Bioethics: Its Philosophical Basis and Application

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Contemporary medicine involves a lot more than technologies that now permit effective medical intervention where none was possible before. Among other things, changes in technology have been accompanied by changes in social and cultural attitudes that are having major effects on health care and medical practice. This article provides a brief overview of many of the more important changes and their relationship to developments in the field of medical bioethics.

Medicine and philosophy are not alien to each other. The questions arising from the cycles of birth, life, happiness, suffering, pain, and death are essential questions of human existence. They are dealt with professionally by different methods in philosophy, ethics, and medicine. Within this context, classic medical philosophy deals with metaphysical concepts of (a) Man's place in Nature, (b) his or her relationship to the Divine, (c) health and disease, and (d) epistemologic and methodologic concepts of diagnosis, classification, risk assessment, and treatment. Classic medical ethics deals with judgments regarding the patient-physician relationship, the patient's "best interest," and the set of virtues required of the good physician.

TRADITIONAL INTERACTIONS OF MEDICINE AND PHILOSOPHY, ETHICS AND EXPERTISE

Pythagorean thinking in the West and Taoist teaching in the East nearly 2,500 years ago laid the foundation for a medical philosophy emphasizing the principles of harmony and balance. Health and happiness were understood to represent a cosmic balance or a goal of harmony in life. Disease resulted from something out of balance. The role of medicine was to reinstitute balance or harmony, to fight imbalances and disharmonies, and to accept and understand the limits of medical expertise as natural limits of human manipulation. Both the *Corpus Hippocraticum* and early Asian medical authorities such as Sun Simiao in China (*1*) stress the importance of philosophic studies for mastery in medicine.

Today the practice of medicine is guided by ethical principles that in turn are rooted in philosophic concepts. Among these ethical principles are *nil nocere*, "do no harm," and *bonum facere*, "do good for the patient." Most classic medical texts point to limitations on the goals of medicine and times when medical expertise may not be used. Euthanasia, abortion, torture, and exercising power or manipulating people by means of medical intervention may be especially excluded from good and masterful medical practice by such limits to professional conduct. Traditionally, medical ethics and expertise belong together. Ethics without expertise can never be effi-

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cacious, while expertise without ethics is unlikely to serve the patient's good.

Progress in medical technology and the rise of pluralistic society have produced a combination of factors responsible for the particular set of priorities prevailing in medical philosophy and ethics as we approach the twenty-first century. Modern medicine allows us to prolong the lives of some patients in intensive care to a point where we have to ask ourselves whether or not such prolongation is mandated by the medical ethos and its proud tradition. "Organ transplantation," "*in vitro* fertilization," "intensive care," "resuscitation," and "psychopharmacopeia" are some of the new terms suggesting the increased moral responsibilities that arise from increased technical capabilities, while other terms like "teamwork," "medical specialists," "shift work," "sickness insurance," and "health care systems" point to organizational changes in the traditional physician-patient relationship. Within this context, terms such as "patient autonomy" and "informed consent" have emerged from trends toward a more "emancipated" lifestyle and individual self-understanding by the educated citizen.

Even the new term "bioethics" indicates that epistemologic and moral aspects of providing health care services can no longer be described in terms of the traditional parameters of the physician-patient relationship. Bioethics encompasses a field that is wider than just the relationship between the individual physician and the patient, one that includes a professional responsibility toward all forms of life as well as the specific ethos that must prevail in modern forms of institutionalized and organized medicine (2).

Among the numerous philosophic issues of bioethics, the following will be taken up in this article: (a) concepts of health and disease, (b) the principles of bioethics, (c) the physician-patient relationship, (d) lifestyle "medicalization" and related value issues.

MEDICAL AND MORAL UNCERTAINTY AND THE MODELS OF MEDICAL SCIENCE

Descartes, during the high days of rationalism, postulated that only those things would be true which could be perceived clearly and distinctly: "*illud omne esse verum quod valde clare et distincte percipio*" (3). However, if such a clear and distinct perception were required before any medical intervention, physicians would rarely be able to act.

Descartes' critics developed the Neo-Kantian theory of science, differentiating between the nomothetic sciences (natural science) and the idiographic sciences (the humanities) (4). Here again, the risky business of diagnosis, prognosis, and therapy did not fit the models, which were confined to setting laws or describing ideas.

Toulmin has suggested that the historical model proposed by Vico provides a better framework for analyzing medical science than does the Cartesian geometric model (5). After all, the human body, its health, the deterioration of its health, and accidents that pose risks to its health all have a history. This history, reconstructed in medical anamnesis, provides information for predicting possible future developments, with or without medical intervention.

Reviewing the various parameters involved, it seems clear that medicine is neither a science in the strict sense of the word (a "natural" science) nor a judgmental art. Rather, it is an expert method of assessing risks, handling uncertainties, and making prognoses in a profes-

sionally responsible manner based on experience, role models, and other factors.

The application of ethics in medicine follows the same rules as the application of technical expertise in medicine. Both require careful and differential diagnosis, a weighing of the options of intervention, and selection of the most beneficial option. Medical diagnosis follows the rules of interpretation, researching and assessing individual patients' stories of well-being and well-feeling; for just as life is a story that can be narrated, so are the changes, improvements, and deteriorations in life. But in contrast to hermeneutics (interpretation) in the humanities, medicine does not just interpret but acts on the results of hermeneutic procedures, dialectically intertwining interpretation and interaction, measurement and manipulation, theory and practice.

Clearly, medicine cannot be reduced to the parameters of a simple natural science. The professional responsibility for healing and comforting cannot depend exclusively on the results of blood tests or other scientific data. The patient's values are as important as such test results for diagnosis, prognosis, and deciding upon a course of therapeutic action.

Similarly, the values of the physician and the values incorporated into the health care environment are as important as the technical abilities of individual health care professionals, the technical capacity of the health care system, and the technical quality of the participating health care institutions. Of particular interest is the role professional organizations play in shaping, protecting, and developing the principles of professional ethics, paternalistically guiding both their members and their members' clients.

When it comes to patient care, it is important to be aware of the value-laden environment of medical intervention. This is the reason that checklists for non-scientific data have been developed—to help deal with personal and value issues in the physician-patient relationship and in the process of determining the "patient's best interest" (*6, 7*). Nevertheless, medical intervention should not be based solely on scientific data—because of the complex nature of medical explanation, because of essential uncertainties in diagnosis and prognosis, and because the aim of medicine is to treat the entire patient rather than isolated symptoms or diseases. Therefore, especially in this age of high medical technology, the history of medical science supports a demand for reappreciation of traditional humanist and ethical values that were a part of the "healing arts and sciences"; for in good medical practice the patient's axiogram is as important as his or her hemogram. The concepts of health, well-being, well-feeling, and happiness, as well as their opposites, involve more than laboratory data. Within this context, bioethics is the necessary complement of bioscience; for while bioscience is based on principles of natural science and risk assessment, bioethics is based on the moral principles developed during the history of general and professional ethics and their application.

PRINCIPLES OF BIOETHICS IN THE MODERN WORLD

Contemporary medicine involves a lot more than the growth of technologies that permit medical intervention in cases where no effective intervention was possible before. The technologic changes of the modern world have been accompanied by changes in social and cultural attitudes that emphasize the individual's importance as the prime decision-maker in value-related questions of life's style and goals. Indeed, modern society has been called pluralistic because it has developed a wealth of different sets of

value-priorities for individuals and because it emancipates the educated citizen from formerly dominating and quite often indoctrinating ideational forces.

Educated citizens, both as clients and providers of services, have to communicate regarding the risks and the benefits that certain services entail—because the cultural and moral assessment of risk by different educated persons in a pluralistic society may not be the same. This new situation in a society rich in different individual value preferences requires concentration on the traditional mid-level moral principles of medical ethics—principles such as beneficence, *nil nocere*, justice, professional responsibility, patient autonomy, individual good, common good, pain care, and not prolonging the process of dying (*8*). These principles of bioethics have been and will continue to be recognized by a broad range of religious, philosophic, and ideologic viewpoints. As Jesus stressed in the study of the Good Samaritan (Luke, 10, 25ff), the mid-level principle of mutual aid to a neighbor can be supported by a variety of metaphysical or religious traditions.

Regarding the traditional principle of medical beneficence, it is comforting to note that this concept can be supported and indeed has been supported by traditions as diverse as Christian ethics of different denominations, the nonreligious humanist tradition, British utilitarian philosophy, Kantian rigorisms of a Categorical Imperative, Marxist concepts of solidarity, even the anarchist concept of mutual aid proposed by Kropotkin. Other principles of bioethics that can be widely supported by various traditions in a pluralistic society include respect for patient autonomy, the principle of "doing no harm," and the idea that the individual patient's case should have priority over general political or economic considerations. As this suggests, it appears that certain mid-level principles are essential for good medical practice, regardless of the different cultural or historical circumstances in which medical services are rendered.

Other principles are harder to apply to specific cases, because people disagree about matters such as contraception, abortion, and withholding treatment from severely handicapped newborns or comatose or brain-dead patients. However, bioethics has developed a number of pragmatic principles for reducing moral risks that can help diminish or resolve some of the problems arising from different world views in pluralistic societies (*9*). Focusing on these mid-level principles instead of contending against others' basic beliefs can contribute to development of a peaceful society rich in diverse values. Among the principles:

- A leading principle of bioethics and all other applied ethical systems in a pluralistic society is that of respecting the individual citizen's priorities—so that no one is asked to perform acts that he or she cannot justify morally. Among other things, this means never asking someone to perform an abortion or to share blood or organs if that person feels aborting fetuses or sharing blood or organs is unjustifiable for religious, metaphysical, or other reasons.
- The century-old Thomist principle of subsidiarity holds that services that can be provided on a decentralized volunteer basis should not be handled by the central government or dealt with at the societal level. Such decentralization tends to reduce political pressure for central government institutions to accept responsibility in controversial areas, while simultaneously encouraging volunteer and decentralized groups to act according to their own specific moral priorities.

- In a similar vein, the individual patient's urgent needs should take precedence over general considerations of justice for all and also over considerations relating to the structure of the general health care system; this allows the physician to differentiate between his or her medical obligations as a professional and civic duties as a citizen.
- Another principle, that of human solidarity, requires that assistance and protection against suffering be given to a fellow human being despite profound individual ideologic or religious differences.
- Also, it should be noted that moral assessments in specific cases require micro-application of bioethical concepts in order to precisely target intended moral and medical goals. For example, informed consent must be applied this way in some particular form—such as proxy consent, presumed consent, educated consent, consent under pain, persuaded consent, or a living will. Similarly, the beneficent physician has to apply his or her good intentions this way in cases where there is a conflict between aims—so as to either reduce pain or provide aggressive treatment, prolong life or comfort the patient, and provide intensive care or palliative care.
- Finally, there are many times when more than one moral principle must be applied to the same case. This requires mixed application of principles in possible conflict with each other—such as respect for the patient's autonomy and a paternalistic sense of medical responsibility, or achieving reduction of pain with drugs that might pose severe risks for the patient's health or life.

THE BENEFICENT PHYSICIAN AND THE PATIENT'S GOOD

Changes in the social and institutional delivery of health care services, as well as societal and cultural movement toward a more pluralistic society, have influenced the physician-patient relationship. In the days of Hippocrates—and indeed, up to the last century—the efficacy of medicine was rather marginal, and the doctor defined what was good for the patient. Today the definition of *bonum facere*—beneficence, doing what is in the patient's best interests—cannot be defined exclusively by the physician, for two reasons.

The first reason is that while medical options for intervention are abundant, the goal of intervention needs to be defined. Should one choose aggressive and intensive postoperative chemotherapy or radiotherapy, or should one choose palliative care? Which best serves the patient's "good"?

The second reason is that different people have different concepts of life and what they want from it. Some place strong emphasis on health, while others abide unhealthy "workaholic" habits or recreational drug consumption; some emphasize paying for health insurance or saving for old age, while others prefer spending to make life more pleasant now.

Pellegrino and Thomasma have found an unhealthy overemphasis on autonomy in contemporary bioethics and have called for restoration of the beneficence principle in the form of *beneficence-in-trust*, i.e., "that physicians and patients hold 'in trust' (Latin: *fiducia*) the goal of acting in the best interests of one another" (*10*). They hold that patients as well as physicians need to orient themselves according to specific sets of virtues; and they propose a "post-Hippocratic oath" that transforms basic

Hippocratic principles, adapting them to the modern world of educated patients and to the sharing of decision-making between patient and physician.

The role of the physician in the post-Hippocratic era relates to at least three different models: (a) The Hippocratic model deals with the anthropologic and existential situation of urgent aid and urgent need; this is the traditional model, one that cannot be replaced so long as fellow humans suffer and are in need of moral and medical attention. (b) The contractual model sees the physician as the provider and the patient as the recipient of specialized services—such as specialized diagnosis and treatment, laboratory work, radiation therapy, anesthesia, and certain specialized kinds of surgery. This model envisions the patient as having full autonomy and the physician-patient relationship as being no different from other provider-client relationships. (c) The partner model makes the physician the patient's consultant and partner in managing long-term health risks or chronic diseases such as diabetes or hypertension. The patient is involved as the main gatekeeper of his or her balance of health, well-being, or well-feeling; the physician's role is to assist the patient's self-help efforts. More than the other two models, this one requires an educated patient ready to accept the major share of responsibility (*11*). All three models describe different physician-patient situations, which in specific cases can be found mixed together in varying degrees.

THE VIRTUOUS PATIENT AND LIFESTYLE-RELATED HEALTH RISKS

Bioethics has focused extensively on the physician's changing role and responsibilities, but has tended to neglect the educated citizen's role as patient, gatekeeper for good health, and preventer of health risks.

Traditionally, the only two virtues required of the patient were compliance and trust. Low levels of education and of means to assure good health kept the ordinary citizen from becoming involved in medical decision-making, prevention of health risks, or responsibility for health. There was classic nutritional teaching, which applied the wisdom of the Golden Rule by telling people to avoid the extremes in life and thereby reduce individual exposure to risk; but this was relatively bland and general compared to the concept that has replaced it—one that regards medicine as intervention to repair defects that could have been avoided in the first place.

Today, more and more diseases and health risks appear lifestyle-related. Within this context, we have a moral obligation to consider not only the citizen's right to good health care, but also the citizen's duty and responsibility for health care. This latter is primarily an obligation to safeguard personal health through proper nutrition, exercise, recreation, and avoidance of occupational and recreational health risks. Two reasons for this obligation: It is morally difficult to accept the idea that the benefits (if any) of lifestyles that pose a threat to health should accrue to the individual, while related health costs are shared socially. Also, it contravenes the concept of citizen and patient autonomy if the individual is disinclined to deal responsibly with personal health care matters.

Wherever public health care is readily available, some personal value conflicts will be dealt with indirectly by "medicalizing" feelings such as unhappiness, frustration, disappointment, and grief. Such action constitutes an abuse of medical knowledge and is actually counterproductive for purposes of confronting

and mastering the personal crises and challenges of life.

CONCLUDING REMARKS

The future of medicine—and of health and happiness—will depend on good and prudent analysis, assessment and management of philosophic questions, and development of moral expertise related to health and well-being—just as over the last hundred years good and successful medicine has depended on careful analysis, assessment, and management of technical expertise. The future of bioethics, however, will depend on the progress that it can make in establishing and reaffirming both physician and patient ethics—the ethics of educated and responsible people who, as Aristotle maintained in a past age, are the most essential ingredients for a peaceable, happy, and culturally rich society.

The health of future individuals and future societies will depend upon the extent to which accumulated philosophic and ethical knowledge can be put into practice—first by the educated citizen and thereafter by the medical community. This will also pose the ultimate test of whether autonomy, responsibility, and beneficence are merely words in oaths, declarations, and philosophy books, or whether they are part and parcel of our human nature—a nature that admittedly still needs refinement and cultivation, but one inclined toward genuine acts of beneficence, comforting, healing, and support.

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