

Yesterday's Ethics in Contemporary Medicine – Is It Still of Concern?

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Abstract: Discussions on questions and problems of medical ethics are on everyone's lips. The debates center for instance around the just allocation of public resources, demographical changes in our society or the guarantee of patient autonomy, thus posing questions on the technical progress in modern medicine. These contemporary conflicts in medicine are numerous, but not all of them are new; rather, the discussion in medical ethics on these dilemmas is bound to contexts and has historical roots. Some of these conflicts reach back to the medicine of the Renaissance and Antiquity, thus assigning actuality to the historical viewpoint. Taking history into account, one can benefit from a timeless content and not least get a feeling for historicity and contingency. Considering the creation of identity, the old authorities also represent central normative reference points for the ethical competence of physicians understood as an attitude within an interpersonal medicine. For this reason, the heritage of Hippocrates, which encompasses values and norms of the Hippocratic Oath, needs to be respected. Apart from other dimensions of knowledge and skills, the development of an individual ethical competence also requires awareness of the past, leading to an understanding for the historical, social and cultural relativity of medical action.

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Discussions on medical ethics are on everyone's lips. The presence of the subject is not limited to the discourse in universities; rather, there is not a day when questions and problems of medical ethics are not in the media (Schmidt et al., 2008). One need only think of the heated political debate overall Europe about the just allocation of public resources. In particular in the German public health system based on the principles of a supportive society, this debate is highly charged with ethical meaning in a time of scarce resources on the one hand and an increased demand on the other hand (Rauprich et al., 2005): more and more people want a cost-intensive and differentiated medicine, but fewer and fewer people produce the financial basis for first-rate medical care. To use a keyword, this is a problem of double-ageing: there are more and more older people and fewer and fewer younger people. One can also think of the difficult question how patient autonomy can be guaranteed. After many years of intense political discussion in Germany, we have created a legal regulation (within the 3rd law on the modification of the law regarding advance directives) which is meant to define the rules concerning the will decreed by the patient (Borasio et al., 2009). It is doubtful whether this normative conclusion is going to facilitate the response to the difficult question of how the intention of a patient can be respected. The fact alone that medical indication shall decide on the question whether the physician in charge shall be obliged by the patient's will at all, reminds us of historically well-documented paternalistic structures, according to which the physician would know what was good for the patient – well-known historical structures which are of current interest (Beauchamp and Faden, 1995; Vollmann, 2000). Anthropological needs for security and support when dealing with borderline issues of life have definitely to be taken into account when looking at the call for legal action, which has increased during recent years – and this call is well-known from history as well (Bergdolt, 2004; Steger, 2011). One just has to think of the history of ethical codification before the Declaration of Geneva (1949) or the Declaration of Helsinki (1964), which provides guidelines for ethics commissions – in a way superior to legal regulations (Schmidt and Frewer, 2007). In a certain sense, these rules are made by physicians for physicians; they are valid internationally and have a long tradition (Wiesing and Parsa-Parsi, 2009). There is a special need to remind of this in a time in which there is constant talk of technical progress, a technical progress that supposedly leads to new – and not least ethical – questions in medicine (Schöne-Seifert et al., 2008; Schöne-Seifert and Talbot, 2009). One can see this very well when looking at advanced intensive-care medicine, especially at the example of neonatology. Basically speaking, these discussions focus again and again on the question of what it means to lead a good life; in doing so, they touch the poles of quality of life, age and life expectancy. Last but not least, it is a central point to these questions how satisfied the patient is with the doctor. And this context must not be seen without economic concerns, as pointed out by Euricius Cordus

(1486–1535) in an epigram (Paschou, 1997). Cordus at first belonged to the Erfurt circle of humanists before being appointed to the chair of Medicine at the University of Marburg and, at last, holding the position of town physician and teacher in Bremen from 1534. So you read in Cordus' Latin elegiac distichs:

*Tres medicus facies habet: unam, quando rogatur,
 Angelicam; mox est, cum iuvat, ipse Deus.
 Post, ubi curato poscit sua praemia morbo,
 horridus apparet terribilisque Satan.*

This may be translated into English as follows:

Three faces has the Doctor: When we are ill
 He seems an angel; when he's cured the evil
 A god we call him. When the little bill
 Comes in long after, he's the very devil.¹

So the doctor is judged by his patient and develops from an angel to God himself and finally to the Devil. All that sounds very modern and is by no means unknown to today's doctors. The change in the judgment of the patient might well depend on the situation. When the doctor is needed, he/she shall help and release one from his/her illness: the patient ascribes positive attributes to the physician, who is even called God. The devaluation starts when the doctor calls for the fee. The epigram dates from the Renaissance, but regarding its timeless content, it could just as well be written by a contemporary poet (von Jagow and Steger, 2005, 2009). This actuality can generally be claimed for the medicine of the Renaissance and Antiquity (Siraisi, 1990; Nutton, 2004). The old authorities (Hippocrates, Galen and Avicenna, to name only the three *principes medicinae*) can in fact claim a certain timelessness with regard to the history of ideas. And that assessment is valid once more for the humanum, as it simply still is the base of our present ethics in the discussion on medicine. So at this point it can be retained that the bases of modern discussions on medical ethics can hardly be found in a more exact way than in the medicine of Antiquity and the Renaissance (Bergdolt, 2004). By the example of medicine, the actuality of Antiquity can once more be proved (Flashar, 1997; Carrick, 2001; Steger, 2008). Thus, ethics in medicine cannot be understood outside of a context. It rather has to be contextualized and, not least, to be discussed in a historical context (Wiesing, 1995; Toellner and Wiesing, 1997). In my courses on history, theory and ethics of medicine – the latter an obligatory subject in the German university curriculum of human medicine since 2002 – I have repeatedly addressed the vicinity and respectively the entanglement between the modern discussion on ethics and a historical reconstruction destined to be a means of reassurance for today's actions. From the corollary research backing an integrative teaching

module on the subject of “Patient Education in Physicians’ Daily Working Routine” developed by us (Schildmann et al., 2007), the following can be stated:

The elaboration of historical backgrounds has helped the students understand current problems of patient education and patient consent. As an example, I would like to quote three commentaries by students regarding this context: (1) History and ethics of medicine have to be considered together, because many ethical problems repeatedly appear in the history of medicine. Relevant cases can be used as examples and for the development of resolution methods. (2) Ethical and moral values depend on social background. In order to understand our present-day views, one should track the historical development of ethical thinking patterns and consider it in present-day ethical discussions. (3) Historical experiences show the necessity of ethical standards in medicine: not everything that is technically possible is acceptable from an ethical point of view. The human being as a subject has to be at the center of any consideration.

Bearing this in mind, I advocate a type of medical ethics which is aware of the past (Baker, 2002). In an increasingly ahistorical society, we can benefit from looking at the past. Taking history into account, one cannot least get a feeling for historicity and contingency. The present is part of the past. Its values and norms have not fallen into our lap; they are part of concrete political, social and economical contexts and will not last forever. Thus, I consider that there is an urgent need to make sure that the heritage of Hippocrates is respected (Steger, 2008).

It is not by accident that the name of Hippocrates is at the center of discussion (Ausfeld-Hafter, 2003). The oath named after him stands at the beginning of a tradition of ethical codifications and serves as a point of reference for doctors, even more so when they discuss ethics. An example: in 2003, the Lübeck-based neonatologist Axel Fenner writes in the German Medical Weekly (Fenner, 2003): (1) “2000 years ago already the Oath of Hippocrates has stated clear guidelines for the conduct of physicians when dealing with death including unborn life; problems which often are very difficult, (...) The Oath states verbatim: “I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion.”² (2) “What now is the position of physicians in our country regarding the question of mass fetocide of embryos? One would expect a permanent and unfading outcry if they continued to feel obliged by the Oath of Hippocrates in their actions and attitudes. But they remain silent – they remain silent and cooperate.” Looking at this, Fenner demands that the coming generation of physicians should be (3) “[trained F. St.] to be doctors who are not satisfied with doing their duty as demanded by the law, but who reflect on their actions and are ready to revolt against a law if they can’t bring it in line with their conscience as doctors or the Hippocratic Oath.”

Hippocrates of Kos has evolved into a role model for physicians (Golder, 2007). He was born about 460 BC on the island of Kos, which is part of the Dodecanese archipelago. He was a descendant of a family of Asclepiads, whose roots went back

to Asclepios, the great god of healing. One can suppose that Hippocrates taught medicine on Kos before wandering through the *Poleis*. He died at an old age. A whole tradition is related to his name; this is preserved in a collection of work: the *Corpus Hippocraticum*, which comprises about 60 writings, united in Alexandria and has been ascribed to the time between 450 and 360 BC. In this compilation, almost all areas of the healing arts are covered (Jouanna, 1992). For the first time in the history of the Occident, health and illness are attributed to reasons detached from the gods; they are rather described using rational observations of analogies in nature including micro- and macrocosm (Wittern, 1996). The collection unites case histories, instructions for therapy, aphorisms or reflective considerations on ethics. The Oath of Hippocrates is part of this group of writings, which does not mean that Hippocrates is its author; generally, the authorship of these writings is not unambiguously clarified. Thus, it is all the more astonishing that so much attention is paid to the Oath, which is even considered to be the fundamental law of medical ethics (Deichgräber, 1955; Lichtenthaler, 1984; Schubert, 2005; Steger, 2008). And it may cause even more astonishment when becoming aware of the fact that the Oath had basically no significance in Antiquity – at least none that can be traced back historically. On the one hand, there was no professional body of medical practitioners in Antiquity to whom the Oath could have been addressed. Doctors were craftsmen, who learned the craft of healing (*iatrike techne*) from their master. There were no binding training rules, let alone training institutions. On the other hand, time was not ripe for a moralization of medicine. This tendency is only recognizable up until the Middle Ages, when the Oath was adapted in a Jewish, Christian and Islamic context, precisely because of its clear moral positions on questions of abortion, surgery and euthanasia. It was then translated into Latin and spread by means of the letterpress, including many commentaries (Boschung, 2003). Only short mention shall be made of the fact that the Oath – as a sign of awareness of the profession – also became politically attractive. It was instrumentalized during Nazi dictatorship, namely as an argument both for (by Karl Brandt) and against euthanasia (by Frank Büchner). Finally, it was cited (by Werner Leibbrand) in the Nuremberg Trials when making an ethical assessment of human subject research during National Socialism, even though the Oath remains silent on the subject of experiments on human beings (Leven, 1994, 1997). This shows that at an extremely high identificatory force was ascribed to the deontological principles of the Oath. The Oath, thus, offered an orientation and satisfied the anthropological need for guidance in difficult borderline questions of life – and basically these aspects contribute to its significance until today.

Structurally, the Oath is artfully composed as a ring. At the beginning, the gods are invoked as witnesses, and at the end there is a closing formula. In the center, there is a promise: “(...) I will preserve the purity of my life and my arts.”³ The central commandments are grouped around this promise: one should honor the teacher, care for him, impart knowledge of the art to his offspring as to one’s own

sons; do good to patients; not give lethal drugs to anyone; not use the knife, even upon those suffering from stones; do no injustice to patients and keep secrets. Even though the Oath is a time-bound document, it can be seen that basic demands of medical self-commitment are contained in it: a physician should protect life, keep secrets, not do harm to patients (non-maleficence), give priority to the well-being of patients (beneficence), respect the human dignity of the ill and be trustworthy as a doctor by professional competence and conscientiousness. In that, the question if we should say goodbye to the Hippocratic Oath in today's discussion on medical ethics is, after all, a rhetorical one. The heritage of Hippocrates, thus, contains lasting rules and values, makes clear the long tradition of the medical ethos and establishes an identity for individuals and for the group. This assertion is backed by the Declaration of Geneva, which was formulated in 1948 by the World Medical Association following the Nuremberg Trials. Today, the declaration forms a preamble of the professional codes of conduct in the different versions of the respective state medical associations in Germany. It offers orientation with respect to the position of the medical profession in society and names the moral norms of medical action – in the tradition of the Hippocratic Oath. An explicit mention of patient autonomy is still missing in it, but – in post-Hippocratic development – there was vehement action in favor of this aspect (Weindling, 2001). So from the 1960's, in German-speaking countries the *voluntas aegroti* has increasingly replaced the *salus aegroti* as *suprema lex* in the requirements concerning informed patient consent. Considering the historical development to patient autonomy as the highest-ranking principle in the doctor-patient relationship (Beauchamp and Faden, 1995), political and legal implementations of this principle – as accomplished by the German Patient Self Determination Act passed in 2009 for example – in my opinion have to be seen as a step backwards for legally binding regulation on medical indication in general can be abused as a paternalistic act.⁴ The possible conflicting consequences of this principle can be found, when one continues to look at Antiquity and remembers Sophoclean *Antigone*, a play in which Antigone – in an act of highest expression of autonomy – buries her brother Haemon in spite of the interdiction by King Creon and the (legally justified) sanctions that would follow her action. And this behavior is responded to by the chorus with the impressive words “Numberless are the world's wonders, but none more wonderful than man. (...)”. In my opinion, this courageous and, thus, impressive decision by Antigone and the literary reflection on it in Sophocles' tragedy of the same name is the best argument for the value of a historical reassurance of our actions today – also and not least in medicine. Contemporary conflicts in medicine are numerous, but not all of them are new. Rather, the discussion in medical ethics on these dilemmas is bound to contexts and has ancient roots, which – as my considerations show – go back to Antiquity. Taking history into account, one rapidly is convinced of the relevance of Antiquity for our time (Grmek, 1996). In times of a marked progress-oriented optimism, such historical considerations have a positive

effect, especially when including pre-modern times. They are also comforting when one reads that the rules of professional medical ethics are reputed to be of no relevance. How can it be that identificatory cultural testimonies of this kind have no significance for human orientation and support? The answer becomes clear when drawing an argument for the limited importance of such testimonies from their missing legal validity.

Of course one will have only little objection to the assessment that the Hippocratic Oath and the Geneva Declaration have no legal significance at all because they are no legal correlate. But that is not the issue. Who will seriously ascribe such a function to the Oath? There is much more at stake, namely central normative reference points for my actions as a human being and as a doctor in contact with my patients. As far as I am concerned, exactly these are represented in the named testimonies and have the function to create an identity. If one just wants to abstract away from this central significance, one has to put up with the question of how these regulations, how legal regulations really help to practice good medicine that does justice to the individual. I will also not tire to remind you once more of the precedent of the German Patient Self Determination Act of 2009. Asking in a different way: do laws really enable one to make a good decision in clinical-ethical conflict situations? Also, do not interventions from outside, for example by law; increasingly limit the fundamental liberal orientation of the medical profession?

In short, I advocate an ethical competence of physicians that is understood as an attitude within an interpersonal medicine. And this ethical competence, apart from other dimensions of knowledge and skills, also requires an understanding of the historical, social and cultural relativity of medical action in the sense that I have explained. Consequently, my point is a (historically) sensitive perception of current questions of medical ethics on a basis of a knowledgeable and trained reflectivity which cannot ignore history. In Germany, discussions on stem cells, euthanasia or abortion are hardly conceivable without historical contextualization – one likes to speak of a special German responsibility for ethics in medicine. Can this responsibility go so far as to consider medicine as a substitute for religion and doctors, in fact, as gods, i.e. as comprehensive and unselfish saviors? As critical as one may see such an attribution, much more responsibility would be ascribed to doctors by it; a responsibility that can – and must – not be free from historical considerations. It certainly is a meritorious enterprise to look for principles absolved from history and context and to introduce them into a rational explanatory discourse. Where human beings are involved, even more so when these stand at the borderline of life, emotionality seems to be an important dimension of an ethical explanatory discourse. And this emotionality again is not imaginable out of contexts. Particularly here, stories of life, that is to say narratives full of every-day morals – history thus – form important arguments. In this context, I am not surprised that Henk ten Have writes in the introduction of

the “Bioethics” he edited in 2001 (ten Have, 2001): “However, even if it is possible to identify a common set of values, a continuous effort will be required in order to critically assess the actual meaning of the values as articulated and codified in the past, and to evaluate and rephrase the underlying traditions (...) When we try to identify what is typical of European approaches to bioethics, we will notice that European literature in the area of bioethics tends to put more emphasis on (1) the historical background of ethical issues, (2) the social cultural context, and (3) substantive normative viewpoints.” So, we should vehemently oppose a type of ethics lacking historical context and, respectively, demand an ethics discussion which is historically contextualized.

Notes

- ¹ English translation of the epigram cited from The British Medical Journal, Sept. 19th, 1908, Literary Notes, p. 845: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2437337/pdf/brmedj07979-0065.pdf>
- ² Translation by Michael North, (US) National Library of Medicine, 2002: http://www.nlm.nih.gov/hmd/greek/greek_oath.html
- ³ Translation of the Oath by Michael North, National Library of Medicine, 2002: http://www.nlm.nih.gov/hmd/greek/greek_oath.html
- ⁴ The advance directive represents the will of the patient. Thus, it determines in which way and to what extent medical treatments and interventions should be accomplished or be omitted. Since the Patient Self Determination Act of 2009 the contents of the patient’s advance directive are legally binding for all members the treating team at all times, irrespective of the prognosis of the patient. Trespassing may lead to legal restrictions including loss of the license to practice medicine.

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