutual love) was incongruous with the modern spirit of individual freedom, e.g. private property. The demands of Kantian autonomy and those of expressive unity were similarly discordant. This insight did however not lead him to abandon one of the three principles; rather, he came to believe that separation was not only inevitable, but also essential; inextricably bound up with the development of freedom. The realisation of man as a free rational being demanded that he break free from the original unity of the tribe (Taylor 1975:68). Hegel's task thus changed from that of recovering unity to that of reconciling opposition. "... [T]he problem cannot be solved by a victory of one side over the other, by a simple undoing of the separation in a spirit of unity, rather the two sides must be

brought somehow to unity while each requirement is integrally satisfied” (Taylor 1975:67). Both separation and identity must be awarded their rights: “[b]ut the Absolute itself is thus the identity of identity and non-identity, opposition and unity are both in it” (Quoted by Taylor 1975:67).

With this new perspective, Hegel developed a view of history as “the necessary unfolding of a certain human destiny... through tragic conflict to a higher reconciliation” (Taylor 1975:68). The conflict of inevitable separation and the need for unity with society and with nature was ineluctable, but so too was the higher reconciliation where these two goals were fulfilled together. History was now seen as a spiral where we return not to our starting point, but to a higher variant of unity. Unity thus yields to division and is then recovered on a higher level.

Hegel believed that certain historical forms of life are troubled by inner contradiction because they either frustrate the very purpose for which they exist (e.g., the master-slave relation<sup>6</sup>), or because they are prone to generate an inner conflict between the different conditions that are essential for the fulfilment of the purpose (as with the Greek polis<sup>7</sup>). These forms are thus destined to be found inadequate and be replaced by others (Taylor 1975:131). The contradictions in man’s ideas are also integral to an understanding of history: because man’s conception of his basic purpose that goes with a certain historical life form is inadequate, he is, at the beginning of history, incapable of realizing his potential. This inadequate conception is essential to the contradiction; “for the contradiction comes not from the fact that men’s purposes go awry, but that men defeat them in trying to fulfil them. So that the contradiction in any historical society or

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<sup>6</sup> The master-slave relation frustrates the purpose of recognition for which it entered into. The drive for recognition powers the fight to the death: while I do not want to recognise you (as this threatens my freedom), I want you to recognise me, and so we are engrossed in a battle (‘the life and death struggle’) for recognition that can only be resolved when one concedes defeat. But if one dies in this struggle, the other cannot achieve recognition; this is what in turn makes the outcome unsatisfactory and requires that both protagonists survive in the relation of master-slave. This relation in turn is shown to be inadequate in the light of the same purpose: the master views the slave as an object - a mere instrument of his will - and the outcome is thus that the recognition is one-sided and unequal (Taylor 1975:216,217; Stern 2002:76-84).

<sup>7</sup> “The city state fails as a realization of the universal because its parochial nature contradicts true universality. The revolutionary state destroys freedom because it tries to realize it in absolute form, by dissolving all the articulations of society, without which freedom cannot exist” (Taylor 1975:216-217).

civilisation can be said to consist in this, that men's basic purposes, conceived in the terms of this society, are doomed to be self-defeating" (Taylor 1975:132). These changing conceptions are as essential to historical dialectics as the change of historical reality; in fact, Hegel thought the one was bound up with the other. The three notions involved in historical development are therefore the basic purpose or standard, the inadequate reality, and an inadequate conception of the purpose that is bound up with that reality (Taylor 1975:133).

The opposition between autonomy and expressive unity led Hegel to his central ontological thesis that "the universe is posited by a Spirit [*Geist*] whose essence is rational necessity" (Taylor 1975:538), and that the absolute as *Geist* is greater than man. Man as a spiritual being is thus related to a larger scheme of spiritual activity, and is seen as the vehicle of the Spirit (or cosmic reason) expressed in the world. *Geist* is "self-knowing spirit, self-thinking thought, pure rational necessity" (Taylor 1975:129). With the development of the concept of *Geist*, Hegel's notion of historical process could no longer be explained in terms of conscious human purposes, but only by the greater purposes of *Geist*. Although man accomplishes transformations in political, social and religious institutions necessary to fulfil his destiny, he does not fully understand the part he is playing; this can only be understood post hoc. Hegel expressed this retrospective understanding of history famously in the Preface to the Philosophy of Right: "the owl of Minerva spreads its wings only with the falling of the dusk" (Quoted by Taylor 1975:74).

It is thus clear that four related transpositions occurred in Hegel's thought from his early to his mature system: the acceptance of separation as part of the ultimate unity, the view of philosophy as the crucial medium for understanding, the shift from a man-centred theory (following Kant) to one centred on *Geist*, and the idea that man's realisation is not planned by him, but can only be recognised retrospectively.

Hegel's philosophy on the nature of history should be understood within the framework of this metaphysical system. He attempted to interpret the meaning of the whole of the history of the world. Hegel was an idealist. He believed that "reality is fundamentally

mental in nature” (Blackburn 1996:184), and thus that everything that is real, can be thought. For him, the appearance of reality was located in the ‘Absolute Idea’ that does not exist independently, but gradually develops dialectically. Hegel postulated that the Idea goes out into nature and is at first lost there. Since it does not yet achieve adequate expression, there is division and separation within the world and between the world and Spirit, which cannot recognise itself. History is responsible for the development of an adequate expression and thus the return of Spirit to itself (Taylor 1975:549).

Hegel therefore incorporated the notions of time, change, and history into his concept of reality – in contrast to the classical idealism of Plato where reality was contrasted with everything that changes and is temporary – and has as such been hailed as the father of historical consciousness. Following his method of dialectic, he developed the super-triad of the evolution of the Absolute Idea in the following way: the *thesis* is the idea ‘an sich’, as reflected in the formal, abstract philosophical discipline of *logic*; in the *antithesis*, the idea is estranged from itself and becomes externalised in the form of nature, reflected in the *philosophy of nature*; finally, in the *synthesis*, the idea is reunited with itself, but on a higher level: the idea comes to self-consciousness in the form of ‘*Geist*’, as presented in Hegel’s *Phenomenology of Spirit*. The spirit similarly develops through a triad: the *thesis* as *subjective spirit* in the form of the individual; the *antithesis* as *objective spirit* as found in the social structures of the family, community, and the State; and the *synthesis* in the form of the ‘*Absolute Spirit*’. This absolute spirit comes to self-revelation through the triad of art, religion and philosophy. Philosophy is seen as the highest form of self-consciousness of the spirit (Van Niekerk 2002).

Modern technology and science have given man control over nature and hence dispelled the perception of the world as the manifestation of spirit. The Enlightenment conception of man as a rational, independent individual has also been entrenched in contemporary civilisation against the expressivist ideas of the eighteenth century. Nonetheless, Hegel’s philosophy has inspired many great thinkers - amongst others Marx and Kierkegaard – and triggered ideas for innovative developments, for instance existentialism. Although his central ontological thesis (that the world only exists as an emanation of *Geist*, and that

spirit knows itself in knowing it) is no longer accepted, his work continues to be topical in a world where man is engrossed in a perpetual struggle against the expressive poverty of modernity. Hegel was crucial in the development of the modern conception of freedom, as total self-creation through cosmic spirit. Yet, he also laid bare the emptiness and potential destructiveness of freedom as self-dependence (Taylor 1975:570). Hegel's writing embodies one of the most profound attempts to "work out a vision of embodied subjectivity, of thought and freedom emerging from the stream of life, finding expression in the forms of social existence, and discovering themselves in relation to nature and history" (Taylor 1975:571).

I am not idealistic enough to believe that we can ever know the 'world as it intrinsically is', or that the dilemmas facing the world - specifically the world of medicine - today will simply dissolve when we abandon our one-sided assumptions, or that history necessarily implies progress. I do however believe that history can be a spiral, that historical consciousness can aid us in an improved understanding of current problems, and that often, when the historical developments and traditions become clear, the dilemmas do not seem as intractable as before. These are the lessons I learned from the writing of the 'father of historical consciousness' and which I wish to apply to the investigation into the critical state of medicine in the world today.

### **3. DIALECTICAL APPROACH TO THE HISTORY OF WESTERN MEDICINE:**

On reflecting about contemporary medicine within the framework of traditional ethics, one is immediately aware of ideals and constraints that defy one another, leading to ambiguities and paradoxes that seem insurmountable. These paradoxes occur on both a personal and interpersonal level. Personally, doctors are torn between their duty towards their patients to assist those in need – regardless of their ability to pay - and their duty towards themselves and their families to run a successful practice and provide a liveable income. They are divided between the ideal to do everything in their power and save lives regardless of cost or long-term implications and their duty (constraint?) to respect the wishes of their patients, even the wishes of non-treatment. Patients are similarly torn

between their respect and reference for the authority of the doctor and their desire and need to make their own decisions and determine their own criteria for a life worth living. Interpersonally, doctors, patients, patients' families or guardians, and service providers frequently disagree about diagnoses, proposed courses of action, treatment options and, arguably most often, the costs involved in all of these. Medical ethics books and journals are filled with accounts where the opinions of the treating physicians and those of the patients were so irreconcilable that the parties had to resort to legal assistance in search of arbitration. And often, even the judges could not agree on the right course of action!

Hegel postulated that these contradictions only exist because we do not look at the world correctly: because we tend to think in an oppositional way, we abstract from the complex interrelation of things, "when in fact to see itself in the world, reason must grasp that there is no genuine dichotomy here" (Stern 2002:13). When we are therefore faced with these apparently insoluble medical dilemmas, we have to step back and think reflectively about how the problem came to arise in the first place. We have to trace the history of the various sides of the problem and seek the underlying one-sided assumptions that led to the impasse. We should ask ourselves whether there is something problematic about our starting point and this initial dichotomy must be broken down if the puzzle is to be solved.

My proposition is that at the heart of many of the current medical dilemmas lies the opposition between paternalism and autonomy. The doctor is torn between his/her own best judgement and his/her duty to respect the wishes of the patient. The patient is torn between his/her desire to act autonomously and his/her desire for the fatherly care of the physician. These two fundamental concepts arose out of two different traditions, and now, because they have been abstracted from the contexts and histories that inform them, seem to be diametrically opposed.

Paternalism arose out of the ethics of competence that has its origin in the Hellenic era. Physicians of ancient Greece were expected to be men of good character and reputation and to know what was best for their patients. Society relied on their benevolence and

competence and this constituted the basis of their professional interactions. As the power of medicine grew with the advent of the scientific revolution however, professionals' authority and competence were reinforced at the expense of adequate protection of the individual. In response to the power differential found in the political and social arena, individual human rights were promulgated in the Eighteenth century. Rights rely on an individualistic perception of society based on voluntary contracts and legal protection – benevolence is no longer an adequate safeguard against abuse. In the medical sphere, the culture of rights has been translated into the right to be informed of one's diagnosis, have access to one's medical records, and have the final say in one's treatment; hence the right to autonomy. Paternalism therefore developed out of a societal system that embraced the virtues and communal responsibility within the bounds of the *polis* of antiquity; autonomy on the other hand arose out of the designs of the Enlightenment where the individual was hailed supreme.

Following the method of dialectic, I therefore postulate a *thesis* of paternalism, and in response to this, an *antithesis* of autonomy. I attempt to show that an intransigent insistence on one side or the other will only serve to strengthen the paradox and fail to lead to an acceptable solution. I then aim to develop a synthesis where both concepts are embraced and propose possibilities for future reconciliation through the ideas of compassion, virtue and responsibility. This is my journey.

#### **4. THESIS: PATERNALISM:**

The notion of paternalism is ingrained in the tradition of Western medicine. We will trace the tortuous and enlightening journey of its history from the cradle of Western civilization, ancient Greece, through the tradition of medieval Christian healing, the Enlightenment and the dawn of the technological age, up to paternalism in practice today.

#### **4.1. The Hippocratic Tradition:**

The practice of medicine in the time of Hippocrates was a skill and its practitioners were craftsmen, devoted to the art of medicine. It was however a new art and physicians had to work hard at earning the trust of the public and building a good reputation. It was necessary for them to not only possess the relevant medical skills and experience, but also to be of good character, in other words, to be honourable, trustworthy and benevolent (Van Zyl 1997:21).

At the heart of Hippocratic medicine was the belief that “all disease has a nature and arises from a natural cause, and is capable of cure”, and accordingly all physicians were encouraged to “acquire true knowledge of medicine before travelling to various places and acquiring the reputation of being a physician in deed as well as in word... There are two things: science and opinion. The first begets knowledge and the second ignorance” (Jones, quoted by Jonsen 1990:22). Physicians attempted to disassociate themselves from quacks and charlatans and prized themselves on the scientific nature of their work. The Hippocratic Corpus, probably not written by Hippocrates himself, embodied “a consistent doctrine of medical theory and practice, relatively free from superstition and speculative philosophies, and [set] forth rational empiricism of a strictly scientific nature” (Van Zyl 1997:15). But the art of medicine comprised more than merely scientific knowledge or *episteme*; it also called for *phronesis*, or practical wisdom, and physicians had to learn how to apply their knowledge in specific situations through apprenticeship to experienced physicians.

Little is known about the historical figure of Hippocrates except that he was generally held in high esteem; Aristotle, for instance, called him “the Great Hippocrates” (Jonsen 1990:19). The writings that are known today as the Hippocratic Corpus were probably written by a number of physicians over a number of decades, and of these, the Hippocratic oath is surely the most illustrious. In essence, the Hippocratic oath expressed the twin ideals of beneficence and non-maleficence. By swearing to abide by the oath, physicians undertook to do everything in their power to benefit the sick and, if this

proved to be impossible, at least not to do any harm. It is significant to note that promoting the welfare of patients, and not merely avoiding harm, was seen as the rationale and justification of medicine - this notion is still evident in the motivations and actions of physicians today. Physicians further promised to observe the requirements of confidentiality in their patient interactions and also in their private lives, thereby establishing a reputation as people of good character (Van Zyl 1997:16). The oath stated:

“I will use treatment to help the sick according to my ability and judgement, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor shall I suggest such a course. Similarly I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art... Into whatever house I enter, I will enter to help the sick, and I will abstain from abusing the bodies of man or woman, bond or free, And whatever I shall see or hear in the course of my profession, a well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets” (Jones, quoted by Van Zyl 1997:16-17).

There is disagreement about whether the primary motive of the Hippocratic physician was philanthropy or self-interest. Proponents of the former view refer to the statement in Hippocrates' *Precepts*: “where there is love of man, there is also love of the art [of medicine]” (Jones by Van Zyl 1997:19) as proof that physicians were mainly compassionate by nature and devoted to altruistic values. Jones (quoted by Van Zyl 1997: 19-20) believes that medicine was an art “inseparable from the highest morality and love of humanity”, and sees that as “the great lesson to us in the Hippocratic writings.” According to the latter view, however, physicians were primarily concerned with their reputation and standing, with precious little altruism evident in the ancient Greek medical literature. Jonsen (1990:9) alleges that the main objective of physicians was to earn a good living and consequently, the ethics of that time consisted of counsels of self-interest: “Act in this or that way with your patients if you want to build a reputation and clientele” (Jonsen 1990:9). He believes that a closer examination of the text and context

of the *Precepts* reveals that the phrase extolled by Jones is merely advice on good advertising! On this interpretation it makes sense that ancient physicians refused to treat terminally ill patients: a dead patient is surely the worst possible advertisement of a physician's art and clear proof of his incompetence and impotence.

Van Zyl believes that both these interpretations are too inordinate and motivates for a more temperate view. She believes that although physicians were clearly concerned with their reputations – refer the conclusion of *The Oath*: “Now if I carry out this oath, and break it not, may I gain for ever reputation among all men for my life and for my art” (Jones, quoted by Van Zyl 1997:20) – they were also motivated by compassion and benevolence. For example, she describes the endless toil of the Athenian physician, Xenotimus, who offered his services freely to the public when the other physicians were ill from overexertion in the care of the sick, and saved many lives. “It is therefore benevolence and competence, ‘good will and care’ for their people that prompted the Athenians to honour this man who had offered ‘to serve gratis as public physician’” (Van Zyl 1997:20). Van Zyl comes to the conclusion that it is only in the Christian tradition, with its demands of selfless dedication to the sick, that altruism and self-interest came to be considered as mutually exclusive values.

It is also important to realise that counsels of self-interest in ancient times did not equate to counsels of greed or self-enrichment. In the *Precepts* Hippocrates writes: “it is well to superintend the sick to make them well, to care for the healthy to make them well, but also to care for one's own self, so as to observe what is seemly (Jones, quoted by Van Zyl 1997:21). Also in *Breaths*, Hippocrates says that the art of medicine is painful for those who possess it, since the medical man “sees terrible sights, touches unpleasant things, and the misfortunes of others bring a harvest of sorrows that are peculiarly his.” But the art is also beneficial to those who practice it, “enabling them to rid themselves of the worst of evils, disease, suffering, pain and death” (Jones, quoted by Van Zyl 1997:21). It would be wise for modern physicians to recall these erudite words. Medicine is an emotionally and physically draining profession; in order to be capable of ‘superintending’ the sick, one also has to take care of one's own spiritual, psychological and physical well-being. There

are too many doleful accounts of physician burn-out and the spectres of alcoholism, substance abuse, marital failure and suicide haunt many a member of the profession.

Within the framework of benevolence and self-care, the Hellenic era thus laid the foundation for an ethics of competence. Physicians practiced the art of medicine with the aid of *episteme* and *phronesis*, caring for the sick that they believed could be cured and establishing a reputation as men of good standing.

#### **4.2. Christianity in the Middle Ages:**

The march of the ethics of competence was however temporarily halted during the Middle Ages. The ideals and aspirations of the Greek civilization were all but destroyed and the art of medicine was no longer practised by professional physicians. After initially having qualms about the practice of medicine, the Christian church adopted the role of caregivers to the sick as a duty of charity. The imperatives of self-sacrifice, characteristic of the lives of nuns and monks, were extended to include the care of the sick and dying. “Medicine became Judeo-Christian, and altruism and medical care were bound in a moral covenant” (Jonsen 1990:10). The parable of the Good Samaritan<sup>8</sup> was used to exemplify the duties and virtues of the Christian physician: selflessness, mercy, kindness, and forgiveness. It emphasised the importance of the duty to care for the sick, whether friend or enemy, regardless of the cost to oneself. Physicians were reminded of the words of the Lord: “I was sick, and ye visited me... Verily I say unto you, inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me” (The Gospel according to St. Matthew: 25). The Samaritanian principle has persisted into our secular era as a cornerstone of medical ethics.

Under Augustinian influence, disease and suffering were no longer seen as natural entities, but as punishment meted out by an omnipotent God: “suffering and death were

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<sup>8</sup> A man travelling from Jerusalem to Jericho was beaten by robbers and left ‘half-dead’ by the roadside. Two travellers, a priest and a Levite, passed by the injured man without rendering help. A Samaritan who saw him had compassion on him, bound up his wounds and took him to an inn where he gave money to the landlord and asked him to take care of the man (The Gospel according to St. Luke: 59-60).

seen as God's punishment for the primal sin which infected all born of carnal generation, so that humanity was condemned to pain in childbirth, to suffering and guilt in life, and to the final evil of death" (Van Zyl 1997:23). Physicians were prevented from mastering disease and staving off imminent death not only by lack of knowledge and skill, but also by religious prohibition. Physicians were now deemed to be in the service of God and expected to display humility and pay tribute to God as the true and only Healer. Patients were similarly admonished not to put all their faith in medicine, but to pray to God for salvation: "Bless the Lord, O my soul, and forget not all his benefits: Who forgiveth all thine iniquities; who healeth all thy diseases" (The Book of Psalms: 461).

Whereas self-interest was seen as a proper motive of physicians in the Hippocratic tradition, doctors were now expected to be selfless and humble. Even in the late eighteenth century, physicians were expected to exhibit the Christian virtues of faith, hope and charity at the bedside of the sick. They were even expected to fulfil the role of priests at times by persuading the sick and dying to adopt Christian beliefs and values (Van Zyl 1997:25). Jonsen (1990:39) believes that the "'Samaritanian principle' deserves to stand beside the 'Hippocratic principle' of competence in its importance for medicine in our culture." "The ideal physician has always been seen as the bearer of both virtues, and departures from either have been deplored" (Jonsen 1990:40).

### **The First Moral Paradox:**

The legacies of these two diverging traditions of medicine, stemming from ancient Greece and medieval Christianity, eventuated in the first profound moral paradox at the heart of medicine: the opposition between self-interest and altruism. This opposition is built into the very structure of medical care, and pervades all terrains of medicine where skills can be used for self-satisfaction and self-support, or alternatively to respond to the needs of others (Jonsen 1990:5). Many moral dilemmas encountered in medicine are merely symptoms of this paradox. "No physician is permitted to be merely a profiteering tradesman; few bind themselves by vow to self-sacrifice. All physicians must live between these principles in institutions that enshrine both" (Jonsen 1990:13). Especially

physicians in private practice face the dilemma of having to run a successful practice with sound business principles and still be compassionate, caring, and willing to help those in need regardless of their ability to pay for the services.

Medical training seems to strengthen the paradox. Self-interest is encouraged by the high standards of admission, the continued insistence on academic performance in the classroom and clinical excellence on ward rounds, in the intense competition for intern placement, resident positions, fellowships, and faculty advancement (Jonsen 1990:12). Altruism, on the other hand, is demanded by the “absolute asceticism” of the internship year: “immediate response to the needs of the patient, to the calls of the emergency room, to the demands for reports; unmitigated responsibility for correct decisions made promptly and communicated clearly; the flagellating denial of sleep, self-indulgence, and frivolity, even to the point of depression and deterioration of personal life, friendship, and love” (Jonsen 1990:13). The ideals of altruism are also widely proclaimed and lauded on every ceremonial occasion.

Although this paradox is surely still prevalent in the lives of doctors and does cause a fair amount of moral discomfort and deliberation, I believe that the most fundamental paradox still had to be born, and indeed in the time of the Enlightenment.

### **4.3 The Enlightenment and the Dawn of the Technological Age:**

During the Enlightenment, in the climate of innovation and progress, scientists came to believe that by freeing themselves from the obfuscation of religious beliefs, superstition and emotion, and by detaching themselves from the objects studied, they would be able to unearth the fundamental truths on which all knowledge could be based. Rene Descartes (1596 –1650), a French mathematician and founding father of modern philosophy, through his conception of man’s mind-body dualism, was instrumental in enthroning human reason as the ultimate authority and ‘liberating’ the physical world from the spiritual world. His work sparked the possibility of science by postulating that the external world has an essence that is simply extension: “all there is to it essentially is that

it takes up space and that it is susceptible to being treated by geometry and the mathematical sciences. All its more colourful aspects – the fact that it *is* coloured, and that there are tastes and sounds – are really subjective. They're on the mental side; they are subjective phenomena that occur in consciousness, caused by this physical, extended, geometrical world" (Williams 1987:87). "Both the human mind and the natural world now stood autonomously as never before, separated from God and from each other" (Van Zyl 1997:28). Modernity thus embraced individuality and rationality and individuals were considered to be able to think independently and systematically and enter into debate with fellow humans on the basis of reason and the scientific method. "Understanding consist[ed] of transparency effected by rational procedures" (Degenaar 1993:52).

In the medical arena these ideas manifested in the attempt to understand the functioning of the human body by means of scientific methods and principles. As the explanatory power of these scientific theories grew and as medical technologies proved successful and promised great rewards, the human dimension of medicine came to be seen as secondary to the importance of 'hard' scientific data. Since the psychological and social aspects of illness defied any attempt at reproducible measurement or laboratory verification, it was seen as subjective and unscientific and hence superfluous. Contingency was problematized as an enemy and order was made the ultimate task. Modernity "prompted an incessant drive to eliminate the haphazard and annihilate the spontaneous" (Bauman 1992:viii). The principle aim of medicine was now to discover the 'truth' behind the patient's illness.

Thomas Sydenham (1624 – 1689) - known as the 'English Hippocrates' because of his embodiment of the ancient Greek empirical and naturalist spirit - effected significant changes in the practice of medicine. He identified individual diseases by their discrete signs and symptoms and proposed that each should be treated with a specific remedy. "For him, maladies were entities, and his outlook upon illness was, therefore, ontological. Hippocrates wrote the histories of sick persons, but Sydenham wrote the history of diseases" (Sigerest, quoted by Jonsen 1990:85). The term 'pathophysiology' thus

changed from the Greek notion of an inquiry into the nature of suffering (*pathos* – suffering – and *physiologia* – an inquiry into the nature of things), to the modern notion of the study of diseases (Van Zyl 1997:15, 28). Physicians gradually started viewing diseases as entities to be conquered by those with the requisite knowledge and skill. The symptoms and signs that patients had in common became more important than the symptoms and signs that seemed atypical; these were merely seen as deviations from the norm (Van Zyl 1997:29). Consequently, in searching for the communal, physicians became increasingly detached from the unique traits of the individual patient and found it increasingly difficult to appreciate the unique psycho-social environment that informed the presentation and course of diseases.

The explosion of technological innovations in the twentieth century has been associated with alienation on various levels: the worker is alienated from the object of his work by the machine and from the sense of his work by the fragmentation of the production process into often monotonous, ‘soulless’ manual sub-operations; man is alienated from nature by the thoroughly artificial world of the modern city (Jonas 1985:154). In medicine, technology also served to alienate physicians from patients. Not only did the technological apparatus of medicine, from the humble stethoscope to the most advanced MRI-scanner, place a physical distance between the physician and patient, but technology also represented a “systematic, disciplined approach to objectives, using a calculus of precision and measurements and a concept of systems” (Bell, quoted by Jonsen 1990:112). By focusing on the objectives rather than on the individual patient at hand, medicine became depersonalised and often mechanistic.

Statistics - an integral part of technology - and the science of epidemiology represent a systematic, disciplined and methodical mode of thinking and acting with the view to produce results in a reliable manner and as such became indispensable to the practice of modern medicine: every procedure and treatment can be analysed and explained in terms of its risk-benefit ratio, probability of success, incidence of adverse effects, and long-term prognosis. It is a valuable tool in meta-analysis where masses of data are brought together and statistically analysed, but for the individual patient, who effectively represents a

statistic of one, these values are nonsensical. For a patient who develops a life-threatening anaphylactic reaction after a Penicillin injection, it is immaterial that the statistical incidence is only 1 in every 5 000 patients! For that patient it only matters that it actually happened to him/her.

Technology did of course bring about many benefits: more accurate diagnosis, more effective and a wider range of treatment, and even prolonged life expectancy. But now the term 'benefit' was no longer understood in the context of the entire patient, his/her value system, wishes and life plans, but rather in terms of narrowly defined clinical effects. 'Harm' came to be seen as merely physical harm e.g. pain, disability, disfigurement and death, and no longer as the Hippocratic notion of physical, emotional or psychological harm. Similarly, the efficacy of treatment was now measured by the extent to which it conformed to the statistically predicted results and not in term of its compliance with the patient's wishes (Van Zyl 1997:31-32). Hence, with this understanding, the successful treatment of infection in a terminal cancer patient for instance, would appear to be effective and of benefit. Jonsen (1990:117) suggests: "It may be that the high reliability and replicability of results that technology makes possible obscures the difference between a result and a benefit." "Evaluation of a result as a benefit requires a much more complex, more personal, and more humane consideration than recognition of the result itself."

Technology therefore not only dramatically increased the scope and reach of medicine, but also reinforced the need for competent and ethical practitioners. Technology and ethics are not strangers, "they are neighbours in the world of human accomplishment", both indispensable in the world of medicine today (Jonsen 1990:120).

#### **4.4 The Ethics of Competence:**

The concept of competence weaves through the tortuous journey of the history of Western Medicine like a golden thread. For the Hippocratic physician competence was understood as the "disciplined understanding of the science and skilled manipulation of

the art” and was of prime importance for the profession (Jonsen 1990:22). Hippocrates’ *Precepts* proclaimed the virtue of competence in the context of the condemnation of medical quackery: “Conclusions that are merely words cannot bear fruit, but only those based on demonstrated fact... One must hold fast to generalizable fact and occupy oneself with facts persistently, if one is to acquire that ready and sure habit we call the art of medicine... for to do so will bestow great benefit upon the sick” (Jonsen 1990:22-23). Competence is thus espoused when the Hippocratic maxim “Be of benefit and do no harm” and the phrase of the Hippocratic oath “I will act for the benefit of my patient according to my ability and judgement” are voiced (Jonsen 1990:23).

When medicine began to be taught at universities in the Middle Ages, competence was heralded as an explicit virtue. Great emphasis was placed on the external elements of competence and these were tested with rigorous examinations. Competence was viewed as the mastery of the knowledge of the theories and observations enshrined in the pages of Galen, Avicenna, and other classical authors. The Royal College of Physicians of London, for instance, expected their students to be able to identify three random passages from Galen and locate it in an unindexed set of the author’s writings (Jonsen 1990:23). A book of the time written by Ahasverius Fritsch, entitled *Medicus Peccans* or *The Sinning Doctor*, said that the first mortal sin of physicians was “practicing medicine without being thoroughly competent in the art” (Quoted by Jonsen 1990:24).

In modern medicine competence is an essential prerequisite. In the beginning of the twentieth century, Dr. Richard Cabot, professor of medicine at Harvard Medical School, augmented the concept of competence to include not only the “mastery of the science and skills of diagnosis, therapy, and prevention of disease”, but also “an appreciation of the personal and social aspects of the patient’s health and disease” and proclaimed it to be the glory of modern medicine. This became “the standards to which all physicians must be held – the goal of medical education and the expectation of the public” (Jonsen 1990:27). However, according to the medical historian Chester Burns, whether a practitioner attended church on Sunday, swore the Hippocratic oath, or adhered to the AMA code of ethics, paled into significance when professional propriety was being judged. What

counted for Cabot was “whether a practitioner understood specific diseases, their causes, signs, symptoms, course, prognoses, treatments – and whether each practitioner applied this understanding in the assessment and management of each individual patient” (Quoted by Jonsen 1990:26).

Today medical training still concentrates on the mastery of data and method, and the so-called humanistic virtues are granted only a cursory mention. Many doctors still defend the old canard: “I’d rather have a competent bastard do my surgery than a bumbling humanist” (Jonsen 1990:26). The power of knowledge is invigorating and competence creates a fellowship of respect and appreciation among those who have attained it. It also challenges them to continually expand its scope, to defy its limits in search of further glory. “Thus competence in medicine implies the inspiration of the practitioner, the unity of the profession, and the impetus of science” (Jonsen 1990:25). It becomes exceedingly easy to forget the patient behind the clinical data, the face behind the disease. In the race to find new diagnostic tools, novel surgical techniques and better and faster cures, the patient’s needs, fears and wishes are all too often ignored or brushed aside.

The explosion of technological innovation in the last three decades that culminated in life-support treatments, organ transplantation and genetic manipulation, promises great benefits but also invites the danger of grievous harm. The question of competence is once again inordinately topical; this time not in the sense of the imperative of competence, but rather the appropriate limits of competence.

#### **4.5 Paternalism in Practice:**

I propose that the ethics of competence that is so deeply ingrained in the practice of medicine, systematically fostered a paternalistic attitude among physicians towards their patients. The term ‘paternalism’ is derived from the Latin root ‘*pater*’ – father – and is explained as “the claim or attempt to supply the needs or to regulate the life of a nation or community in the same way a father does those of his children” (Oxford English Dictionary, quoted by Beauchamp & Childress 1994:273-274). Some would argue that

because the term is gender-biased and therefore not felicitous, it should be replaced by the term 'parentalism'. But interestingly enough, some feminist writers have argued that it is correct to retain the term 'paternalism' since it appropriately links the privileges of a father in a patriarchal family and the privileges of physicians in an authoritarian medical system (Beauchamp & Childress 1994:319-320). The analogy of a physician and a father rests on three cardinal features as analysed by van Zyl (1997:32-33):

1) *The father's authority*: to be able to help others it is necessary for the physician as caregiver to assume a certain amount of power over his/her patients so that they might benefit. This idea stems from the Hippocratic tradition where the relationship between physicians and patients were constructed in terms of family: patients were seen as children who depended on the kindness and unselfishness of physicians. In the Christian tradition this paternal relationship was furthered by the view of physicians as instruments of God, the true Father and only Healer.

2) *The superiority of the father's knowledge and insight*: because of the physician's training and experience, it is assumed that s/he is in a better position to decide what will be in the patient's best interest; much the same as when a father decides what his children should do based on his greater wisdom and experience of the world. This idea was strengthened by the epitome of the Christian physician, a well respected and educated member of the community, fulfilling the role of medicine man, moralist and priest.

3) *The father's intentions are beneficent*: the physician, just like the father, has the desire to act in the best interests of his/her 'children'. This desire is rooted in the altruistic values of benevolence, unselfishness and compassion, characteristic of the parent-child relationship.

Thus, through the years of training aimed at the mastery of knowledge and skill, medical students gradually come to believe that they know what is best for their patients. When a patient disagrees with a proposed course of treatment, it is often attributed to a lack of knowledge or irrational fear. Since doctors perceive themselves to be competent in

matters of health and benevolent in their attitude towards their patients, they expect to be respected in their position to make the 'correct' decision on behalf of their patients. The environment in the teaching hospital serves to further strengthen this conception. Because the patients are often grievously ill and consequently unable to actively participate in the decision-making process, because family members are often far away and not available for deliberation, and because of the severe time-restraints placed on doctors by the many patients waiting to be treated, it is often easier just to make the correct clinical decision and justify it as acting in the best interest of the patient. It is here that paternalism is born: because the doctor comes to believe that his/her judgement is correct and is in the best interest of the patient, he/she feels justified to disregard or overrule the wishes of the patient. This is particularly common in the South African context, where patients and doctors often do not speak the same language, often grew up in different cultures with different value systems, and patients mostly come from previously disadvantaged groups with poor or no education and little understanding of Western medicine and technology.

In the twentieth century the doctor-patient relationship is no longer viewed in parental terms, but rather in contractual terms. Paradoxically, this has served to strengthen the hold of an ethic of competence and thus also paternalism. In modern medicine "[i]t is no longer enough to have good intentions: we also expect physicians to perform the duty of benefiting patients, and may hold them accountable if they were to fail to accomplish this" (Van Zyl 1997:36). This duty of care demands that everything possible should be done for a patient, irrespective of the costs, burdens or consequences for those involved. Sir William Osler expressed this ideal famously: "If a life is worth living at all, it is certainly worth living to the very end, a position from which the conscientious physician has no possible escape in the care of the cases which he is called upon to treat" (Quoted by Van Zyl 1997:36). Young doctors quickly realise that they have an obligation to do what is medically good for their patients, and that they can be held legally accountable for failing to perform their duties competently. In this way, I believe the ethics of competence once again encourages a paternalistic approach in physicians, an approach where the patient's wishes are subordinate to the objectives and possibilities of medical science.

Paternalism always involves some form of interference with or opposition to another's wishes. This can manifest either as force and coercion, or as deception, lying, and the manipulation or nondisclosure of information. In health care paternalism is therefore understood as "the intentional non-acquiescence or intervention in another person's preferences, desires or actions with the intention of either avoiding harm to or benefiting the person" (Beauchamp & Childress 1994:274). This definition is normatively neutral in that it does not presume that the paternalistic action is either justified or unjustified.

In 1935 Henderson (Quoted by Beauchamp & Childress 1994:276) argued that the primary principle of medicine is to do no harm. "You can do harm by the process that is quaintly called telling the truth. You can do harm by lying... But try to do as little harm as possible, not only in treatment with drugs, or with the knife, but also in treatment in words." Henderson thus proposed that information which in the physician's opinion might harm a patient, should be withheld from that patient or only disclosed to the family. He believed that undue reverence for the patient's autonomy was dangerous as it compromised clinical judgement and posed a hazard to the patient's health. This appeal to non-maleficence and often to beneficence has long been regarded as the justification for paternalistic action.

There is however a prominent school of thought that appeals to consent to justify paternalistic intervention. Consent theorists like John Rawls and Gerald Dworkin believe that completely rational agents would consent to a limited authorization for others to control their actions by paternalistic policies and interventions; hence paternalism becomes a type of 'social insurance policy' individuals would subscribe to in order to protect themselves. Rawls and Dworkin argue from the Kantian conception of what a fully rational and autonomous person would consent to in a set of hypothetical situations. This seems attractive since it attempts to incorporate both the principle of beneficence and respect for autonomy, so that paternalistic actions do not override autonomy, but indeed respect it. But as Beauchamp and Childress (1994:281) correctly point out, it does not incorporate the individual's *actual* consent and will therefore always be open to the possibility of abuse. It would thus seem as if "appeals to consent obscure more than they

clarify the issues.” Beauchamp and Childress’ (1994:281) solution is one where only beneficence can justify truly paternalistic actions, and only in a way where benefit is balanced with autonomy interests. “Thus, preventing minor harms or providing minor benefits while deeply disrespecting autonomy has no plausible justification; but preventing major harms or providing major benefits while only trivially disrespecting autonomy has a highly plausible paternalistic justification.” This however remains controversial.

Passive paternalism constitutes a physician’s refusal to execute the positive preferences of a patient for paternalistic reasons. This is more readily justified than active paternalism as “physicians generally do not have a moral obligation to satisfy the patient’s desires when they are incompatible with acceptable standards of medical practice or are against the physician’s conscience” (Beauchamp & Childress 1994:288).

In 1971 Joel Feinberg developed the distinction between weak and strong paternalism. Weak paternalism entails interventions to prevent *substantially non-voluntary* conduct, as in cases of compromised ability, dysfunctional incompetence or cases with an encumbrance in deciding, willing or acting (e.g. severe depression or addiction where rational deliberation is impossible or cases of consent that are not adequately informed). Feinberg argued that weak paternalism should not be seen as ‘real’ paternalism and most contemporary commentators agree that some acts of weak paternalism can be justified. By contrast, strong paternalism involves intervention in cases where choices are informed, voluntary and *substantially autonomous*. Antipaternalists hold that strong paternalistic interventions display disrespect towards autonomous agents by failing to treat them as moral equals, “treating them as less than independent determiners of their own good” (Beauchamp & Childress 1994:278). According to this view, the rightful authority resides in the individual.

Proponents of paternalism argue that patients are often incapable to make fully informed and reasoned decisions because of some impediment following from their illness or injury. Secondly, because of the explosion of medical information and the complexity of

diagnostic and treatment possibilities, even educated and intelligent patients may not possess the requisite knowledge and cognitive skills to make decisions that would yield maximum benefit. Since the layman's perceptions cannot compete with the expertise of the physician, it is prudent for the physician to lead the patient on the path to recovery. "Together, the physician's *duty* to benefit patients and his *ability* to do so form the justification for his authority to overrule or ignore his patient's wishes" (Van Zyl 1997:42). To these charges proponents of autonomy reply that patients should be safeguarded by legal protection of autonomy rights precisely because of the power differential that stems from the patient being ill and medically ignorant, and the physician being healthy and medically knowledgeable. It is hoped that patient rights will correct this imbalance by insuring that patients will be given due consideration and respect as individual human beings. They also remind doctors that "a physician often cannot heal a person just by curing a disease, especially if the physician systematically ignores or disregards the patient's view" (Pellegrino & Thomasma 1988:23).

A classic example of disputed paternalistic action involves suicide intervention. The state, religious institutions, and health care professionals have all traditionally proclaimed jurisdiction to intervene in cases of attempted suicide. But "[d]o individuals have a moral right to decide about the acceptability of suicide and to act unimpeded on their convictions?" (Beauchamp & Childress 1994:285). John Stuart Mill believed that intervention is only justified in order to determine the quality of the person's autonomy. Once it has been determined that the person's actions are indeed substantially autonomous, further intervention is unjustified. But Beauchamp and Childress (1994:286) argue that failure to intervene communicates to potential suicides a lack of communal concern and diminishes our sense of communal responsibility. Physicians have fundamental commitments to caring, healing and preserving life, and condoning suicide would undermine these commitments and erode the trust patients have in physicians to act in their best interests (Landman 1997:868). Furthermore, many patients who attempt suicide are not sufficiently autonomous as they are mentally ill, clinically depressed, or

destabilized by a crisis. They believe that if the attempted suicide stems from depression or is indeed a cry for help, a failure to intervene shows disrespect for the patient's deepest autonomous wishes, including his/her hopes for the future.

Willem Landman (1997:867) of the Ethics Institute of South Africa, however holds that "respect for autonomy is a fundamental ethical principle which asserts that competent persons have a moral right to make their own choices, even choices about their continued life, and to act upon them." Moreover, the South African Constitution "speaks of a right to life, but not of a duty to live. Given their conceptual logic, rights may be waived. If continued life is no longer in somebody's best interest that person should be free to waive the right to life" (Benatar *et al.*:1997:3). Landman (1997:867) further argues that assistance with suicide is morally equivalent to the withholding or withdrawing of life support, which is widely regarded as ethically acceptable. "All these practices have a benevolent motive, result in death and may have the same consequences for others, like family and health care providers." He also believes that death is not necessarily the enemy that should be avoided at all costs, and that physicians who attempt to preserve life at all costs overextend their powers over life and death. There are unfortunately tragic situations where physicians are unable to heal or preserve life, and when assistance with dying constitutes appropriate care. There seem to be occasions in health care where it would be appropriate to step aside and allow a suicide, and even to assist in a suicide.

Many health care providers are however concerned that laws to legalize physician-assisted suicide or to discourage suicide intervention might encourage suicides by persons who are not substantially autonomous, especially those that are terminally ill and in need of care and resources. These laws might also encourage insensitive attitudes on the part of health care professionals and patients, especially in a system focused on cost reduction. They are scared that safeguards put in place to regulate suicide might be eroded over time and that society might slide down the slippery slope of allowed suicide to physician assisted suicide to involuntary active euthanasia. Where does one safely and appropriately draw the line? Once again the opposition between paternalism and autonomy appears to be insurmountable.

## **5. ANTITHESIS: AUTONOMY:**

### **5.1 Universal Human Rights:**

Western societies no longer revere doctors' authority to make decisions on behalf of patients. The doctor-patient relationship is now one between equals with an emphatic recognition of patients' rights to make free and fully informed decisions in all matters affecting their lives and health. There is also a growing recognition of and respect for the diversity of values and beliefs held by different individuals and different societies.

#### **5.1.1 The Origin of Human Rights:**

“Human rights are fundamental international moral and legal norms that aim to protect people from severe social, political, and legal abuse, simply because one is a human being” (Hayden 2002:155).

The general notion of universal human rights has antecedents in ancient Greek and Roman law and medieval political theology. The roots of its conception are in the doctrine of natural law which was developed in ancient Greece through a debate that focused on the contrast between two concepts thought to be integral to an understanding of human affairs: *nomos* and *phusis*. *Nomos*, which can be translated as ‘autonomy’ or ‘self-rule’, referred to established customs and positive laws (laws that depend entirely on the legislative actions of human beings). Since these laws varied between societies - and even within societies - and typically changed over time, what was *nomos* was changeable. *Phusis*, translated as ‘physics’, by contrast, referred to what was unchangeable: nature or reality. Plato believed that there existed an unchangeable moral reality, but one of which human societies – with their variety of conventional practices – were largely ignorant. Knowledge of goodness could be achieved by penetrating beyond the veil of appearances to the hidden, unchanging reality of the ‘forms’. Plato thus rejected the claim of the Sophists that morals and laws were merely conventional constructs, and held that human behaviour was subject to an ‘unwritten law’, whether understood to be imposed by the

gods, or a rule to which the gods themselves were subject (Buckle 1991:162). Plato thus planted the seeds of natural law ethics, which was further developed by Aristotle.

In the *Nicomachean Ethics*, Aristotle distinguished between two kinds of justice: legal (or conventional justice) and natural justice, “which everywhere has the same force and does not exist by people’s thinking this or that” (Quoted by Buckle 1991:162). But in sharp contrast to Plato’s view, Aristotle did not believe that the natural was unchangeable, but rather that change occurred as the result of the natural inner workings of a being<sup>9</sup>.

Accordingly, if one were to determine what human nature was, one had to discover the inner principle governing distinctly human life, and this was reason. Aristotle thus provided the raw materials from which the Stoic philosophers and their Roman descendant, Cicero, constructed the principles of natural law. The Stoics developed a deterministic account of the cosmos in which the interconnectedness of all things was a central theme. Human reason was seen as a spark of the creative fire – the *logos* – that ordered the universe. The natural law, or the law of nature, was thus the law of *human* nature, and this law was reason (Buckle 1991:163-164).

The Roman lawyer, Cicero, rejected the metaphysics of the Stoics and set out to prove that the laws governing human conduct were indeed founded in nature, but by virtue of the more-or-less universal and equal possession of certain human features: upright posture, speech and expressive features, a natural sense of fellow-feeling, and rational thought. He formulated the most famous account of the natural law in his *Republic*: “True law is right reason in agreement with nature; it is of universal application, unchanging and everlasting... Whoever is disobedient is fleeing from himself and denying his human nature, and by reason of this very fact he will suffer the worst penalties, even if he escapes what is commonly considered punishment” (Quoted by Buckle 1991:164). A naturalistic conception of rights thus draws upon specific characteristics of the ‘universal

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<sup>9</sup> For Aristotle, a thing’s nature was its inner principle of change e.g. a plant changes over time from seed to seedling to mature plant and eventually dies. These changes are natural because they are in accordance with the inner principles that govern its development and decay. These changes are contrasted to those that result from external factors e.g. the effects of human intervention (Buckle 1991:163).

human nature' as the basis for human rights: rights are seen as traits of individuals that they bear because of their humanness (Van Niekerk & Van Zyl 1996:140).

Hugo Grotius (1583-1645), the Dutch philosopher and father of modern international law, translated natural law into a theory of human rights. In his famous treatise *On the Law of War and Peace*, he formulated the idea that the moral domain could be construed as a body of individual rights. He said that the law could be understood as "a body of rights..., which has reference to the person. In this sense a right becomes a moral quality of a person, making it possible to have or to do something lawfully" (Quoted by Buckle 1991:168). He thus invested the individual with an independent moral significance and changed the perception of morality from that of a "cluster of obligations generated by the patterns of interdependence of human social life", to that of "the result of voluntary transactions between independent moral agents" (Buckle 1991:168). Grotius was instrumental in the establishment of the modern notion of the moral significance of the separateness of persons.

The modern concept of rights was thus conceived in the late Renaissance and fully developed in the seventeenth century, particularly also through the work of the British political philosopher John Locke (1632 – 1704). (For our express purposes, it is interesting to note that Locke was a physician.) Locke championed civil liberty over royal authority and conceived of a social order in which individuals could associate freely with one another and share the goods of liberty, knowledge and enterprise. Locke was also a believer in a natural law, grounded in the reasonable nature of man. By virtue of such a law, there were natural rights to life, liberty, health and property, and of these, the right of property, in things with which men have mixed their labour, was cardinal (Barker, quoted by Jonsen 1990:86). Locke's ideas found expression in the American Declaration of Independence of 1776, in which the claims to the right to 'life, liberty and the pursuit of happiness' are fundamental.<sup>10</sup> In 1789 the French National Assembly followed suit and issued the Declaration of the Rights of Man and of the Citizen, which asserts the rights to liberty, property, security and resistance to oppression (Almond 1991:260).

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<sup>10</sup> Note that 'the pursuit of happiness' has been substituted for 'property'.

During the nineteenth and early twentieth century appeals to rights were mostly overshadowed by influential utilitarian and Marxist movements. During this time, and advocates of human rights would say because of this, unprecedented human rights violations occurred, especially during the Second World War. Ever since, declarations of rights have been more comprehensive and far-reaching, often taking the form of international agreements. The European Convention for the Protection of Human Rights and Fundamental Freedoms (1950) gives legal force to the countries endorsing it and the International Court at The Hague judge cases of alleged violation. The United Nations' Declaration of Human Rights (1948), though mainly a statement of aspiration, is supported by the more specific International Covenants on Economic, Social and Cultural Rights and on Civil and Political Rights (1976). In contrast to the eighteenth-century rights that were mainly protective and negative, entailing the freedom of individuals from governmental interference, the modern concept of rights incorporates a positive element by including rights to various kinds of welfare goods (Almond 1991:260). These 'positive' rights require the promotion of governmental policies designed to create the social conditions that enable individuals to flourish (Hayden 2002:150).

Drawing on the distinction between 'positive' and 'negative' rights, human rights are often delineated according to three stages. Civil and political rights – the so-called negative rights – are defined as first-generation human rights, and economic, social, and cultural rights – the 'positive' rights - are defined as second-generation rights. More recently a third generation of human rights have been articulated: so-called 'solidarity' rights that include the right to development, a healthy environment and peace. These rights inhere in groups and stem from the recognition of the broad common interests of humanity, particularly to certain basic conditions of life that are indispensable to the promotion of human dignity and well-being and to the effective fulfilment of other human rights. Although all human rights are essentially indivisible and interdependent, these distinctions serve an analytical and pragmatic purpose by identifying the character and content of different types of rights (Hayden 2002: 149-150).

A prime example of the three generations of rights can be found in the South African Constitution, as adopted in 1996. The comprehensive Bill of Rights enshrines the inalienable rights of all South African citizens and aims to ensure equality, dignity and freedom for all. "Equality includes the full and equal enjoyment of all rights and freedoms" (R.S.A. Constitution 1996:5). Apart from negative rights such as freedom and security of the person, freedom of expression and association, freedom of movement and residence, and specific property rights, South African citizens can claim among others, the right to housing, the right to health care, food, water, social security, the right to education, and the right of access to information.

Rights are not seen as merely claims to certain freedoms or benefits; they are claims against certain parties to act so as to make those freedoms or benefits available (Hayden 2002:154). To qualify as a human right, at least four criteria need to be satisfied as individually necessary and collectively sufficient conditions of a justified claim. First, proponents have to demonstrate that the proposed rights-holders have a strong claim to the object of the right by showing that the object is of great value to the individual and society, and that these values are frequently imperilled by military or political abuse. Second, it has to be shown that this claim cannot be adequately satisfied by weaker forms of protection (e.g. diplomatic disapproval or mass non-violent movements). Third, it must be demonstrated that the parties that bear duties under the right can legitimately be subjected to the negative and positive duties required for compliance with and implementation of the right. Finally, the proposed right must be practicable in the current economic climate with the available institutional resources (Hayden 2002:156).

It is therefore argued that certain claims to rights are unjustified when the financial resources and institutional endeavours needed to implement those rights are limited or unavailable, and it therefore proves to be impossible for duty-bearers to satisfy the obligations following from those rights.

### **5.1.2 The Justification of Rights:**

However pervasive the language of rights might be, its justification remains contentious. John Stuart Mill offered a justification based on utility: principles such as liberty and justice contribute to happiness in the long run. But contemporary philosophers like the American, John Rawls, is convinced that the principle of utility is incompatible with the notion of social cooperation among equals for mutual benefit. He contends that no rational person would agree to a scheme merely because it maximized the mathematical advantages, irrespective of its implications for the individual's interests. This is counter-intuitive. "The right is prior to and independent of the good, and cannot be defined as that which will promote or maximize the good" (Nagel 1995:745). A utilitarian justification can therefore not give priority to rights.

Following in the footsteps of theorists like Hobbes, Locke and Rousseau, Rawls developed one of the most influential justifications of rights in the form of a social contract theory. Rawls' main objective, 'justice as fairness', aimed at a conception of justice divorced from all that seemed inconsistent from a moral point of view and sought to eliminate the inequality of natural capabilities and the randomness of social circumstances. He thus conceived of a hypothetical social situation he called the 'original position' where no one knows any of the socially significant facts about themselves: race, gender, religion, social status and class position, natural abilities, not even what their conception of the good life would be. Behind this so-called 'veil of ignorance' rational parties have to decide on the principles they would agree to on the basis of a desire of each to further his/her own aims and interests (Nagel 1995:745). They are thus expected to decide in advance what the foundation and guiding principles of their society will be, and Rawls believes that those principles would be basic conditions of liberty and qualified equality. Since no one is able to manipulate the decisions to advance his/her particular position, these principles are the result of a fair agreement between individuals as moral persons.

Rawls' contract theory thus offers an alternative to utilitarianism. Instead of choosing the theoretical maximisation of good, people in the 'original position' would rather choose two different principles, the first having priority over the second. The first is equality in the assignment of basic rights and duties and the second the so-called 'difference principle': "social and economic inequalities - for example inequalities of wealth and authority - are just only if they result in compensating benefits for everyone, and in particular for the least advantaged members of society" (Rawls 1971:14-15). Since everybody's welfare depends on successful cooperation, advantages should be divided in such a way that all, even the worst off, would be willing to participate. Although Rawls acknowledges that people do not enter into any society voluntarily in the literal sense, he contends that a society that complies with the principles of justice as fairness comes as close as possible to a voluntary scheme, since its members are autonomous and the obligations they acknowledge are self-imposed (Rawls 1971:13).

Rawls' view is an egalitarian view of liberalism. The strength of his argument lies in the condemnation of racial, sexual and religious discrimination, and the rejection of all forms of persecution, discrimination and political oppression. Equal opportunity ensures that everyone with equal ability and motivation has an equal chance of success, regardless of the class they are born into. The difference principle ensures that unequal abilities can produce differential rewards only to the extent that it is good for all (Nagel 1995:745). Furthermore, Rawls moves away from the idea of morality as determined by the self-governing individual. He believes that problems of justice cannot be resolved by decisions individuals make separately; the issues are too complex. Justice can only be achieved through mutual agreement (like in a social contract). "Rawls thus tries to combine an Hegelian recognition of community with a reinterpretation of the Kantian insistence on autonomy" (Schneewind 1991:156).

The Kantian notion of abstraction that Rawls supports, leads to two of the major criticisms of his theory. Firstly, since the approach is purely abstract with no content, it does not guide everyday decisions. It leaves society to battle out the application of the principles and can therefore potentially generate a lot of controversy and animosity.

Secondly, theorists like Nancy Fraser (1995:68) have argued forcibly against the concept of the 'original position' since it requires people to negate all the differences that make them unique - race, gender, ethnic group, religion, etc. Fraser believes that these differences are fundamentally important in the way they influence decisions and ambitions. Similarly, in the African context, Kwame Anthony Appiah in his book *In my Father's House* argues for the importance of acknowledging difference: "The psychology of race has led, that is, not only to a belief in the existence of a peculiar African *form* of thinking but also to a belief in special African *contents* of thought." "Yet nothing should be more striking for someone without preconceptions than the extraordinary diversity of Africa's peoples and cultures" (Appiah 1992:24). I believe that although the acknowledgement of difference is surely important, it does not preclude the use of social contract theory. The most fundamental criticism, however, rests on the fact that social contract theory fails to supply a justification for rights since it seems to require a prior commitment to the rights it seeks to justify (Almond 1991:265).

Human rights are popularly justified for broad normative reasons: they secure claims to life, liberty, equality and fairness and in so doing protect our fundamental interests and central human capabilities (Hayden 2002:155). Rights safeguard what the contemporary philosophers, Amartya Sen and Martha Nussbaum, call 'central human capabilities' – those functions characteristically performed by human beings that 'are so central that they seem definitive of a life that is truly human' (Nussbaum 1999:39). These include:

1. *Life* - being able to live to the end of a human life of normal length.
2. *Bodily health* - being able to have good health, being adequately nourished and having adequate shelter.
3. *Bodily integrity* - being able to move freely from place to place, secure against violent assault, and having opportunities for sexual satisfaction and choice in matters of reproduction.
4. *Senses, imagination and thought* – being able to imagine, think and reason, informed and cultivated by an adequate education; being able to experience and
5. produce expressive works and events of one's choice; being able to use one's mind protected by guarantees of freedom of expression with regards to political

and artistic speech, and freedom of religious exercise; being able to have pleasurable experiences and to avoid non-beneficial pain.

6. *Emotions* - being able to have attachments to things and persons outside ourselves.
7. *Practical reason* - being able to form a conception of the good and to engage in critical reflection about the planning of one's own life.
8. *Affiliation* - being able to live for and in relation to others and to have the social bases of self-respect and non-humiliation.
9. *Other species* - being able to live with concern for and in relation to animals, plants, and the whole of nature.
10. *Play* - being able to laugh, play, and enjoy recreational activities.
11. *Control over one's environment in a political* - having the rights of political participation, free speech and freedom of association - and *material sense* - being able to hold property and seek employment on an equal basis (Hayden 1999:153).

Philosophers and politicians alike are however still divided on the issues of the origin, justification and validity of rights. Jeremy Bentham (1748 – 1832), the founder of utilitarianism, famously dismissed the notion of natural rights as nonsense, and absolute natural rights as “nonsense upon stilts” (Almond 1991:266)! Akin to the criticism levelled at Rawls' ‘original position’, natural law theories have been attacked by modern utilitarian thinkers for being unable to accommodate human diversity within its unified system of distinctly human goods. They hold that human diversity is so deeply rooted, and the realm of human values so fragmented, that it cannot be comprehended by general principles of human nature.

Karl Marx argued against basing social and political change on rights because such rights “supposedly are predicated on the egoistic separation of humans from one another and weaken the bonds of community relations” (Hayden 2002:157). Subsequent Marxist thinkers have followed this pessimism by arguing that, because rights provide the individual with independent and inalienable moral standing outside the community, they do not fit in with the cultural and historical relativism that is central to Marxist theory.

Marxists view the needs of the individual as subordinate to the needs of society in the march of social progress, and thus tend to be sceptical about the validity of individual rights. From the other side of the political spectrum, conservative thinkers have also argued against rights, but because it undermines the integrity of culture and customs as these are context dependent and not universal. The pressure for recognition of rights by Western liberal nations has been interpreted as cultural imperialism and has been rejected by conservative religious societies like Islam (Almond 1991:267).

Furthermore, it has been argued that rights are not characteristic of a being as such, but should rather be seen as claims that are made on other people: "... that someone has a right to something, implies that there is someone else against whom s/he has a right" (Van Niekerk & Van Zyl 1996:140). Rights are thus better thought of as conventions adopted by individuals for the purpose of regulating interactions in a community. One therefore cannot talk about rights without also mentioning responsibilities. On this conception it is therefore preferable to talk about 'participating in rights-relations' rather than claiming to 'have rights' (Van Niekerk & Van Zyl 1996:140).

Against all these criticisms, some advocates of rights argue that rights require no further justification; that they are "morally exigent in themselves" (Almond 1991:265).

Furthermore, the language of rights is widely understood and respected under all types of political regime, and therefore provides an accepted 'international currency' for moral and political debate. A pragmatic advantage of rights-based vocabulary is that it focuses on issues from the point of view of the victim or the oppressed, rather than from the perspective of those in power, and is thus integral to equality in society. Similarly, since rights have legal innuendos that suggest that the use of force might be justified in securing them, they are powerful agents in the battle for social justice.

But even if rights were self-justifying, they cannot stand on their own; they are only one element of a universal morality. Alasdair MacIntyre (1999:2&6) recently offered a critique of the entire state of moral philosophy based on the argument that we have lost an understanding of the importance of living in, and being radically influenced by, a

community and a tradition, and are therefore unable to make substantive, generally accepted moral judgements, for instance about contentious issues such as abortion, euthanasia and justice. MacIntyre (1999:52-53) alleges that morality can only make sense within a conceptual scheme that reinstates the idea that man has an ultimate purpose, or *telos*, in the world. It is based on the work of Aristotle and supplemented by St. Thomas Aquinas, and consists of three elements: “untutored human-nature-as-it-happens-to-be, human-nature-as-it-could-be-if-it-realized-its-*telos*, and the precepts of rational ethics as the means for the transition from one to the other.” Modernity replaced this teleological model of explanation with a deductive-nomological model with the consequence that moral disputes came to be viewed as independent of the historical context and traditions that inform them. MacIntyre concludes that ethics can only become coherent when we cease worrying about rules and principles that supposedly have universal validity for all rational people irrespective of their communal ties, and start asking what sort of people we ought to become; in other words, when virtue once again becomes the central category of morality.

Rights should therefore not be seen as political or moral ‘trumps’ – as envisioned by Ronald Dworkin – that can decide an issue irrespective of the circumstances surrounding and the consequences of the action. Rights remain integral to moral discourse, but as one feature among many competing *prima facie* duties and principles (Dancy 1991:227). The ultimate justification of rights would appear not to be the observation that they are universally accepted, but rather that, by contributing to the realization of human flourishing, they have the *potential* for securing widespread agreement and acceptance (Almond 1991:267).

There do however remain a few unanswered questions. Brenda Almond (1991:264-266) raises the following: Who or what can have a right? What can be the object of a right? How can rights be justified? Are rights inalienable? Are there absolute rights? Furthermore, a simple theory of rights fails to account for the moral significance of motives, supererogatory actions, and virtues. I have two specific concerns with the prevalence of rights-based language in medicine: firstly, the intransigent insistence on

rights can isolate individual patients at a time when they need to be enveloped in a caring, healing environment. Remember that Buytendijk (1961:10) said: “man is a creature, who, despite all moral and religious ties, remains physically vulnerable in his existential loneliness and desire for society”. Secondly, the language of rights is often unnecessarily adversarial and might lead to the neglect or undermining of sympathy and trust when these are most needed in a time of illness. Norman suggests that the focus should not be on rights as such, but rather on a more basic account of human needs.

Both doctors and patients however frequently lay claim to special rights.

### **5.2 Doctor's Special Rights:**

The notion of special rights for doctors stems from the Middle Ages when physicians formed guilds and received special privileges for services rendered. During Locke's time the philosophical grounds for these rights were established and rested on two principle convictions. The first belief was that only those who ascribed to certain systems of medical science should be recognized as physicians and licensed to practice. All unorthodox practitioners were slated as quacks and denied a licence. This move was justified by the claim that orthodox medicine conformed to current science and therefore embodied 'true knowledge'. This belief was strengthened as proof of the efficacy of orthodox medicine started to appear by the second half of the nineteenth century, through the methods of inoculation, aseptic surgery and bacteriology (Jonsen 1990:87-89).

Secondly, it was held that the transactions between physicians and patients created a special relationship between them over which the physician exercised authority. This belief was justified by the perception that patients could only receive the benefits of medicine within the privacy of a relationship in which the physician ordered the regime and the patient complied, hence the adage “on doctor's orders”! These claims asserted that physicians should exercise jurisdiction over a range of activities - specifically the teaching and practicing of medicine, as well as the specifics of the physician-patient interactions - and that others, e.g. employers of physicians, insurers, or governments,

were obliged to acknowledge this authority and refrain from interfering. The authority of the physician, resting on his expertise, benevolence and intention to structure the relationship to the benefit of the patient, was essential (Jonsen 1990:88-90).

The social and economic arrangements of the doctor-patient relationship were also structured in these times, in terms of rules governing consultations, fees, advertising, and criticism of colleagues. The establishment of licensure contributed to the formation of a profession in the modern sense: “Its members share an identity, a language, lifetime membership, self-regulation, values, explicit social boundaries, and implicit socialization of new members. Professionals enjoy autonomy based on knowing what is best for the client, subjecting their decisions only to peer review, and establishing standards of behaviour through their organization” (Jonsen 1990:87). Through licensure, the state effectively delegated the authority to educate, admit, and discipline its members to the profession.

In America the medical licence was protected as a property right. Doctors can therefore view their practices as property, brought into existence by their training and hard work. They offer services that can be priced and purchased. Those who wish to be helped enter into a fiduciary contract with the doctor in which they entrust themselves to the doctor’s care and benevolence. The doctor sets the conditions for the contract and oversees the patient’s compliance. If the patient fails to comply, or if treatment is unsuccessful because nature did not react as predicted, the doctor is effectively absolved of responsibility; the patient, however, remains responsible for payment. Solo practice, on a fee-for service basis following the rules of free enterprise envisioned by Locke, was considered to represent the ideal social and economic circumstances for a successful doctor-patient interaction (Jonsen 1990:91-92).

Jonsen (1990:92-93) in his book, *The New Medicine and the Old Ethics*, claims that doctors not only believed that they had a right to structure their practices as they saw fit, but also that they had a right over disease as such! John Locke said: “whatsoever a man removes out of the state that nature hath provided and left it in, he hath mixed his labour

with it and joined to it something that is his own, and thereby makes it his property.” On Jonsen’s interpretation, “medical skills constitute the labor that the physician mixes with the natural entity of disease and, in doing so, dominates it and makes it his property.” Thus, although the disease might be in the patient, it belongs to the physician who has a right to destroy it. In order to gain access to the disease, the doctor has to contract with the patient to renounce certain freedoms in order to obtain the benefits that the doctor has to offer. However capricious this interpretation might be, it is true that many contemporary doctors do act as if they had an independent right over disease. Patients often complain that mainstream doctors seem only to be interested in the disease as such, and not in them as patients. Doctors seem indignant when a patient refuses treatment, or in Jonsen’s (1990:94) words “if prevented by the patient, or by other interfering bodies, from getting at the site of disease and mastering it.”

These special rights of doctors were bound to be challenged. Lockean rights in medical practice came effectively to an end in England in 1946 with the passing of the National Health Service Law, and in America in 1965 with the institution of compulsory national health insurance in the form of Medicare and Medicaid. Since the government now had an interest in controlling costs, it started limiting payment, reviewing quality of care, and promoting more cost-effective prepayment group practices. In recent years the South African government has effected sweeping changes in the entire medical field. Their reformation commenced with the training of medical doctors where they remodelled the curriculum to incorporate an orientation towards primary, community-based care with less focus on specialist knowledge traditionally reserved for tertiary institutions. In 1997 they introduced an additional year of training over and above the existing seven, in the form of community service. Despite many objections, the Department of Health reserves the right to allocate posts according to their judgement, with seemingly little regard for the wishes or circumstances of individual doctors.

In 2002, the government announced its intention to implement significant changes in the Medicines and Related Substances Control Amendment Act, to be implemented by the end of the year, in order to curtail escalating medicine costs. According to the proposal,

pharmacists will no longer receive a percentage mark-up on medicine, but rather a 'professional dispensing fee', which will give them an incentive to dispense cheaper generic medication rather than so-called ethical medication. The Act will also make it easier to substitute generics for more expensive brand-name drugs, since, at the moment, pharmacists may only do so with the permission of the prescribing doctor. These amendments have resulted in jitters rippling through the industry (Changes to law on drugs causes jitters 2002). Also on the cards are changes to medical licensing whereby doctors will only be granted licences for new practices in areas of demonstrated need, and possibly an end to the dispensing rights of general practitioners. Never before has the government or any other regulating body managed to transform the face of medicine to such an extent. The profession has however reacted with scathing criticism of these proposals, maintaining that care will be undoubtedly be compromised.

Jonsen (1990:92) alleges that behind the indignation the medical profession feels at any attempt to interfere with the practicing or prescribing of medicine, may hide a belief that the "very essence of being a physician" is being challenged. "The feeling of being beleaguered arises when one's property is invaded, when one's rights are infringed" (Jonsen 1990:94). Since doctors view their work, and disease as such, as their property, they become irate when others (i.e. patients, regulators, insurers, lawyers) attempt to erect barriers between them and the sphere of work that is 'rightly' belongs to them. On this interpretation it makes sense that 'a profession under siege' has built around itself a fortress of rights in order to protect their property.

It would seem as if the walls of the fortress are crumbling however. While the profession has been quite outspoken in its criticism of third party interference, it seems to be powerless to stem the tide of change flooding their erstwhile 'property'. In addition to increasing government intervention, the authority of doctors has been challenged on other fronts. The extension of legal restraints in areas where doctors previously exercised personal discretion has initiated a culture of litigation - the American example being the most notorious. The rapidly changing technological context of medicine with its ability to make pre-natal diagnoses and sustain life artificially, has raised the question whether

doctors are qualified to make these crucial decisions. The popular conception of the 'right to health care' (Jonsen 1990:96) has even challenged the professions' age-old right to a fee for service.

The benevolent intent of doctors has also increasingly been questioned. The introduction of the ethical and legal requirement of 'informed consent' made many doctors feel indignant since their discretion and judgement were now openly called into question. It seems that doctors seem to feel beleaguered when patients started reclaiming the right over their bodies and minds. Patients further complain that even when doctors are acting benevolently, they exhibit a tendency to apply their skills in the authoritarian manner of a parent toward a wayward child (refer discussion of paternalism in Chapter 3). For too long patients have been 'infantilised' by doctors, denied the opportunity to make their own decisions regarding their bodies and the diseases that might afflict them. The South African Medical Association (SAMA) has taken these allegations to heart and followed the international example by reformulating their SAMA Member Credo (2000). They supplemented the Hippocratic version of the credo stating: "I will therefore strive to use my knowledge and skill to promote and protect the health of my fellow human beings", to include amongst others: "I will strive to foster a good relationship with my patients based on mutual respect, communication and trust", and "to respect the right of my patients to full information about their condition in order to take informed decisions regarding acceptance or refusal of proposed treatment."

Doctors of today are of course still products of their environment and in such an individualistic, rights-orientated society as ours, it is only to be expected that they will be focused on their rights and demand that those be respected. They view regulatory requirements, institutional restrictions, insurance limitations, malpractice threats and patient pressures as infringements on their right to practice good medicine according to their "ability and judgement". They oppose managed care since it will impair their right to provide optimum care for their patients, and resist measures to control income, choice of speciality, and place and mode of practice, since it infringes on their right to earn a living. Dr. Robert Sade voiced this sentiment when he wrote: "Any physician can say to

those who would shackle his judgement and control his profession: I do not recognize your right to my life and my mind, which belong to me and me alone.” He continued: “Medical care is neither a right or a privilege: it is a service that is provided by doctors and others to people who wish to purchase it. It is the provision of his service that a doctor depends upon for his livelihood” (Quoted by Jonsen 1990:82-83)

Dr. Sade’s words found widespread appeal in medical circles. It appears to me as if the prominence given to patients’ rights in recent years has made doctors more aware of their own rights as well. While they mostly acknowledge and respect the rights patients are increasingly demanding, they are insisting that their own rights should receive similar acquiescence.

### **5.3 Patients’ Rights:**

Before considering various patients’ rights, I would like to place it in context by examining the history of the basic right to health care. Historically, the right to health care was one of the last to be proclaimed in the constitution of most countries. While a number of other human rights are specifically mentioned in constitutions of the eighteenth and nineteenth century, there are no references to the right to health. At international level, the Universal Declaration of Human Rights established a breakthrough in 1948 by proclaiming that “[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family including food, clothing, housing, and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control” (World Health Organisation 1976:10).

The Preamble to the WHO Constitution similarly affirms that it is one of the fundamental rights of every human being to enjoy “the highest attainable standard of health” and that “governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.” In 1970 Resolution WHA23.41 of the World Health Assembly went even further by declaring without

qualification that “the right to health is a fundamental human right” (World Health Organisation 1976:10). Although the right to health can be interpreted as a negative right in that a person may not be deprived of his/her health by the action of another, it seems as if the World Health Assembly conceived of the right to health in a positive way, in the sense of a right to health care: in this context it is a legally enforceable right in that a legal duty to provide such care can be created and applied to individuals and communities (World Health Organization 1976:11). The South African government acknowledged this right for the population of pregnant women and children below six years of age, by providing them with access to free health care. The extent to which the duty to provide health care can actually be enforced remains unclear, however, but most ethicists agree that people should be able to claim a right to equal access to health care and a right to at least a decent minimum of health care (Beauchamp & Childress 1994:355). An absolute right to health however remains controversial.

The right to health has to be considered in relation to a number of other rights, such as the right to food, clothing and housing - which are fundamental components of health - and the right to freedom and privacy, which may on occasion need to be curtailed. Specific human rights, like health and personal liberty, may under certain circumstances conflict with one another, and then the right of the freedom of the individual might have to be restricted for the sake of the health of the greater society<sup>11</sup>. The right to health may thus involve duties to preserve the general welfare and the rights of the community; duties that may override the right of the individual citizen. The attainment of the right to health may also vary considerably between nations because of differences in standards of living and economic and educational conditions. Although the right to health constitutes a fundamental human right, it is clearly not a panacea the individual can resort to for the fulfilment of all his/her wishes.

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<sup>11</sup> For instance, measures for the control of communicable diseases such as quarantine or vaccination may be considered as infringements of personal liberty, but must none the less be accepted for the sake of the protection of the community. At the Thirteenth World Health Assembly it was stated: “Vaccination is not simply a private affair. Indeed, it is essentially a community matter, since the objective of most vaccination programmes is to produce a herd immunity” (World Health Organization 1976:43).

In the last three decades, advances in technology and medical treatment have refocused attention on the protection of the individual's right to health. On 19 December 1968 the United Nations General Assembly, in resolution 2450 (XXIII), asked the Secretary-General and the executive heads of the relevant specialized agencies to address the problem of the "[p]rotection of the human personality and its physical and intellectual integrity, in the light of advances in biology, medicine and biochemistry" (World Health Organization 1976:7). They specifically tackled thorny issues such as abortion, artificial insemination, human research, tissue and organ transplantation, and psychosurgery, and paid special attention to the patient's right to autonomy.

### **5.3.1 Patient Autonomy:**

One of the fundamental human rights in health care today is the right to autonomous decision-making. This right also stems from the philosophy of the Enlightenment era with the German philosopher and founder of critical philosophy, Immanuel Kant (1724 – 1804), being one of its principle promoters. He held that it follows logically from the principle of universalizability that respect for autonomy is a necessary feature of being a rational agent, and that this is only possible within the context of respect for the autonomy of all rational agents. A person's autonomy is violated when s/he is treated as a means to an end, i.e. when that person's own goals are ignored in pursuit of the goals of others. Kant's third formulation of the categorical imperative entails respectful treatment of persons as ends: "So act as to treat humanity, whether in your own person or in that of any other, never solely as a means but always also as an end" (Norman 1998:76). Accordingly, the autonomous decisions of rational beings should always be respected, regardless of the consequences.

John Stuart Mill (1806-73) developed this idea further in his essay *On Liberty*, which proclaimed individual liberty to be an essential component of the general good. Using a utilitarian argument, Mill argued that respect for autonomy would maximise human welfare since mature people generally know what is in their best interests. While it is inevitable that people will occasionally err, this is not sufficient reason to overrule their

autonomous decisions. People should be free to develop according to their personal convictions and pursue their own ends, provided they do not impede the similar pursuit of others. “[T]he sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection” (Schneewind 1967:320).

In health care the autonomy model is grounded in the dignity of persons and the claim they have on each other to privacy, self-direction, the establishment of their own values and life plans based on information and reasoning, and the freedom to act on the results of their contemplation (Pellegrino & Thomasma 1988:12). The recognition of the principle of patient autonomy signifies the reaction against paternalism as an attempt to safeguard the freedom and dignity of human beings as persons, as people who have goals of their own. This translates into being informed of one’s diagnosis, having access to one’s medical records, and having the final say in one’s treatment.

Alasdair MacIntyre believes that the problems of medical ethics are not those of the medical profession, but rather of patients. Because of the climate of moral pluralism, patients should not seek to return to tradition or authority; rather, they should make their own decisions regarding treatment. “[P]atients have to become agents” (Van Zyl 1997: 62). But this suggestion does not absolve physicians from at least partial responsibility for moral decision-making. The question is rather to what extent physicians should respect patient’s wishes, beliefs and values in deciding on the means and ends of treatment.

Beauchamp and Childress (1994:123), the authors of the influential book *Principles of Biomedical Ethics*, instrumental in defining the current bio-ethical landscape, analyse autonomy in terms of “normal choosers who act intentionally, with understanding, and without controlling influences that determine their action.” Since the last two conditions can both be satisfied to a greater or lesser extent, actions can be autonomous by degrees. While they hold that an unrealistic idea of autonomous action should be avoided and that only a substantial (not complete) degree of understanding and freedom from constraint are required, they believe that thresholds should be fixed in light of specific objectives in

specific contexts. Since theirs is a formal theory, the abstract obligation of the right to autonomy has to be specified in a particular context in order to become a practical guide for conduct and to note valid exceptions. Beauchamp and Childress do not give autonomy authority in the moral sphere, but views it as one of four principles – non-maleficence, beneficence, autonomy and justice - with only *prima facie* standing, open to the possibility of occasionally being overridden by competing moral principles.

The principle of respecting an autonomous agent entails for Beauchamp and Childress (1994:125) “at minimum, to acknowledge that person’s right to hold views, to make choices, and to take actions based on personal values and beliefs.” Such respect should manifest in attitude and action, and demands more than an obligation of non-intervention; it includes the obligation to maintain an agent’s capacity for autonomous choice. (This does not apply to persons who cannot act in a sufficiently autonomous manner and cannot be rendered autonomous.) The principle also entails the affirmative demand of “respectful treatment in disclosing information” (Beauchamp & Childress 1994:126) and is supported by the right to self-determination that is inherent in confidentiality, privacy, consent, and truth telling. This obliges professionals not only to disclose information, but also to probe for and ensure understanding in order to promote adequate decision-making.

The basic standard of autonomy is ‘express and informed consent’. The requirement of informed consent not only enables autonomous choice, but also protects patients from harm and encourages the medical professional to act responsibly in interactions with patients. Beauchamp and Childress argue that of the two ways of analysing informed consent - an *autonomous authorisation* by an individual for a medical intervention or for involvement in research, or the *social rules of consent* in institutions where legally valid consent must be obtained from patients before therapeutic procedures or research – the former should serve as a guideline for determining the moral adequacy of institutional rules. Seven elements of informed consent can be distinguished: threshold elements – competence and voluntariness – information elements – disclosure, understanding, and recommendation – and consent elements – decision and authorization.

i) Competence: The validity of consent centres on competence: whether a patient is capable, psychologically or legally, of adequate decision-making. Competency judgements serve a gate-keeping function by distinguishing patients whose decisions should be accepted from those that should not. Beauchamp and Childress (1994:133) believe: “[a] competent decision is necessarily one for which a person can be held responsible, and a general presumption should exist that adults are competent to make decisions.” A patient is competent to make decisions if she has the capacity to understand the material information, to make a judgement in the light of her values, to intend a certain outcome, and to freely communicate her wish to caregivers. If a patient is found to be incompetent, it is mandatory to establish whether capacity for autonomous decision-making can be restored. Competence should be understood as specific rather than global, since the criteria of particular competencies vary according to specific contexts. A patient’s competence might also vary as a function of time because of reversible or irreversible changes in intellect, language, and memory. The ability of patients to make decisions can be seen as a continuum; competence however, should be seen as a threshold below which a person will be deemed unfit for the specific task at hand.

The standards for determining competence remain controversial. All methods for assessing competence encounter the difficulty of whether to focus on the patient’s autonomy or on protecting the patient against harm. The rival standards of competence cluster around three kinds of abilities, from the weakest to the strongest: simple ability to state a preference, ability to understand information and appreciate one’s situation, and the ability to reason through a consequential life decision. Standards of competence should be connected to levels of experience, maturity, responsibility and welfare, such as in the sliding-scale strategy: “as an intervention in medicine increases the risks for patients, the level of ability required for a judgement of competence to elect or refuse the intervention should be increased” (Beauchamp & Childress 1994:138). Although this rightly incorporates the professional’s interest in ensuring a good outcome, Beauchamp and Childress (1994:140-141) allege that there is no basis for believing that risky decisions require more ability at decision-making than less risky decisions. They propose that this problem be resolved by holding that the level of evidence for determining

competence should vary according to risk, but that competence itself only varies along a scale of difficulty in decision-making. "It follows that judgements about whether to override patients' decisions should be distinguished from questions of whether the patients are competent."

ii) Voluntariness: Voluntariness involves the independence of the patient from others' manipulative and coercive influences, and takes the patient's right to refuse treatment seriously. Beauchamp and Childress advocate the establishment of general criteria for the point at which autonomous choice is endangered and advise health professionals to consider each person's resistibility to influence individually.

iii) Disclosure: Disclosure is understood as the provision of information that the patient and the professional deem to be material, the professional's recommendation, the purpose of seeking consent, and the nature and limits of consent. Three standards of disclosure are operative. The *professional practice standard* - determined by a profession's customary practices - faces the difficulties of determining customary standards, the possibility of perpetuating negligence, undermining the patient's right to autonomous choice, and the question whether doctors can decide what information are in their patients' best interests. The *reasonable person standard* - determined by reference to a hypothetical reasonable person - underscores the belief that the obligation to respect autonomy generally outweighs the obligation of beneficence. Unfortunately, the abstract and hypothetical character of this standard makes its practical implementation difficult, and it encounters the problems of determining what would qualify as 'material information' and a 'reasonable person', and whether the information for the reasonable is the same as for the individual patient. Lastly, the *subjective standard* judges the adequacy of information by reference to the specific needs of the individual, and is therefore the preferable moral standard of disclosure. Exclusive use of this standard is unfortunately insufficient since patients often do not know what information is relevant to their particular situation, and it would be unreasonable to expect doctors to do a character analysis of each patient to determine the information that would be relevant. Nonetheless, the focus should not be on the amount of information disclosed, but rather on what doctors can do to aid

informed decision-making. As such, Beauchamp and Childress advocate that legal and professional rules of disclosure should only initiate the communication process and that special attention should be paid to active participation through mutual exchange of information.

Van Zyl (1997:188) alleges that the legal requirement of informed consent as a means of protecting patient autonomy does not guarantee that the patient will receive the type or amount of information she requires. For instance, the more inquisitive may not receive the detailed information they require, while others might be bombarded with information they do not understand or do not desire to know. Furthermore, being informed of the relevant facts may not be sufficient for patients to make decisions that are in their best interests and correspond to their moral views and religious beliefs. The physician who relies solely on the consent of a patient would often fail to act according to the values of the patient, since s/he is unaware of the extent of that patient's dependency and vulnerability to fear, trauma, or ignorance. This is particularly true in a multi-cultural society like South Africa and highlights the importance of Beauchamp and Childress' insistence on active participation through mutual exchanges of information.

Although intentional non-disclosure of information is difficult to justify morally, Beauchamp and Childress do allow for situations where information might rightfully be withheld. They believe that the 'therapeutic privilege' may be used if the physician has good reason to believe that disclosure would render the patient incompetent to decide on treatment. Jonsen (1990:100) disagrees: "Therapeutic privilege depends on the perception of the radical inequality between patient and physician. In the democracy of present-day medicine this inequality is abolished by proclamation of the rights of patients, who now come to physicians as equal partners in care." The therapeutic use of placebos and the wilful withholding of information from research subjects are equally paternalistic and are frowned upon in the current ethical climate.

iv) Understanding: Disclosure is augmented by the concept of understanding. This concerns what professionals can do to facilitate good decisions based on substantial (not

necessarily complete) understanding and includes the essential features of what is authorised and the terms of the authorisation. Although the focus on effective communication is a more burdensome way of structuring the consent-solicitation process, it is needed in order to protect the patient's right to autonomous choice. Physicians should be wary of information overload though, and should be educated in providing information in a balanced, unbiased way, especially where risk disclosures are involved. The way that risk is statistically portrayed can be very confusing for patients (and doctors!). In the recent Woman's Health Initiative trial on the safety of hormone replacement therapy (HRT) in post-menopausal women, conducted in the United Kingdom, the way that the media reported the results caused widespread panic and caused many women to summarily stop their therapy. The media reported the **relative risk** of heart attacks, strokes and breast cancer in women on HRT as respectively being 29%, 41% and 26% increased when compared with placebo. But when one analyses the **absolute risk** it equates to an increase of only 7, 8 and again 8 cases per 10 000 women per year – well under one percent (SASOG Position Statements 2002:6). Hardly any reason to panic! It is controversial whether a patient can waive the right to information; Beauchamp and Childress feel that each case should be considered individually in order to eliminate the abuse of waivers and to protect the patient.

v) Recommendation: Physicians make recommendations based of the material disclosed.

vi, vii) Decision, Authorisation: Some of the most perplexing ethical dilemmas ensue when patients are unable to make their own decisions e.g. when they are of doubtful autonomy or non-autonomous. The notion of surrogate decision-making has been developed in order to deal with these cases. There are three standards of surrogate decision-making observable. The *substituted judgement standard* is a weak autonomy standard and requires the decision-maker to make the decision the incompetent person would have made if competent. This fictional quality makes this standard controversial and Beauchamp and Childress (1994:173) advocate that it only be used in cases of once-competent patients whose relevant prior preferences can be discerned. This in essence eliminates the substituted judgement standard in favour of a *pure autonomy standard*.

This standard is based on the principle of respect for autonomy and is employed in cases of “past, self-regarding, autonomous decisions reached by now-incompetent but previously competent persons” (Beauchamp & Childress 1994:174). Care should be taken to ensure that surrogates act responsibly in interpreting the past wishes of a patient and only explicit instructions (not vague comments and ideas) should be accepted. In cases where previously competent persons left no reliable traces of their wishes, the *best interest standard* should be employed. Accordingly, the surrogate should determine the greatest benefit among the available options. Beauchamp and Childress stress that these quality-of-life judgements are not about the social worth of a patient, but about the value of the life for the person who must live it. It is crucial that this standard should only concentrate on tangible factors, e.g. medical diagnosis and physical suffering, and not be extended into other domains (e.g. psychological trauma), in order to avoid including values that are irrelevant to a patient’s benefits.

### **Criticism of the Principle of Respect for Autonomy:**

Respect for autonomy is a relative newcomer to the realm of medical ethics and has consequently been subjected to much scrutiny and criticism. It has especially been slated for being too individualistic and for marginalizing the importance of communities and traditions. Respect for the autonomy of the patient does however not imply that people are absolutely autonomous or are not shaped by the values and institutions in society. It merely insists that patients should have a say in the decisions regarding their health.

Liezl van Zyl (2000:37) asserts that although no one can deny the empowering and liberating effects of this principle, it has disappointed as an effective answer to the dehumanising effects of modern medicine. She traces this back to the origin of the principle of autonomy in the scientific ideals of the Enlightenment: objective knowledge of the external world, uncontaminated by prejudice and subjectivity. When John Locke subsequently appropriated autonomy in the political arena as a necessary tool in the transformation of the British monarchical society to democratic self-government, “man became the proprietor of his own person, in control of his own destiny.” Since the principle of autonomy therefore rests on the ideals of rationality, objectivity and independence,

unconstrained by emotional and spiritual qualities, it is not surprising that it fails to rectify the dehumanisation and depersonalisation of modern scientific medical practice.

Similarly, the notion of autonomy fails to overcome the problematic power differential between patient and doctor. Van Zyl (1997:190) alleges that the emphasis on rational decision-making only exacerbates the problem since the autonomy of the typical patient is necessarily reduced when compared with that of the doctor, as the patient lacks the medical knowledge and is suffering from the debilitating effects of his/her illness. Van Zyl (1997:193) proposes that “the recognition of human equality with regard to their moral status should not be based on their rational nature, but on their shared vulnerability to suffering.” This involves the recognition that dependence upon each other and external means is a characteristic feature of human beings. “The autonomous and independent individual is a mere philosopher’s abstraction, as unreal as Kant’s attempt to separate the phenomenal world from the noumenal world.” Thus in medicine, the patient’s dependency should not be viewed negatively as a lack of autonomy or incompetence, but rather as the result of our shared human vulnerability to illness, disease and injury. The compassionate physician should realise that the patient’s suffering is undeserved, that the sufferer’s losses are significant, and that a similar misfortune might befall him/her too.

Another problematic implication of the prominence given to the principle of patient autonomy is that one can medically benefit a patient who refuses to give consent for a potentially beneficial treatment only by either overriding his/her express wishes or having him/her declared incompetent. The first option exposes the physician to litigation; the second cannot be seen as being respectful towards the patient.

The notion of autonomy has also been widely abused. In an inflammatory article, “A high society is a good society”, arguing for the legalisation of heroin, cocaine and marijuana, Grayling (2002:19) states that “[a] society in which such substances are legal and available is good not because drugs are in themselves good, but because it respects the autonomy of those who wish to use them.” “The place of drugs in the good society is not about the drugs as such, but the value to individuals and their society of openness to

experimentation and alternative lifestyles.” It is worrisome that the principle of autonomy can so effortlessly be used to serve immoral ends. Patients also often act as if their right to autonomy were a veto right, and the attitude of ‘this is my life and I can do as I please’ is unfortunately common. I believe however, that this simplifies the moral life and does not appreciate the complexities of our social interconnectedness and interdependence.

Despite all the criticisms and potential for abuse, respect for patient autonomy forms a cornerstone in medical ethics today. The notion of physicians as the sole decision-makers in matters of health is obsolete and patients have taken up their rightful place beside them, intimately involved in all aspects of their care. It is therefore rightly incorporated into any approach to bio-medical ethical dilemmas, without it being a trump in matters of conflict.

### **5.3.2 Patients’ Rights and Responsibilities in the South African Constitution:**

For many decades the vast majority of the South African population experienced either a denial or violation of fundamental human rights, including rights to health services. To ensure the realisation of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa (Act No. 108 of 1996), the Department of Health released the National Patients Rights Charter as the embodiment of their commitment to uphold, promote and protect the rights of patients. The Ministry of Health proclaimed the Patients Rights Charter a common standard for achieving the realisation of the right to health care.

The South African National Patients Rights Charter (2002) commits itself to the following:

1. **“Healthy and safe environment**

Everyone has the right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection.

**2. Participation in decision-making**

Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision-making on matters affecting one's health.

**3. Access to health care**

Everyone has the right of access to health care services that include:

- i. receiving timely emergency care at any health care facility that is open, regardless of one's ability to pay;
- ii. treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;
- iii. provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, persons living with HIV or AIDS patients;
- iv. counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;
- v. palliative care that is affordable and effective in cases of incurable or terminal illness;
- vi. a positive disposition displayed by health care workers that demonstrate courtesy, human dignity, patience, empathy and tolerance.
- vii. health information that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient.

**4. Knowledge of one's health insurance/medical aid scheme**

A member of a health insurance or medical aid scheme is entitled to information about that health insurance or medical aid scheme and to challenge, where necessary, the decisions of such health insurance or medical aid scheme relating to the member.

**5. Choice of health services**

Everyone has a right to choose a particular health care for services or a particular health facility for treatment provided that such choice shall not be contrary to the

ethical standards applicable to such health care providers or facilities and the choice of facility is in line with prescribed service delivery guidelines.

**6. Treated by a named health care provider**

Everyone has a right to know the person that is providing health care and therefore must be attended to by only clearly identified health providers.

**7. Confidentiality and privacy**

Information concerning one's health, including information concerning treatment, may only be disclosed with informed consent, except when required in terms of any law or an order of court.

**8. Informed consent**

Everyone has the right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and the costs involved for one to make a decision that affects any one of these elements.

**9. Refusal of treatment**

A person may refuse treatment and such refusal shall be verbal or in writing provided that such refusal does not endanger the health of others.

**10. A second opinion**

Everyone has the right to be referred for a second opinion on request to a health provider of one's choice.

**11. Continuity of care**

No one shall be abandoned by a health care professional worker or a health facility, which initially took responsibility for one's health.

**12. Complaints about health services**

Everyone has the right to complain about the health care and to have such complaints investigated and receive a full response on such investigation.”

The Charter not only informs patients about their rights, but also makes them aware of their responsibilities. Accordingly, every patient or client has the following responsibilities:

1. “To take care of his or her health.
2. To care for and protect the environment

3. To respect the rights of other patients, health workers and health care providers
4. To utilise the health care system optimally and not to abuse it
5. To know his or her local health services and what they offer
6. To provide health workers with relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes
7. To advise the health providers of his or her wishes with regard to his or her death
8. To comply with the prescribed treatment and/or rehabilitation procedures
9. To enquire about the related costs of the treatment and/or rehabilitation and to arrange for the payment
10. To take care of health records in his or her possession.”

#### **5.4 Modern Medicine and the Culture of Litigation:**

The recognition of universal human rights has brought much needed respite to many oppressed and minority groups, and aims at securing at least a decent minimum standard of living for all. In medicine, the recognition of specific patients' rights has been a necessary and valuable counter for paternalism. The pendulum has swung from an emphasis on the physician with a focus on the ethics of competence in the Hippocratic era, to an emphasis on the patient with the recognition of individual human rights in the last two centuries. I believe though that the present pervasive rights-based attitude has contributed greatly to the so-called 'culture of litigation' that has engulfed the medical profession. Particularly in the United States of America, most doctors have been affected by or threatened with litigation. Mal-practice suits in South Africa have not been as pervasive, but are, according to professional indemnity insurers, on the increase. No modern doctor dare practice medicine without proper mal-practice insurance and these costs run into tens of thousands of rands per year for every individual, especially in the high-risk disciplines like obstetrics, orthopaedics and anaesthetics.

The fear of litigation has had the regrettable consequence that doctors have become reluctant to render help in emergency situations. In the past, members of the profession were obligated by an implicit code of conduct to volunteer assistance in the case of an

emergency or accident; today many doctors feel that the legal risks outweigh the moral obligation to intervene. In South Africa, the risk of violence when parked on the side of the road and the ubiquitous fear of HIV transmission in trauma situations, serve to further discourage doctors from these 'Good Samaritan' acts. There have been calls for the institution of mandatory Good Samaritan laws, making it incumbent on doctors to assist by means of legal sanction. In the current climate of human rights, controversy however exists as to the extent to which society can enforce obligations of general and specific beneficence that are not based on explicit contracts and agreements (Beauchamp & Childress 1994:271).

Another worrisome consequence of the perennial threat of litigation has been that more hospitals are including indemnity clauses in their admission forms. In a recent landmark case in South Africa, the Supreme Court of Appeal ruled that these clauses in the fine print of admission papers were indeed enforceable against patients. The test case involved a hospital owned by Afrox Health Care that was sued for R2 million by a patient after a nursing sister dressed his operation wounds too tightly, constricting the blood flow to the area and causing extensive damage. After the patient initially won the case in the Pretoria High Court, the ruling was overturned by the Supreme Court. The judges ruled that the patient had indeed indemnified the hospital against "any claims which may be instituted by any person due to damage or loss of any nature whatsoever which may arise directly or indirectly from any injury occasioned by or due to injury to the patient with regard to any illness suffered by the patient irrespective of the cause or causes, only with the exclusion of intentional acts or omissions by the hospital, employees or agents" (Ellis 2002:6). Professional indemnity insurers have been quick to realise the implications of this ruling and have advised individual practitioners to follow suit in creating their own indemnity clauses specific to their practices.

This ruling is disquieting since a patient, especially when s/he is severely ill, is hardly in an equal or favourable position to bargain with health care providers, especially large hospitals. The hospital, by asserting its rights, effectively negates the rights of the individual patient. This leaves the questions of whether a hospital can refuse to treat a

patient who refuses to sign indemnity clauses; whether a hospital could be held liable for damages to the dependants of a patient who died after it refused to help him/her because s/he would not sign an indemnity form; and whether a family member who signed admission papers on behalf of a patient can be held liable if s/he did not demand that the indemnity clauses be excluded? It also raises the pivotal question of whether indemnity against liability is really beneficial to the maintenance of acceptable standards of medical care in hospitals? It appears to me that patients' insistence on their rights have caused doctors and health care providers to reactively assert their rights as well. I believe that a mere assertion and counter-assertion of rights will not resolve any medical dilemmas and that both sides can only lose in the process.

### **5.5 Nietzsche and the Culmination of Individualism:**

I would like to propose the hypothesis that the modern insistence on rights and the culture of litigation that it effectively created, have been integral in the systematic alienation of the individual. The language of rights presupposes independence and promotes self-determination; these two 'values' have been embraced by contemporary society and have become the common denominators in human relations. This prevailing atmosphere stifles feelings of compassion and shared vulnerability that tie communities together. The work of the German philosopher, Friedrich Nietzsche, especially in the books *Beyond Good and Evil*, *The Gay Science* and *Thus Spoke Zarathustra*<sup>12</sup>, perhaps best illustrate the natural conclusion of this focus on individuality and independence.

Friedrich Nietzsche (1844-1900) was arguably the most insightful and powerful critic of the moral climate of the nineteenth century (Blackburn 1994:262). His work is notoriously daunting because his many-layered and ironic writings are hardly ever straightforward, and because he employs an array of stylistic and literary devices such as humour, irony, exaggeration, aphorisms, verse, dialogue and parody in a unique way that

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<sup>12</sup> Zarathustra (*Greek Zoroastres*) was the founder of the ancient Persian religion, and the book with which he is credited, the *Zend-Avesta*, is its Bible. He is conjectured to have lived in the 7<sup>th</sup> century B.C. The heart of his religion is a conflict between Ahura Mazda (Ormuzd), the god of light and good, and Angra Mainyu (Ahriman), the god of darkness and evil (Hollingdale 1969:30).

echoes his perspectivism<sup>13</sup>. He has been accused of undermining morality and rationality by exposing their respective non-moral and irrational bases, and of “abolishing the ‘higher’ world, the metaphysical<sup>14</sup>, by accounting for its supposed manifestations in terms of human, phenomenal and even animal world” (Hollingdale 1969:13). Yet he remains an influential critic of ethical discourse, particularly because of his work on unconscious motivation and the will to power. In the words of Richard Bernstein (1986:117), Nietzsche is “the one ‘moral philosopher’ of the modern period who had the perspicacity to reveal the false pretensions of modern ‘moral’ life and philosophy.”

In *The Gay Science*, Nietzsche famously claimed that morals have no metaphysical grounding and dismissed the notion of basing morality on inner moral sentiments or conscience, on the one hand, or on the Kantian categorical imperative or universalizability, on the other. He said that “all rational vindications of morality manifestly fail and that *therefore* belief in the tenets of morality needs to be explained in terms of a set of rationalizations which conceal the fundamentally non-rational phenomena of the will” (MacIntyre 1999:117). Nietzsche claimed that morals are made up in accordance with our own interests and pursuits of power. To will power always means to will superior power over something else, i.e. another figure of will to power. “Will to power is a will to subdue, to overpower, to appropriate something (or someone) else that is offering resistance because it is itself a will to subdue, to overpower, to appropriate” (Van Tongeren 2000:162). This will to power is indeed all too transparent in our society!

According to Nietzsche, the will to power culminates in the master morality. “The noble human being honours himself as one who is powerful, also as one who has power over himself, who knows how to speak and be silent, who delights in being severe and hard with himself and respects all severity and hardness.” The noble man has little regard for compassion: “[n]oble and courageous human beings who think that way are furthest

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<sup>13</sup> Perspectivism is the view that all truth is truth from or within a particular perspective (Blackburn 1994:284).

<sup>14</sup> Nietzsche famously declared in *The Gay Science*: “God is dead. God remains dead. And we have killed him” (Hollingdale 1969:14).

removed from that morality which finds the distinction of morality precisely in pity, or in acting for others, or in *desinteressement*; faith in oneself, pride in oneself, a fundamental hostility and irony against 'selflessness' belong just as definitely to noble morality as does a slight disdain and caution regarding compassionate feelings and a 'warm heart'." This power is also evident in the confines of medicine: "... the noble human being, too, helps the unfortunate, but not, or almost not, from pity, but prompted more by an urge begotten by excess of power" (Nietzsche quoted by Van Tongeren 2000:188).

Nietzsche believed that pity is disrespectful of the worth and dignity of a person and advanced the following arguments to substantiate this claim, as analysed by Van Zyl (1997:87-90):

**1. Pity disregards the positive value of suffering.** Against Schopenhauer's view that suffering is ultimately pointless and intrinsically abhorrent, Nietzsche claimed that pain, as an essential part of life, grants man the opportunity for self-development through enduring the suffering. In an aphorism entitled *Wisdom in Pain*, Nietzsche (1974:252-253) wrote: "[t]here is as much wisdom in pain as there is in pleasure: both belong among the factors that contribute the most to the preservation of the species. If pain did not, it would have perished long ago; that it hurts is no argument against it but its essence." He agreed with the Stoics that pity inflated the importance of worldly goods such as money, status, and friendship - Nietzsche even regarded health as a worldly good that man overemphasized! In *The Will to Power* he wrote: "[t]o those human beings who are of any concern to me I wish suffering, desolation, sickness, ill-treatment, indignities - I wish that they should not remain unfamiliar with profound self-contempt, the torture of self-mistrust, the wretchedness of the vanquished: I have no pity for them, because I wish them the only thing that can prove today whether one is worth anything or not - that one endures" (Nietzsche 1967:481).

**2. True compassion is impossible.** Nietzsche believed that a person's suffering cannot be comprehended by anyone else. "Our personal and profoundest suffering is incomprehensible to almost everyone; here we remain hidden from our neighbour, even if

we eat from the same pot” (Nietzsche 1974:269). When people therefore notice someone’s suffering, they tend to interpret it superficially without comprehension of the complexities and uniqueness of the experience. Their attempts at compassion thus end in disrespect for the sufferer: “[o]ur ‘benefactors’ are, more than our enemies, people who make our worth and will smaller” (Nietzsche 1974:269). Nietzsche further believed that the essential subjectivity of pain and the isolation stemming from it, cannot be subdued by sharing that pain with others without losing one’s self-worth. The only option open to the sufferer is to assert his individuality by rejecting the pity of others and choosing the solitary road: the courageous person deals with pain alone and grows stronger for it.

**3. Pity is based on the perception that humans are weak and shameful.** Nietzsche rejected the Christian belief that man consists of a shameful bodily nature that led him into temptation and sin, and that suffering was the rightful punishment for this innate weakness. Pity belittles not only the pitied but also the pitier, since, by feeling pity for another or identifying with his plight, the pitier is pulled down to the level of the herd by acknowledging man’s weakness and inadequacy, and displaying his disgust with humanity. Man’s courageous endurance of suffering thus separates him from the herd: “[p]rofound suffering makes noble; it separates” (Nietzsche 1989:220).

**4. Pity is not altruistic, but rather egoistic.** Nietzsche claimed that pity is based on the fears one has for one’s own life and that the pitier’s act of pitying is actually an attempt to rid himself of his own pain. In addition, by pitying another, the pitier feels superior and more virtuous than the other, and more assured of procuring a place in heaven, and is thus driven by egoistic concerns (Van Zyl 1997:90).

Nietzsche here follows in the footsteps of Plato who argued that the virtues of compassion and benevolence insult the sufferer by insinuating that he lacks the self-sufficiency to achieve his own goals without outside help. Socrates said: “a good man is pre-eminently capable of providing himself with a good life entirely from his own resources, and is absolutely the last person to need anyone” (Plato 1994:81). Nietzsche’s hero similarly sees suffering as an opportunity for growth, by overcoming adversity

through his independent efforts. His 'Übermensch' is a "human being who has mastered passion, risen above the senseless flux, and given creative style to his character" (Blackburn 1994:262). He opposes those who "flee into the conscience of others and into the lovely temple of the 'religion of pity'", who find their own way "too hard and demanding and too remote from the love and gratitude of others" (Nietzsche 1974:269-270). He sees the appeal for pity as the attempt of the weak to recover some sense of power and importance by inflicting pain on others.

These ideas live on in our culture: independence and self-sufficiency are valued and respected, whereas dependence is equated to incompetence. The hero of modernity does not ask for compassion or pity. Buytendijk (1961:149-150) warned that the ethical consequences of an attitude demanding self-sufficiency and independence, even in the event of profound pain and suffering, can be disastrous, resulting in a "cold climate of pessimism and pride" in which "love and simplicity ... wither away." According to Max Scheler (Quoted by Buytendijk 1961:147), Nietzsche's hero "is no longer a hero; he is a fool or sick man suffering from algophilia<sup>15</sup>." The hero of modernity finds himself in an ethical vacuum, independent, yet isolated from the compassion and care of others. Especially in a litigious society where people have rules and laws that safeguard their rights, it becomes increasingly difficult to lay claim to compassion or assistance outside these legal boundaries. Professionals are required to do only as much (or little) as the letter of the law requires. This can be a very lonely place when you are ill and longing for a healing and caring environment.

## **6. The Either-Or Dichotomy:**

Modern medicine finds itself faced with a seemingly intractable dilemma: paternalism versus autonomy. Doctors, schooled in the ethics of competence, insist that they know what is best for their patients and that they only act in their patients' best interests; patients, raised in the culture of universal human rights, insist that only they can know

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<sup>15</sup> 'Algophilia' means "a morbid pleasure in inflicting or suffering pain" (<http://www.members.aol.com/tsuwm/abc.htm>).

what is in their best interest and that they have a right to autonomous decision-making and self-determination. This opposition has played itself out in countless medical cases in courts all over the world: *Schloendorff v. Society of New York Hospital* – Mary Schloendorff sued her gynaecologist for “trespass or unlawful interference with her body” after he removed a fibroid tumour when she had only given permission for an examination of the tumour under general anaesthetic (Poland 1997:193); *Bouvia v. Superior Court* – the court ordered removal of a permanent naso-gastric tube doctors inserted into Elizabeth Bouvia, a 28-year old quadriplegic, after she announced her intention to starve herself to death (Poland 1997:194); *Superintendent of Belchertown State School v. Saikewicz* – under the principle of self-determination and the right to privacy, the court found that Joseph Saikewicz, age 67 with a mental age of 2 years and 8 months, suffering from leukaemia, had the right to refuse the chemotherapy advised by his doctors (Poland 1997:195). There are of course countless similar cases.

Many of the most enigmatic ethical dilemmas centre on this opposition between paternalism and autonomy: can a doctor justify withholding information - like a diagnosis of cancer - from a patient, based on beneficence?; should doctors be allowed to interfere in cases of suicide?; can a doctor perform a life-saving procedure against the patient’s express wishes - e.g. a necessary blood transfusion for a Jehovah’s witness?; can patients insist on a right to die and to what extent can they expect their doctors to assist them?

Edmund Pellegrino and David Thomasma (Quoted by Beauchamp & Childress 1994:272-273) argue that “[b]oth autonomy and paternalism are superseded by the obligation to act beneficently... In the real world of clinical medicine, there are no absolute moral principles, except the injunction to act in the patient’s best interest.” Beauchamp and Childress (1994:273) however believe that “[n]o premier or overriding authority exists in either the patient or the physician, and no pre-eminent principle exists in biomedical ethics, not even the admonition to act in the patient’s best interest.” They hold that “beneficence provides the primary goal and rationale of medicine and health care, whereas respect for patient autonomy (and non-maleficence and justice) sets moral limits on the professional’s actions in pursuit of this goal.” Jonsen (1990:99) again believes that

“modern medicine has to find the proper apportionment of rights among its own practitioners, its patients, and those who pay for their services, the government and the citizenry.”

When analysed from the perspective of the current medical context, these dilemmas and proposed solutions appear equally implacable. Rights, principles and virtues all pull in different directions. By following Hegel’s method of dialectic, however, one appreciates that each of these positions developed within a particular socio-political context and should therefore be interpreted within the scope of its history. It then becomes clear that the paternalistic tendencies of doctors stem from the legacy of the ethics of competence that was conceived by Hippocrates and developed by modern thinkers like Sydenham and Cabot, and is still being reinforced by medical training. When the scope and power of medicine was significantly extended with the aid of the technological revolution during the Enlightenment, patients’ rights were conceived within the greater recognition of individual human rights, as a necessary counter for excessive paternalism. In the contemporary practice of medicine, remnants of these two traditions remain and do battle for supremacy. I believe that it is necessary, now that we have analysed the past, to look to the future for a higher synthesis in which both the thesis of paternalism and the antithesis of autonomy can be incorporated.

### **7. Synthesis: Possibilities for the Future:**

We have realised that neither the tradition of paternalism nor that of individual rights can satisfy the demands and needs of the participants in contemporary health care. I believe that the most promising possibilities for the future can be found in the ideas of virtue ethics - based on the human need for compassion and the human desire to become virtuous -, the ethics of responsibility – centring on man’s responsibility towards himself, his progeny and the biosphere – and moral pluralism – that incorporates both with the aid of *phronesis*.

### **7.1 The Need for Compassion:**

Dr. Oliver Sacks (Quoted by Van Zyl 1997:41) described his experience when he was suddenly on the other side of the knife, so to speak, when he became a patient: “though as a sick patient, in hospital, one was reduced to moral infancy, this was not a malicious degradation, but a biological and spiritual need of the hurt creature. One had to go back, one had to regress, for one might indeed be as helpless as a child, whether one liked it, or willed it, or not. In hospital one became again a child with parents (parents who might be good or bad), and this might be felt as ‘infantilising’ and degrading, or as a sweet and sorely-needed nourishing.”

This feeling of helplessness is due to a combination of patients’ lack of medical knowledge and their temporarily restricted capacity for rational decision-making. Patients are often so ill and their judgements so affected by illness, trauma, fear, depression, and the threat of death, that they are not only incapable of understanding important information, but are also in no position to deliberate carefully and rationally about their medical treatment. Medicine has become so specialised that it is difficult for laymen to stay adequately informed of all the options. Jonas (1985:167) calls specialisation the ‘price of scientific progress’: the exponential growth of the contents of knowledge and its proliferating subdivisions has led to extreme fragmentation of the “existing total of knowledge” among the experts. Outside this charmed circle, the whole of knowledge and each of its parts have become increasingly abstruse and increasingly difficult to communicate to laymen. “[T]hus the scientific estate excludes the overwhelming majority even of literate contemporaries from the role of intelligent witnesses.” When the ‘witness’ is acutely ill or fearful, the inequality of the situation is of course exacerbated.

Liezl van Zyl (2000:37) blames the process of modernisation, with its reliance on technology and scientific explanations, for focusing on the elimination of disease, physical pain and disability, at the expense of the patient’s emotional and existential suffering: “Indeed, for a patient to be taken seriously, to be respected as an autonomous person, he or she has to demonstrate the ability to think rationally, to reach judgements

that are uncontaminated by emotional and spiritual qualities and independent of the opinions of family or friends.” She follows John Hick who said: “... the greater part of human misery transcends physical pain” (Quoted by Van Zyl 1997:145). He cited fear of death, anxiety about one’s family, finances, or career, frustration of one’s plans, and the humiliation of helplessness and dependence, as sources of suffering. Van Zyl therefore alleges that physicians who lack compassion and focus exclusively on relieving physical pain, though acting beneficently, might do nothing to relieve patients’ more profound suffering and thus actually fail to benefit them. Compassionate understanding of a person’s illness should therefore supplement a scientific knowledge of disease.

Biologists, psychologists and ethicists have attempted to expound the human need for compassion. I find the systematic exposition offered by the esteemed Carl Jung to be the most persuasive.

#### **7.1.1 Jung and the Healer Archetype:**

The Swiss psychoanalyst, Carl Gustav Jung (1875-1961), the third in the triumvirate that famously included Sigmund Freud and Alfred Adler, systematically developed the concept of the need for healing and the ‘healer archetype’ in his book *Anatomy of the Soul*. In order to explain the concept of the archetype, it is necessary to briefly sketch Jung’s metapsychology<sup>16</sup>. He developed a biological model of the psyche that consisted of three concentric spheres: the outer layer representing consciousness with the focal ego, the middle layer representing the personal unconscious with its complexes, the inner layer the collective unconscious with its archetypes, and at its core, as the co-ordinating nucleus of the entire system, the Self. The ego is the focal point of consciousness and as such carries the conscious awareness of existing, together with a continuing sense of personal identity. It has access to unrepressed memories and mediates between the subjective and objective realms of experience. The personal unconscious arises from the interaction between the collective unconscious and the environment in which an

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<sup>16</sup> Freud first used the term ‘metapsychology’ to describe his theories about the structure and functioning of the psyche. It can best be described in terms of the “anatomy and physiology of the mind” (Stevens 1990:27).

individual is raised. It consists of everything that an individual feels, thinks, remembers, wants and does without being conscious of at the moment, and all the more or less intentional repressions of painful thoughts and feelings. The functional units of the personal unconscious are the complexes; they harbour nuclear elements that are components of the collective unconscious, namely the archetypes (Stevens 1990: 27-32).

An archetype becomes a complex through the laws of association: the *law of similarity* and the *law of contiguity*. Thereby, an archetype becomes active in the psyche when an individual comes into proximity (*contiguity*) with a situation or a person with similar features (*similarity*) to the archetype in question. When an archetype has been successfully activated, it gathers ideas, precepts and emotional experiences associated with the original source of activation, and these are built into a complex that then becomes functional in the personal unconscious (Stevens 1990:32). There are human figures that can be arranged under a series of archetypes, the chief of them being the shadow, the wise old man, the child, the mother and her counterpart the maiden, the anima in the man and the animus in the woman (Jung 1968:183).

Jung was the first to develop the hypothesis of the collective unconscious. His ideas contrasted sharply with the popular view of the time that the individual begins life as a blank slate (*tabula rasa*) and that the environment determines all mental contents. Jung thought that the entire personality was present, *in potentia*, from birth and that the environment merely brings out what is already there (Stevens 1990:36). The term archetype denotes “an inherited mode of functioning, corresponding to the inborn way in which a chick emerges from the egg, the bird builds its nest, a certain kind of wasp stings the motor ganglion of the caterpillar, and eels find their way to the Bermudas. In other words, it is a ‘pattern of behaviour’”. “There are as many archetypes as there are typical situations in life. Endless repetition has engraved these experiences into our psychic constitution, not in the form of images filled with content, but at first only as *forms without content*, representing only the possibility of a certain type of perception or action” (Jung, quoted by Stevens 1990:37). Archetypes thus predispose us in our approach to and experience of life to act in certain ways according to the patterns laid

down in the psyche. Archetypes also organize experiences so as to make them conform with these patterns. There are archetypal figures – e.g. mother, child, father, God, healer - archetypal events – e.g. birth, death, marriage - and archetypal objects – e.g. sun, moon, water, predatory animals – all bequeathed through evolution in order to equip us for the struggle that is life (Stevens 1990:38-39).

Jung thus believed that human beings are ‘pre-programmed’ to seek and experience central figures in their lives; one of these being that of the healer. The healer or doctor is also often embodied in the archetype of the wise old man, a superior master and teacher who brings help and counsel (Jacobi 1959:71). “The wise old man appears in dreams in the guise of a magician, doctor, priest, teacher, professor, grandfather, or any other person possessing authority. The archetype of spirit in the shape of man, hobgoblin, or animal always appears in a situation where insight, understanding, good advice, determination, planning, etc., are needed but cannot be mustered on one’s own resources. The archetypes compensates for this state of spiritual deficiency by contents designed to fill the gap” (Jung 1968:183).

It is clear that Jung’s archetypal hypothesis is indebted to Plato’s *ideas*. In the *Phaedo*, Plato developed his Theory of Forms, according to which an idea is “immutable, timeless, one over many, intellectually apprehensible and capable of precise definition at the end of a piece of pure ratiocination *because it is an independent existing real thing or entity*. As our everyday world contains people, trees, stones, planets, storms and harvests, so a second and superior, or transcendent world contains concept-objects” (Ryle 1967:322). Like *ideas*, Jungian archetypes are collective as they embody general characteristics. But they differ from *ideas* in the sense that they are not mere abstractions, but living biological entities, existing in the central nervous system where they actively seek their own activation in the psyche and in the world (Stevens 1990:39-40).

If Jung is thus correct, humans seem to be biologically preordained to experience the concept of a healer. Man’s nature determines that he needs healing and counsel in times of illness. But however one chooses to look at it, whether from a biological,

psychological or existential point of view, it would seem as if every patient would have an innate need to be treated with compassion and care in a healing environment. This environment finds expression in the ethics of virtue. Traditionally the medical practitioners and allied professionals have been called upon to provide such an environment; one can't help but wonder whether they are still capable of doing so in the sterile corridors of contemporary medicine.

## **7.2 Virtue Ethics:**

In recent years people inside and outside the medical profession have appealed for a more holistic understanding and treatment of patients. Starting with Elizabeth Anscombe, there has been widespread dissatisfaction with the narrow, impersonal, Kantian and utilitarian focus on obligations and rights and consequences, with more people realising the importance of focusing on the agents who perform actions. Thus following the tradition of Plato and Aristotle, virtue-ethicists assign virtuous character a pre-eminent position. They emphasize the skills necessary to be a good person rather than the skills necessary to carry out professional duties.

Aristotle defined virtue as a “state of character which makes a person good and makes the person do his or her work well” (Quoted by Pellegrino & Thomasma 1993:5). Virtue thus has a teleological quality in relation to both the person and to the ‘work’ of living a good life, in other words, the moral quality of human action is derived from its relationship to the final end of human life (Pellegrino & Thomasma 1993:8). Aristotle believed that virtues were dispositions in which feelings and emotions were guided by reason so that behaviour would be appropriate to a situation. In particular, the guidance of reason required the avoidance of excess or deficiency, and therefore each virtue could be conceived of as a mean between these extremes – this ‘doctrine of the mean’ proved to be the greatest weakness of Aristotle’s theory.<sup>17</sup> But virtues are also concerned with choice, and acts of virtuous persons thus proceed from three things: “a knowledge of the good in

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<sup>17</sup> Not all virtues can be located as the mean between two extremes. It is difficult to see how one can be too just, for example (Pellegrino & Thomasma 1993:6).

any actions, a choice of the good for its own sake, and a source for knowledge and choice in a good character” (Pellegrino & Thomasma 1993:5). Aristotle divided the virtues into intellectual virtues – art, science, intuition, reasoning, and *phronesis* (practical wisdom) – and the moral virtues – incorporating the cardinal virtues of courage, temperance, wisdom, and justice. Aristotle believed that virtues resulted from their habitual exercise and could thus be acquired through training and practice.

In the thirteenth century, Thomas Aquinas attempted to reconcile Aristotelian philosophy with Augustinian and scriptural theology. Aquinas appropriated the cardinal virtues of Aristotle and supplemented them with the theological virtues of faith, hope and charity. Because he believed that the ultimate end of human existence was spiritual, he held that the natural virtues needed to be complemented with the supernatural virtues that were directed to God as their end. Aquinas did not see these two categories of virtue as conflicting; in fact, he deemed faith and reason to be complementary in the moral life. *Phronesis*, “the virtue that disposes the reason to fit the good end of an act”, was assigned a cardinal role as it was considered to bridge the gap between the moral and intellectual virtues (Pellegrino & Thomasma 1993:8). To possess *phronesis* is to know what to do in a particular situation. It is not a matter of appealing to rules and general principles, or a matter of logical argument or intellectual ability; it consists simply in knowing what to do here and now. This knowledge is acquired through practical experience and ‘habituation’ –being told in particular situations that one’s behaviour is appropriate or inappropriate – and thus through moral training in a morally civilized society (Norman 1998:39).

During the Enlightenment there was a shift away from virtue and character towards pure reason, and it is here that current-day promoter of virtue-ethics, Alasdair MacIntyre, thinks that things went wrong. MacIntyre hypothesised that modern societies did not inherit a single ethical tradition from the past, but rather fragments of conflicting, incommensurable traditions and values leading to interminable and irresolvable moral disagreements. In the modern world there is no shared moral vocabulary and no shared conception of the good human life. We have lost an understanding of the importance of living in and being influenced by a community and a tradition. He agreed with Nietzsche

that there is no knowledge that is purely objective and neutral, but only “truth-from-a-point-of-view” (Fuller 1998:21). MacIntyre (1990:52) thus advocated a return to an Aristotelian account of the human good, which could ground a set of virtues. He proposed a conceptual scheme with three components: man-as-he-happens-to-be (untutored human nature), man-as-he-could-be-if-he-realised-his-*telos* (purpose), and the moral precepts that enable him to move from the one to the other. The concept of a human *telos* is missing in modernity and this is what we have to rediscover if morality is to make any sense. We have to focus on what sort of people we ought to become, and this entails the restoration of the tradition of the virtues.

In his book *After Virtue*, MacIntyre (1990:174) developed a “unitary core concept of the virtues”. Accordingly a meaningful life would then consist of a person belonging to a *moral tradition*, which allows for a *narrative order of a single life*, and which depends on standards of excellence in certain *practices*. “It is not that the virtues serve some external purpose, but rather that they make up a conception of the good human life, *from within which* it can be seen as rational to pursue certain aims and values” (Norman 1998:198). Greg Pence (1997:251) analysed what this would translate to in the medical setting:

“[M]edicine has a moral tradition dating back at least to Hippocrates and Galen. This tradition sets out what a physician is supposed to do when a patient comes bleeding into the emergency room or a plague begins. Within this traditions, physicians’ lives can achieve a certain unity or ‘narrative’. They can look backwards (and forwards) and see how their lives made (make) a difference. Moreover, medicine has its internal ‘practices’ which allow for intrinsic pleasure beyond its extrinsic rewards: the deft surgical hand, the perspicacious diagnosis of the esoteric disease, the esteem of a great teacher by students.”

The virtue ethical approach assumes that “...all humans have inherent capacities that constitute the ultimate basis for all ethical claims. Actions are evaluated in terms of whether they promote or hinder, coincide with, or conflict with these capacities” (Donaldson & Werhane 11). Instead of following rules and principles, the emphasis falls more on acquiring virtues appropriate to fulfilling roles in particular cultural and institutional settings. The importance of what is particular and context-dependent is

emphasized over what is universal (Flyvbjerg 1993:14). In the process, each person becomes his/her own moral evaluator. This approach is more demanding on the individual since every person has to ask him/herself whether his/her actions are morally just, or whether they merely comply with the letter of the law.

Virtue theories are appealing since they are sensitive to social dimensions and consider the whole spectrum of human abilities. Edmund Pellegrino and Thomas Thomasma (1993:xii) argue that the moral essence of a health profession is the special relationship that illness creates between the doctor and the patient. They thus emphasize the virtues that arise from this caring bond and the public trust implied by the commitment to care for others: fidelity, compassion, *phronesis*, justice, fortitude, temperance, integrity and self-effacement. Many contemporary philosophers are exploring pragmatic questions about virtue, for instance the degree to which one is responsible for one's own character, and the relation between character and friendship. New virtues such as forgiveness, loyalty, shame, guilt, and remorse are also being analysed and incorporated into virtue ethics.

Van Zyl (1997:12) analysed the virtue of compassion in her book on euthanasia, *Death and Compassion*. She accused technological medicine, as guided by a principle-based approach, of neglecting a patient's emotional, psychological and existential suffering. She focused on three aspects of suffering: the solitary patient, the helpless patient, and the disrespected patient, and attempted to show how compassion is valuable as a means to understand suffering - offering a valuable corrective to the purely scientific, distanced approach of modern medicine - and is closely related to the virtues of benevolence and respectfulness. She defended her view against the claim that compassion is irrational and rests on false beliefs, by exploring the cognitive elements of compassion, and argued against the Nietzschean notion that compassion is disrespectful towards the sufferer, by denying the Augustinian theodicy that sees suffering as a form of punishment.

Van Zyl further espoused the virtue of benevolence, which is motivated by a concern with the suffering of an individual and aims at alleviating that suffering, in contrast with

the principle of beneficence. Drawing on the Aristotelian notion of *phronesis*, she developed a teleological account of respect for persons in response to the shortcomings of the principle of autonomy with regard to end-of-life decision-making, claiming that respectfulness need not require humans to be rational and autonomous, and need not lead to the preservation of life at all costs. These arguments are all very persuasive, but it remains unclear how one could enforce the exercise of these virtues in medical practice.

The concept of a virtuous person has gained widespread acceptance in the public conscience. A recent survey in Newsweek found that 42% of parents interviewed thought that their most important goal as a parent was to raise their children to be moral persons (Kantrowitz 2000:6). Tufts University psychologist, David Elkind, advised parents that: “[t]he way to raise a moral child is to be a moral person. If you’re honest and straightforward and decent and caring, that’s what children learn” (Springen 2000:71-72). This reinforces the belief of Aristotle that people are the products of the societies they are raised in and that virtues can be taught. This approach is intuitively appealing, but is not without its problems, as is clear from the following criticisms.

### **Criticism of the virtue-based approach:**

Beauchamp and Childress (1994:68) doubt whether all questions in the moral life can be solved within the framework of virtue-theory. They believe that ‘vital moral protections’ – especially in relations between strangers – will be lost if rules and principles are not used as guides. For instance, when a patient meets a doctor for the first time, they believe that the doctor’s conformity with rules or even contracts may be essential for their future relationship.

Beauchamp and Childress further contend that virtue is not enough. They express their doubt whether virtue-ethics can adequately explain and justify beliefs of the rightness or wrongness of actions. They correctly deny the claim that if a person displays a virtuous character, his/her acts will necessarily be morally acceptable. They believe that since virtuous people can perform wrong actions, principles and rules are necessary to guide

conduct. Greg Pence similarly rejects the idea that ideals of virtuous characters can do all the work of ethics. Pence (1997:255) furthermore rejects the idea of the existence of a 'core of virtues' that holds for any time and place. "Virtues may be seen as skilled excellences and there are myriad things at which one can excel. The idea that there 'must' be a core of all virtue is really the assumption in disguise that there is only one good way to live or one correct way for society to develop." It would therefore seem as if different societies will have different mixes of institutions and practices, each requiring different kinds of virtues for its ideal development.

Louden argues that contemporary accounts of virtue ethics have a "negative rather than positive thrust" and tend "to criticize the traditions and research programs to which it is opposed rather than to state positively what its own alternative is" (Van Zyl 2000:70). It thus seems as if virtue theories are not constructive in solving novel problems and do not help in the confrontation between different ethical codes. When confronted with the question of which actions should be performed, it can only reply: "[p]erform those actions that an exemplary moral agent would perform" (Van Zyl 1997:141). Finally, virtue ethicists have also been accused of moral egoism by attaching more importance to their own integrity than to other people's suffering. It seems to imply that any concern one has for others should be derivative from one's concern to make oneself a morally good person. "Altruistic action thus becomes a means to the promotion of one's own moral virtue" (Norman 1998:199).

### **Attempts to transcend the criticisms:**

Leon Kass, a Christian moralist, attempted to incorporate both virtues and principles in his approach centring on 'the essence of medicine'. Kass claims that there are no fixed rules of conduct within the limits of medicine: "the wise physician will find and adopt the best outcome of action in the light of the specific circumstances, and will be guided by the virtues of moderation and self-restraint, gravity, patience, sympathy, prudence and discretion" (Van Zyl 2000:44). The outer limits of medicine are however fixed and

absolute and includes the rules that forbid killing patients, breaking patient confidentiality, and seducing patients.

Kass rejects the pure virtue ethics approach on the grounds that it cannot make sense of specific duties and restraints that are thought to be absolutely inviolate in traditional medical ethics. He further argues that the goal of medicine requires the physician to have a detached, unemotional attitude towards patients and not to allow compassion to tempt him into doing wrong. "For a physician, to be sure, things go better when the patient is freely willing and the physician is virtuous and compassionate. But the physician's work centres on the goal of healing, and he is thereby bound not to behave in contradiction to that central goal" (Van Zyl 2000:45). Since he believes that the physician should promote 'the wholeness of the one who is ailing', he is obliged to further this goal of 'wholeness', regardless of the patient's current wishes - this argument forms the basis for his rejection of euthanasia. Beauchamp and Childress (1994:67) also agree that virtues need principles and rules to regulate and supplement them. They allege that in circumstances of conflicting motivation from virtues, the moral agent needs to consider which action is right, best or obligatory. These decisions are based on general norms, and not on the virtues alone.

Pellegrino and Thomasma (1993:xiii) suggest the following seven theses to justify and complement virtue ethics: virtue is an irreducible element in medical ethics; virtue ethics must be redefined, however, to take into account the contributions of analytical ethics; virtues characteristic of the good physician are a fusion of general and special virtue ethics; the virtues of medicine are derivable from the nature of medicine as a human activity; the derivation of the physician's virtues from the ends of medicine helps to escape some of the difficulties inherent in a 'free-standing' virtue ethic; some link must be made between principle-, duty-, and virtue-based ethics; some link must be made between moral philosophy and moral psychology, that is, between cognition of the good and motivation to do the good.

### **7.3 Ethics of Responsibility:**

Hans Jonas, in his book *The Imperative of Responsibility*, alleges that the old ethics still used in moral discourse today (including virtue ethics) is no longer adequate to deal with the new demands placed on humanity by the technological age. He claims that the excessive dimensions of the scientific-technological-industrial civilization that stemmed from the success of the ‘Baconian program’ – to aim knowledge at power over nature – lacked in its capitalist execution from the outset the rationality and justice necessary to counter the threat of a universal catastrophe inherent in its unforeseeable magnitude (Jonas 1985:140). Jonas (1985:x) advances five major theses:

**1. Ethics no longer concerns only direct dealings of man with his fellow man within narrow horizons of space and time. A new ethics is required to deal with the moral issues that are raised by the enlarged nature of human action.** The old ethics was based on the following three premises: a) the human condition is given (determined by the nature of man and of things), b) the human good is readily determinable, and c) the range of human action – and thus responsibility – is narrowly circumscribed (Jonas 1985:1) – “[t]he short arm of human power did not call for the long arm of predictive knowledge” (Jonas 1985:6). Jonas believes that modern technology has changed the nature of human action: nature has become vulnerable to man’s technological intervention and man now poses a threat to the integrity of the entire natural order – i.e. the biosphere of the planet - by affecting the self-sustaining nature of things. This has had the consequence that ethics can no longer be only anthropocentric - thus only dealing with man’s interactions with man – but has to consider “the biosphere as a whole and in its parts, now subject to our power.” Jonas believes that the planet makes a moral claim on us not only for our ulterior sake (following a utilitarian argument), but for its own and in its own right.

Furthermore, the entity ‘man’ and his basic condition are no longer constant and are continuously reshaped by technology – “*Homo Faber* is turning upon himself and gets ready to make over the maker of all the rest” (Jonas 1985:18). Man himself has been

added to the objects of technology through the possibilities of extension of life span, behaviour control and genetic manipulation. Effects of human action are no longer proximate, but are extended in time and space. It has therefore become morally imperative to also consider the impact of our actions on future generations: “[t]he non-existent has no lobby, and the unborn are powerless. Thus accountability to them has no political reality behind it in present decision-making, and when they can make their complaint, then we, the culprits, will no longer be there” (Jones 1985:22) Ethics is therefore no longer only concerned with the here and now, with typical situations of private and public life. In addition, the knowledge required to ensure the morality of actions is no longer readily available. This is so because the movement of science that gave man the powers that now have to be regulated by norms, eroded the foundations from which norms could be derived e.g. religion or a metaphysical understanding of nature; “it has destroyed the very idea of norm as such” (Jonas 1985:22).

**2. The increased reach of man’s deeds moves responsibility to centre stage. Jones espouses the principle that “responsibility is a correlate of power and must be commensurate with the latter’s scope and that of its exercise.”** In order to act responsibly in the face of unprecedented situations brought about by the cumulative self-propagation of technological change, man’s prime duty becomes that of acquiring knowledge. Jonas argues for increased foresight, or in his words ‘scientific futurology’. “It [knowledge] must be commensurate with the causal scale of our action. The fact that ... the predictive knowledge falls behind the technological knowledge that nourishes our power to act, itself assumes ethical importance” (Jones 1985:8). Recognition of ignorance becomes the obverse of the duty to know and thus becomes part of ethics. The dimensions of responsibility have thus changed since the irreversibility and aggregate magnitude of modern technological practices have added a novel factor into the moral equation: man is now not only responsible for himself, today, but also for the condition of the biosphere and the future survival of mankind.

**3. Because man cannot accurately predict the full future impact of his technological deeds, an imaginative ‘heuristics of fear’ should replace the previous projections of**

**hope.** Jonas motivates this statement with an analogy of life and death: “[j]ust as we should not know about the sanctity of life if we did not know about killing... so also, in our search after an ethics of responsibility for distant contingencies, it is an anticipated *distortion* of man that helps us to detect that in the normative conception of man which is to be preserved from it. And we need the *threat* to the image of man ... to assure ourselves of his true image by the very recoil from these threats” (Jonas 1985:26-27). Thus, as long as we do not know what dangers are involved, we do not know what to preserve and why. Jonas holds that we gain knowledge about what to preserve not from logic and method, but rather from the perception of what to avoid. “This is perceived first and teaches us, by the revulsion of feeling which acts ahead of knowledge, to apprehend the value whose antithesis so affects us. *We know the thing at stake only when we know that it is at stake*” (Jonas 1985:27). Jonas calls it a ‘heuristics’<sup>18</sup> of fear because it is the projection of probable or arguably possible end effects: “... it is a prognostic which extrapolates from presently recognizable trends in the technological-industrial process” (Jonas 1985:30).

Jonas (1985:29) thus foresees the first duty of an ethics for the future as the visualisation of the long-range effects of technological enterprise. Because that which has to be feared has not yet happened and does not have suitable analogies in the past or present, it has to be creatively imagined. He concedes that the uncertainty of all long-term projections might make this ethical insight ineffectual for the long-range responsibility he calls for, but believes that the uncertainty itself should be included in the ethical theory and yield the rule that bad prognoses should receive prevalence over good ones (Jonas 1985:31).

The reasons why bad prognoses should predominate are threefold. Firstly, in the really important, irreversible matters that go to the roots of the whole human enterprise, no mistakes can be sanctioned. Technology, unlike evolution that leaves itself time for self-correction, takes big steps with great causal extent and tempo. We should thus rather err on the side of caution and perhaps even eschew “eschatological fulfilment”, for the sake

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<sup>18</sup> ‘Heuristic’ is a “process, such as trial and error, for solving a problem for which no algorithm exists” (Blackburn 1996:173).

of preventing apocalyptic prospects (Jonas 1985:31). Secondly, we need to contend with the cumulative dynamics of technological developments: technological enterprises with short-term aims tend to acquire an independent compulsive dynamic by which they become irreversible and usurp the plans of the initiators. Thirdly Jonas (1985:32) advances the metaphysical claim of the “sacrosanctity of the subject of evolution.” Accordingly, the heritage of a past evolution has to be preserved since it has imparted its present incumbents with the capacity to judge what is good and bad. He bases this on the idea that “[s]ome kind of authority must be asserted for the determination of models, and unless we subscribe to dualism and say that the cognitive subject is from above the world, this authority can only base itself on an essential sufficiency of our nature such as it has evolved within this world” (Jonas 1985:33). Jonas (1985:37) thus espouses the ethical axiom: “[n]ever must the existence or the essence of man as a whole be made a stake in the hazards of action.” The pragmatic expression of this principle is the rule of giving bad prognoses precedence over good.

The second duty of the ethics of the future consists of “summoning up a feeling appropriate to what has been visualised” (Jonas 1985:28). Jonas believes that the imagined future fate of man or the planet does not automatically appeal to our innate instinct of self-preservation. We thus have to purposefully accommodate it in our considerations: “... we must educate our soul to a willingness to let itself be affected by the mere thought of possible fortunes and calamities of future generations” – a new kind of *education sentimentale* is thus called for (Jonas 1985:28).

**4. In order to bridge the alleged chasm between the scientifically ascertainable “is” and morally binding “ought”, Jonas develops a metaphysics that underlies his ethics, based on “man’s duties toward himself, his distant posterity, and the plenitude of terrestrial life under his domination”, within the framework of a philosophy of nature.**

The starting point of Jonas’ ethics, the principle of responsibility, can neither be based on religion - since it has been eclipsed by secular reason - nor on traditional rights and duties

– since responsibility towards future generations cannot be grounded in reciprocity (Jonas 1985:38). Jonas therefore attempts to establish a reasoned metaphysics based on the duty we have towards posterity. His first proposition is that because future generations have a right to exist, we, as causative agents, have a correlative duty to ensure their means of existence. The conscientious pessimist could however counter this argument by maintaining that there do not *have* to be humans at all costs and, if the circumstances were dismal enough, it would even be irresponsible to continue procreating. The first proposition thus proves to be insufficient for ethical theory. Furthermore, future generations might in fact be quite happy with their condition, dismal as it might appear to us, and Jonas sees this conceived lack of protest, if it had indeed been purchased with the dignity and vocation of man, as the worst possible accusation against humanity. Therefore, “in the final analysis we consult not our successors’ *wishes* (which can be of our own making) but rather the “ought’ that stands above both of us. To make it impossible for them to be what they *ought* to be is the true crime...” (Jonas 1985:41). Jonas’ (1985:42) second proposition is thus that it is not the right of future generations that binds us, but rather their duty to be truly human. Our cardinal responsibility is to guard posterity’s capacity for this duty – “the capacity to even attribute it to themselves at all” – and from this all specific duties toward their well-being are derivative.

This responsibility can only be grounded in the imperative of existence. With this imperative we are not responsible for the future of individuals as such, but only to the ontological *idea* of man (Jonas 1985:43). This ontological idea generates a categorical (not a hypothetical) imperative: the categorical demands only *that* there be *human beings*, with equal emphasis on the *that* and the *what* of mandatory existence. This means that we are no longer only faced with the ever-open question of *what* man ought to be (the answer to which is changeable), but to the unstated ‘first commandment’, *that* man should be (Jonas 1985:139). “[I]t follows that the first principle of an ‘ethic of futurity’ does not itself lie *within* ethics as a doctrine of action (within which thereafter all duties toward future beings belong), but within *metaphysics* as a doctrine of being, of which the idea of Man is a part” (Jonas 1985:44).

Jonas, alas, still has to answer the charge of the pessimist: ought there be anything at all? Non-existence can undeniably be chosen over all the options of being, *unless* an absolute pre-eminence of being over non-being can be demonstrated (Jonas 1985:46). Jonas (1985:48) proposes that “value, or the ‘good’, if there is such a thing, is surely the only thing that of itself urges the *existence* of its subject from its mere possibility”, that grounds a valid claim to being. Consequently, it all comes down to demonstrating that there is such a thing as ‘value’, not only as something actual, but as something possible in its very *concept*. In order to achieve this, Jonas cannot shirk the task of establishing the ontological and epistemological status of value in general, and must specifically evaluate the question of its objectivity. Jonas (1985:78) attempts this prodigious task by developing a philosophy of nature. According to the theory of ends, values are present in nature as the objects of purpose, and Nature thus harbours values because she harbours ends. With any *de facto* pursued end, attainment of it becomes a good and frustration of it, an evil. This however begets the question of whether Nature can legitimate purposes simply by having them. Jonas attempts to ground the ‘good’ or ‘value’ in being and in doing so, to bridge the alleged chasm between ‘is’ and ‘ought’.

**5. Jonas thus attempts to demonstrate objective imperatives for man that would enable him to discriminate between legitimate and illegitimate goals in order to save humanity from the excess of his own power.**

One does not have to subscribe to Jonas’ philosophy of nature or his metaphysics to appreciate the importance of a principle of responsibility, especially in the advanced biotechnological sphere of modern medicine. Biotechnology is revolutionizing human reproduction, sustaining human life in terms of increased life expectancy and by means of artificial life-support, cloning human beings and mapping the entire human genome. Technology is enabling man not only to alter the life and prospects of his own generation, but also that of his progeny. Manipulation of gene sequences that promise great rewards today in terms of disease elimination (e.g. Cystic Fibrosis and Huntington’s Disease), prevention of the ageing process, and selection of ‘super genes’ (e.g. extraordinary intelligence, athletic ability and beauty) might, because of the necessary limitation of

human knowledge and foresight, have unfortunate (some would say disastrous) consequences for future generations. Products of biotechnology used in diagnostic tools (e.g. mercury in thermometers and sphygmomanometers) and in treatment (e.g. fluoride in drinking water for the prevention of tooth decay) are notoriously difficult to dispose of and pose a threat to the integrity of the biosphere. These biotechnological developments and by-products, coupled with the increasing cost of health care and the maldistribution of resources worldwide, present ethical-social challenges that need to be addressed in a novel way.

It has become imperative that scientists, specifically in the medical disciplines, should be sensitised to the ethical responsibilities that are implicit to their profession. The Centre for Research in Medical Education and Health Care in Philadelphia has called for the international standardisation of the medical education curriculum and for medical educators to share a universal responsibility to prepare physicians to perform three distinct, yet interrelated professional roles. The first role is that of a clinician with the necessary knowledge and technical skill to care for individual patients and the public. The second is that of an educator with the interpersonal skills and personal qualities to advise and counsel patients about their health, life-style, risk factors and illness. The third is that of a resource manager, skilled at judiciously drawing on available material assets and prudently using scarce resources to the benefit of most, if not all, patients (Gonnella & Hojat 2001:371).

Medical professionals should however not only be taught the benefits and possibilities of knowledge and technology, but also their limitations and dangers. They should understand the provisional nature of knowledge and appreciate the long-range implications of biotechnological interventions. It has been suggested that 'Cindynics'<sup>19</sup>, the science of danger, based on past experience, should be incorporated into the practice of medicine (Sargos & David 2002:1041). This is a new field of knowledge, dealing with all aspects of problems (scientific, cultural, social and legal) as they affect individuals

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<sup>19</sup> The term 'Cindynics' is derived from the Greek word *kindunos*, which means danger. The basic concept of this new science emerged during the Symposium on Technological Risks, held in UNESCO in Paris in 1987 and the European Cindynics Institute was created in January 1990 (<http://www.cindynics.org>).

and organisations (Cindynics Organisation). In medicine, this will translate into accessing prior legal medical cases and using them in order to learn from the lessons they might provide. But according to Jonas' hypothesis on the changed nature and increased scope of human action, this will not be sufficient: the past cannot adequately prepare us for the challenges of tomorrow and therefore an ethics of futurity, based on an imaginative heuristics of fear, should be developed. Although I believe that such a theory is too abstract and speculative to become an independent guide for moral conduct, I do believe that the notion of responsibility should be incorporated in all ethical theories aiming at illuminating the moral path.

Patients should similarly be made aware of their responsibilities. Patients firstly have a duty towards themselves to maintain a healthy lifestyle and avoid unnecessary risks. They have a duty to be knowledgeable and to inform themselves, with the help of their health care advisors, of the available methods for prevention of disease and the treatment options in the event of illness. They have a similar duty to recognise the limits of their knowledge and that of medical professionals. Patients need to take responsibility for their illness and become partners in their treatment. They secondly have a responsibility towards their fellow human beings by not exposing them to unnecessary health risks and by the judicious use of health care resources. They have a duty to protect the environment from pollution and to preserve scarce resources. They should respect their fellow creatures by insisting, for instance, that they not be used in painful experimentation. Lastly, they arguably have a metaphysical responsibility toward their offspring by ensuring that they inherit a healthy and safe environment conducive to a worthwhile existence. It is controversial if a future person could have a legitimate grievance that his/her identity had been changed by germ-line therapy (refer discussion of gene therapy by Ruth Chadwick 2001:189-197), but moral agents are obliged to give this possibility due consideration before embarking on genetic treatment.

#### **7.4 Moral Pluralism:**

In view of the failure of all the available ethical theories to satisfactorily resolve the plurality of moral dilemmas faced by modern (wo)man, some moralists have motivated for a Hegelian methodology of critical analysis of past theories and synthesis of the valid elements of each into a pluralistic, overarching theory. Thomas Nagel in an essay *The Fragmentation of Value* put the case for moral pluralism. He identified five fundamental types of value that need to be incorporated in such an ethical theory:

- 1) “*Specific obligations* to other people or institutions, arising out of deliberate undertakings or special relations.
- 2) Constraints on action arising from *general rights*.
- 3) *Utility*, that is, consideration of the effects of one’s actions on everyone’s welfare.
- 4) *Perfectionist ends or values*, that is, the intrinsic value of certain achievements or creations, such as scientific discovery or artistic creation, distinct from their value to the individuals who experience and enjoy them.
- 5) *Commitment to one’s own projects or undertakings.*” (Norman 1998:200)

None of these values are irreducible to one another and cannot be ranked on a single scale. The problem with such incommensurable values is that it seems to imply that some moral conflicts are bound to be irresolvable. Nagel therefore suggests that, when faced with such conflicts, one should exercise judgement in the Aristotelian sense of *phronesis*, or practical wisdom (Norman 1998:201). David McNaughton developed a similar idea of ‘moral vision’ in his defence of internalist moral realism<sup>20</sup>. He explained it in terms of the experience of coming to see a situation in a new light. This may come about when a person, through perceptual experience, newly notices a particular feature of a situation or when someone else points this out, “thereby revealing an overall shape or pattern... The only method of arriving at correct moral conclusions in new cases will be to develop a sensitivity in moral matters which enables one to see each particular case aright” (Norman 1998:211-212). The concepts of *phronesis* and ‘moral vision’ both focus on the particulars of a situation. Norman, although agreeing with a particularistic account of

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<sup>20</sup> This view holds that moral beliefs are sufficient to provide someone with a reason to act in a certain way, independent of that person’s desires.

morality, warns that we first need to understand the appropriate universal concepts before we can recognise an action as right or wrong. The universal is not merely applied to the particular case, but the universal is recognised *in* the particular, thereby allowing the agent to see the particular in the right way. “A moral understanding of the particular situation and the particular life encapsulates and is informed by an understanding of human life in general” (Norman 1998:213).

Norman further incorporates the metaphor of ‘meaning’ in his moral theory and uses it in the manner of making sense of our experience, to orientate ourselves practically in the world. “To recognise that we live within a network of ties and loyalties is to recognise what those relationships require of us” (Norman 1998:214). This recognition involves both a cognitive and an affective awareness of the world and our place in it, and informs our world-view. Norman believes that both the conception of our relations to others and the conception of needs and a worthwhile life are essential components of a worthwhile moral theory. His moral view attempts to allocate a central place to altruistic concern that, although it meets the needs of the individual, does not fall into the trap of moral egoism, and also recognises the limits of individual responsibility.

Norman’s moral view is both personal and inter-subjective, based on rational argument, and offers a shared moral vocabulary in which to rationally debate diverse moral beliefs. I believe that dialogue is an indispensable component of the moral life and should be given greater prominence in biomedical ethics. Dialogue is vital in bridging divides formed by mistrust. Through dialogue the stakeholders create a space in which the voices of all the people can be heard, “regardless of their race, gender, sexual orientation, culture, moral values, religious beliefs, and socio-economic status” (Lotter 2001:97). Participants in dialogue provide one another with the opportunity to express their differences in a tolerant environment and help all the parties to identify areas of consensus and dissensus. Dialogue leading to empathy and mutual understanding of differences may be sufficient to defuse some conflicts.

Ideally: “[t]rue dialogue exemplifies a willingness to find just solutions. When citizens are prepared to invent new options through dialogue, a best possible solution might be created that imaginatively accommodates all interests. Such a solution must conform to, or extend, our firmest convictions of justice and fairness and be consonant with the underlying values embodied in a constitution. Solving problems in this way educates participants. This happens through articulating their own interests, engaging in debate and argument, listening to knowledgeable partners, and learning from mistakes, successes, partners, and outcomes reached in dialogue” (Lotter 2001:98). “Through dialogue citizens become aware of conflicts, confusions, uncertainties, and inconsistencies in their views and this awareness leads them to modify, give up, or tone down some of their values, wishes, preferences, and objectives” (Lotter 2001:99).

In any debate one should however be aware of existing power differentials and how they can impact on the discussion. It is paramount to determine what mechanisms of power are at work and for what reasons. Flyvbjerg’s (1993:11) motto makes it clear: “[n]o practical discussion is going to take place unless you understand the relevance of *phronesis*. But no practical philosophy can be adequate for our times unless it confronts the analysis of power and how it operates in our everyday lives.” The presence of unequal power relations does however not make dialogue ineffectual; it merely implies the need for specific constraints to be applied.

Matthias Kettner (1993:34) formulated five such morally relevant constraints of practical discourse. The **generality constraint** states that discourse should be open to all speakers whose interests are or will be affected by regulations adopted to resolve the issue. The **autonomous evaluation constraint** implies a principle of non-paternalism: all participants have symmetrical chances to introduce and challenge assertions and to express their needs, wishes and interests. Individual as well as collectively shared values and ideals can be challenged. The **role-taking constraint** aims to enable people to take an interest in each other’s concerns by asking them to adopt a hypothetical stance towards their own interests and values. The **power-neutrality constraint** involves the absence of external coercion and determines that existing power differentials between participants have to be neutralized in some way so that they have no bearing on the debate. Lastly, the

**transparency constraint** requires all participants to share a full understanding of their goals and intentions relevant to the issue.

A pluralistic ethic still has to overcome many challenges and much criticism. Norman acknowledges the difficulty of a pluralistic ethic to deal with conflicts between radically different kinds of values, for instance the conflict between rights and utility. He rejects the notion of a formula for solving the conflict though, and proposes that if we identify the underlying attitudes and needs in which the conflict is rooted, we will see how to think about it. If we recognise, for instance, that *utility* is based on (Humean) sympathy - a concern to help in promoting other's well-being - which corresponds to the basic human need for assistance from others, and that *rights* are based on (Kantian) respect - recognising that the other person has his/her own life to lead - which corresponds to the need to be in control of one's life and to have a sense of one's own agency, it will cease to be an abstract moral conflict between utilitarian and rights-based arguments. Although the dilemma will still be difficult to resolve, Norman believes that we will have a better understanding of what is at stake (Norman 1998:216-225).

A pluralistic ethic is at home in a postmodern understanding of the world. The fundamental principle found of a postmodern ethic is that it restores the individual to his/her place as author of his/her own morality, in contrast to the ideals of modernity that sought to shift the responsibility for making moral rules and promoting them to a supra-individual level. Instead of just being expected to follow rules, the individual now takes responsibility for his/her own choices. Furthermore, there is not just one set of rules to obey or disobey. The choice is rather between different sets of rules and different authorities preaching them. "With the *pluralism* of rules, the moral choice appears to us intrinsically and irreparably *ambivalent*. Ours are the times of *strongly felt moral ambiguity*" (Bauman 1993:20). The moral agent finds him-/herself in a state of ethical confusion and experiences a lack of clarity of moral choices that can never be resolved to his/her full, unclouded satisfaction. This is the ethical paradox of the postmodern condition: "it restores to agents the fullness of moral choice and responsibility while simultaneously depriving them of the comfort of the universal guidance that modern self-

confidence once promised” (Bauman 1992:xxii). We yearn for guidance we can rely on, but the authorities we may entrust are all contested, and none seem powerful enough to give us the degree of reassurance we need. While the moral task of the individual grows, the social means with which to accomplish it shrinks. “Moral responsibility comes together with the loneliness of moral choice” (Bauman 1992:xxii).

The postmodern condition rejects the supremacy of reason and the possibility of universal laws on the one hand, but it does not replace this void with a universal God. It makes morality a private affair and leaves the individual in a state of chronic uncertainty. The emphasis shifts from an attitude of merely applying a rule (modernity) to taking responsibility for your interpretation of the rule. Every situation has to be analysed anew and decisions made on the basis of the available information. The individual never has the assurance of having made the right decision, sanctioned by ethical rules or based on religious grounds. It is for this very reason that some view postmodernity not as unethical (as some critics claim), but as the first truly ethical condition.

I thus propose that a pluralistic ethic, incorporating the main concepts of virtue and responsibility, with due attention to the need for competence in the skilful fulfilment of duties and the importance of human rights, adequately circumscribed by general rules and principles, can be the only possible guide out of the maze of ethical confusion characteristic of this post-modern society. Exactly how such pluralism can be practically applied and enforced remains to be analysed. The magnanimity of this task should however not subtract from its promise.

## **8. CONCLUSION:**

“Throughout its history, medicine at its best has been praised for scrupulously competent clinical care; fidelity, even friendship, towards patients; honest, rigorous science; educated concern for the health of the public; and a general willingness to welcome the needy sick. Medicine at its worst has been condemned for obscurantism, faddishness, venality – for being monopolistic of its benefits and dangerous in its power” (Jonsen

1990:151). Distrust of medicine has become commonplace in our contemporary society and doctors are feeling besieged by the barrage of attacks coming from administrators, governments and patients. Patients and doctors all too frequently become adversaries around the hospital bed and in the courtroom. This essay attempts to make sense of the animosity and mistrust evident in the once-respected doctor-patient relationship.

By undertaking a Hegelian journey through the history of Western Medicine, I hope to have recast some of the ethical dilemmas facing the medical profession today. In my view, much of the current conflict between medical professionals and patients stem from the opposition between the traditions of paternalism and autonomy, which have been divorced from the historical contexts that necessitated them. Paternalism was conceived through the ethics of competence that developed in ancient Greece as necessary proof of the respectability of this new art of medicine. The power of medicine was magnified by the scientific and technological breakthroughs of the Enlightenment era and this reinforced the notion of competence. Medical students are today still schooled in the ways of competence and with this mastery of data and method, come to believe that they know what is in the best interest of their patients.

The Enlightenment not only escorted in a new science, but also a new conception of humanity and social interaction. It gave birth to the idea of universal human rights that revolutionized the socio-political sphere. In modern medicine great emphasis has been placed on the rights of the individual and rights such as respect for autonomy have surely been necessary counters for the excesses of paternalism. Rights-based language however tends to be unnecessarily adversarial and often serves to further the divide between doctors and patients, rather than contributing to closing it. Doctors have also become more aware of their own rights and are demanding that they should be treated with equal respect and consideration. Clearly, with both parties uncompromisingly or acrimoniously insisting on their rights, little room is left for compassionate understanding and empathy! Moral dilemmas thus stemming from either a simplistic opposition between paternalism and autonomy, or between conflicting rights, appear intractable. With an adequate understanding of the history of the two traditions, one however comes to view the scope

and purpose of each tradition anew. I believe that both the thesis of paternalism and the antithesis of autonomy are necessary features of the moral life, but that they need to be brought to a higher synthesis where the opposition can be transcended.

Possibilities for such a higher synthesis rest on the ethics of virtue and responsibility, and culminate in a pluralistic ethic. While moral rules and principles are necessary in the moral life to guide human action, they cannot function independently. Equal emphasis should be placed on the agents performing actions - on the doctors and the patients. They should be trained in the tradition of the virtues and be made aware of their responsibility to themselves, their fellow-citizens, their progeny and their planet. This approach relies heavily on the principles of phronesis and dialogue. Keeping Kettner's constraints of practical discourse as absolutes, I believe that a space can be created where all participants are treated as equals in the moral debate and be able to air their views openly. Through rational discussion everyone's hopes, needs and fears can be evaluated. I believe that a one-dimensional ethical theory only provides a simplistic top-down solution and therefore cannot do justice to the complexity of the moral life. Similarly, I do believe that a return to an ethics of old can satisfactorily answer the questions raised by contemporary society. Our present position calls for a novel approach where participants accept responsibility for their actions and for their moral status as human beings. This requires knowledge and practical wisdom. We will however have to accept that some degree of ambiguity will remain in the moral life and that this is part of our postmodern condition.

Jonsen (1990:132) stated: "disguising or forgetting ambiguity is one of the perils of the moral life. It is much more comfortable to see life as a seamless whole, or as ordered by a single rule, than as inherently ambiguous. One has to recognise that our resolutions will not dissolve these ambiguities: "competence will always have to rediscover its limits, compassion will always have to suffer its finitude, authority and autonomy will always have to coexist in the unstable democracy of medicine" (Jonsen 1990:133). But with the help of a reflective understanding of the history of Western Medicine, I hope that at least some of the mistrust and acrimony can be removed from the doctor-patient relationship and mutual empathy be reintroduced in the corridors of medicine.

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