

# The birth of medical ethics

Medical ethics as a systematically cultivated field of knowledge is the work of the second half of the twentieth century. Although the past was not indifferent to its subject area, it did not feel the need to elaborate on the ethics of various professions, including the medical one, because it respected - albeit often inconsistently - "ethics in general".

Classic moralistic texts, the authors of which are important figures in the history of medicine, contain, in addition to sentences that are moral norms, also instructions whose goal is to preserve status prestige. Those moral norms are not justified there, because they are a mere concretization of the moral views of their time, considered self-evident. This is the case, for example, in the Oath of HIPPOCRATES, which forbids artificial abortion and euthanasia, which would have shamed the doctor of that time in the eyes of the public (therefore, it is an appeal to recognized morality), but at the same time commits to social solidarity, the aim of which is, among other things, to ensure the doctor's material existence. But HIPPOCRATES is no longer interested in the doctor-patient relationship. He did so for the first time only in XXX, X century later.

Also, the Middle Ages and the Modern Age did not spare individual moral appeals to doctors (or wrongdoers), derived from the moral views of the time, but did not feel the need **to rethink the actions of doctors from an ethical point of view and to justify the results of these considerations**. It was created only recently because the existing moral conventions of our culture proved to be unreliable and it was impossible to rely on them. **The need to consistently cultivate medical ethics is therefore one of the signals of the moral and ethical crisis of our culture.**

## Establishment of medical ethics

The impetus for the establishment of medical ethics as a field, even as a subject of study, was the appalling findings about the behavior of Nazi doctors during the Second World War. In the given context, it was not so much a case of doctor-sadists of the Josef Mengele type (there was nothing to solve there from an ethical point of view), but rather of those doctors who performed experiments on concentration camp prisoners. From a methodological point of view, these were completely rational research projects, e.g. monitoring the organism's reactions to extraordinary physical and toxic influences. Some of the results of these experiments even became a practical benefit (eg hibernation in surgery) - with the fact that the involuntary experimental subjects were prisoners who were **denied their human nature**; neither their will nor their suffering was taken into account, and many did not survive the experimentation, and if they did, they were permanently scarred physically and mentally.

The Nuremberg Tribunal dealt with the case of Nazi doctors only in 1947. The interrogations showed how far they had been depersonalized by the voluntarily accepted ideology. However, the self-defense of these experimenters caused deep consternation: they invoked the **common utilitarian morality**, the key value of which is utility: *the maximum benefit for the maximum number of people*. After all, whole generations will benefit from the results of the experiments! - This surprised not only the tribunal, but also the entire European culture with its moral pluralism, whose palette includes moral utilitarianism alongside other -isms. The shaken public, including the medical public, did not readily have a strong intellectual counter-argument, but intuitively felt the need for *a wider context of perception*, in which the unacceptability of obvious evil would be convincingly justified. This context was to become - *medical ethics* as a consistently cultivated *discourse* (= debate) based on concern for the good. Its aim was to formulate principles that would guide *professional morality*, taught by the horrors of Nazism. That's what the medical professional organizations of the free world decided then.

In the 4th chapter, we followed, among other things, the **birth of ethical consciousness in the maturation continuum**: in the "embryonic" Self, oriented according to the principle of pleasure, a new structure of conscience was gradually created, initially heteronomous (Superego), dependent on external authority, which gradually acquired autonomy (in KANT meaning) so that - in a non-pathological case - it merges with the mature Self, oriented according to the principle of reality, into one harmonious whole. What takes place in this way in *an individual plan* can have its analogy in a *collective plan*, i.e. in the history of a certain specific culture. - The post-war situation shows us (in a collective plan) the **birth of ethical consciousness from an upheaval**. In the first case, the conscience was slowly **awakened**. In the second, it is **recovered** by the intervention of a shocking experience (for which, however, it has retained a kind of preliminary understanding, see Chapter 2; otherwise the shock would not have occurred). This is also one of the possible ways.

The monstrosity of the Nazi ideology was fully understood only after the war. Only then was a complete "inventory" of the devastation caused possible. It was especially the *Holocaust* (Hebrew: *Shoah*), i.e. the rationally planned and technically perfectly executed extermination of European Jewry, which called into question the previous European emphasis on *mere technological rationality* (let's not forget that a number of members of other nations, including Slavic ones, assisted the German Nazis in this regard). It became clear that "technique (or professionalism) without ethics" leads not only to a dead end, but directly to the abyss. The technology itself (or professionalism), pursuing its own perfection, is blind to various non-technical, non-professional interests, which then easily become motivations for its practice. - This inspired an attempt to formulate **firm, simple and evident principles, which should henceforth become unquestionable guidelines for ethical reasoning and decision-making by any physician**.

## Formulation of four basic principles of medical ethics

The initiative was primarily taken by the Anglo-Saxons: continental Europe, previously the hotbed and scene of Nazi atrocities, did not have the proper distance at first, even though it was shocked. The construction of the principles of medical ethics therefore bears the seal of traditional *English empiricism*. Let those principles apply as axioms, based on simple empirical evidence. Let them not require any special rational justification to be acceptable to anyone who is not pre-directed by ideological interest, whether he subscribes to any religious faith, or is an atheist or a skeptic. Let rational argumentation come to the fore only after their acceptance, which itself should be *self-evident*. **After a series of discussions, four basic principles of medical ethics** were formulated – , a kind of analogy of the biblical Ten Commandments. They are:

1. **principle of nonmaleficence** ,
2. **principle of beneficence** ,
3. **principle of respect for (patient's) autonomy** and
4. **the principle of justice** (more about them in the next chapter ).

These four principles do not create any "ready-made" medical ethics. They are only its starting point and guideline, which has so far always proven itself in solving the ethical problems of medicine. It is possible that it will be necessary to expand them by others (currently, among other things, discussions are taking place about the principles of handling experimental animals), but there is no need to withdraw or change them.

## Deficient models of medical practice

### Socialist healthcare and the bureaucratic model

Formulating principles is not yet putting them into practice. This requires will, and it may be lacking (similarly, even more self-sufficient legislation is not a guarantee of the rule of law). The birth of medical ethics as a consistently cultivated field and the announcement of its basic principles was one of the most significant milestones in the history of modern medicine. **The practice of socialist healthcare** , mostly post-war, has shown that even such a fact can be ignored. Its total bureaucratization enabled a far-reaching **depersonalization** of the doctor-patient relationship: too often the patient was accepted by the doctor not as a unique personality, but as one of many, as the one who "has a diagnosis", needs a prescription or an intervention, as someone who demanding and harassing. This is how a disinterested official accepts the demanding "party". This fundamental disrespect for the patient's autonomy (i.e. neglect of the 3rd basic principle of medical ethics) also had an adverse effect on therapy, as it deprived it of its psychotherapeutic dimension. After all, even the doctor was depersonalized. Mutual mistrust then led to the mutual alienation of the medical state and the lay public (bureaucratization also broke the team-spirit of the medical state itself).

### Other deficient models

**The bureaucratic model** is only one of the **deficient** (= insufficient) **ways of practicing the medical profession** . All of them in one way or another contradict the principle of respecting the patient's autonomy and depersonalize both sides of the doctor-patient relationship. Today, when healthcare is being privatized in our country, a **commercial (market) model** that imitates the relationship between producer and consumer, or seller and buyer, is particularly attractive. The interest of the former is maximum profit, the interest of the latter is minimum expenditure. – In **the jurisprudential (lawyer) model** , the doctor and the patient treat each other with distrust as opposing parties to the dispute, where the patient represents the potential plaintiff and the doctor the potential defendant, whose misconduct (real or perceived) the court intervenes. is also subtly deficient – **The expert (scientific) model** , when the dominant interest of the doctor is the pursuit of professional erudition, possibly scientific knowledge and their publications, while the patient is subtly relegated to the position of an observed object or experimental person. – From an ethical point of view, it is the only acceptable one **partnership model** , in which the doctor and the patient openly communicate as individual free human beings. Interests that dominate in deficient models to the detriment of partnership can also be seamlessly integrated into this model.

## Adoption of the Constitution of Medical Ethics

The very establishment of medical ethics as a separate field was generally received positively. After 1989, also here. However, this friendliness is not always spontaneous. mentioned the Chapter 6 difficulty of ethical debate in the intellectual atmosphere of our contemporary culture. **Even in the medical environment, one can encounter an embarrassed reaction to the thematization of the ethical dimension of the medical profession.** One-sided emphasis on *expert* or *the technological* component of medical practice, on the professionalism of the performance and its success, i.e. the **pragmatism of the doctor** , is an attitude from the point of view of which ethical consideration is something unproductive and redundant. The pragmatist doctor usually abandons this position only when he himself becomes a patient. It is evident from this that it is an egocentric attitude.

Another difficulty with the acceptance of medical ethics by doctors themselves lies in the idea that its purpose is to provide **directive guidance on how to act in a particular situation** . That it is actually a kind of refined, luxurious analogue of healthcare legislation. It is a fairly widespread opinion here, in a country spiritually devastated by half a century of totalitarian regime. **It overlooks the non-identity of ethics, morality and law** (see Chapter 3 ). Even medical ethics is primarily a reflection and discussion about what is good (in a given situation), i.e. searching and finding. Often even in unique situations that have no precedent, when it is necessary to make a decision even in uncertainty and simply bear the risk of this decision. Even medical ethics can reach conclusions that can be generalized, or generalizations of which can be offered. However, in doing so, consideration

and decisions justified by that consideration can never be bypassed. The effort to do the opposite, to mechanically respect norms, is a manifestation of the regressive need to follow only heteronomous (preconventional - see Chapter 4 ) morality, i.e. a form of alibi.

## Summary

**Medical ethics as a separate field was created by a collective decision** . His impetus was the uproar caused by the behavior of Nazi doctors during the Second World War. The need to establish medical ethics signals the disorientation and unreliability of the morality of our contemporary culture. Its establishment is a respectable attempt to counter this demoralization.

The first of the performances of medical ethics was the establishment of **four basic principles** based on empirical evidence. They are: the principle of *nonmaleficence* , *beneficence* , *respect for autonomy* and *justice* . They are the starting point and guideline for every ethical consideration and every doctor should adopt them as a matter of course.

Medical ethics illuminates the ethical dimension of medical practice. This intention of hers encounters resistance, the most common source of which is the pragmatic attitude of the doctor and his reluctance to bear the weight of consideration and the risks of autonomous decision-making.

The principles of medical ethics are contradicted by **insufficient (deficient) models of medical practice** . The most common are the bureaucratic (official), commercial (market), legal (lawyer) and expert (scientific) model. The partnership model is optimal.

## Links

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5. Ethics and (psycho)pathology
6. Ethical culture
7. **The birth of medical ethics**
8. Four basic principles of medical ethics
9. Informed consent
10. Allocation

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- INCIDENT, Peter. *Ethics : The Birth of Medical Ethics* [online]. [feeling. 2011-12-23]. < <http://www.lf2.cuni.cz/ustav-lekarske-etiky-a-humanitnich-zakladu-mediciny-2-lf-uk/etika> >.