Contents

1 Henk ten Have **iii**

1

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1. Why philosophy of medicine?

When I started studying medicine in 1969 many controversies existed about university education in general and medical education in particular. Just after the students' movement in France, Dutch students also demanded to be more involved in university policies. They organized protests and manifestations for various reasons, but particularly because the government proposed to increase tuition fees while university education at that time started to become less elitist. In Leiden medical school, the curriculum has just been reformed with less emphasis on the natural sciences. For the students, however, the reform was not sufficient; they wanted more teaching in social and psychological subjects as well as practical exercises earlier in the curriculum to show the relevancy of the courses for later medical practice. In retrospect what we experienced in this first year of medical education was disappointment (we learned later that this has been described by sociologists as the institutional development of cynicism). Most of us had chosen to enter medicine out of idealistic motives; we wanted to care for other human beings although the profession was certainly not the best paid one and the educational career was exceptionally long. The personal idealism of helping people was however confronted with impersonal structures, procedural approaches and psychological detachment. The first year of the curriculum focused primarily on statistics, physics, chemistry, biology. The very intensive program of courses did not provide the impression that medicine has anything to do with human beings in specific conditions and differing social and cultural settings. Activist students protested in order to put pressure on the faculty to revise the curriculum more

substantially. But it was also clear to some of them that in fact an overall conception of medicine and its purposes, a more philosophical approach, was missing. Around the same time, the reputation of philosophy professors was spreading among the students. Quite a number of medical students decided just for curiosity to attend the public lectures of two of the most famous professors. In fact they involved themselves in an alternative rather than 'hidden' curriculum. Every friday afternoon in the ancient academy building of Leiden University, Professor Gabriel Nuchelmans, specialist in analytic philosophy, logic and medieval philosophy was teaching two courses on different subjects. His courses were open for anyone, and over the years a large audience has been gathering, not only interested in the subject but also because he was an excellent teacher. The other professor attracting many students was Cees van Peursen, an energetic, stimulating teacher with a very broad range of interests. Epistemology and philosophical anthropology were his main areas, but he also made explorations in metaphysics and philosophy of culture. His public lectures were focused on particular philosophers (such as Levinas or Spinoza) or philosophical schools (such as existentialism); they were connected with intensive reading sessions during which a small group of students was slowly reading a major volume. These exceptional teachers created a real interest in philosophy among their students. At the same time, it was obvious that they did not address fundamental questions regarding medicine and health care, at least not in a direct way. Philosophical reflection, however, is at the end aimed at elucidating basic queries concerning human existence. The philosophical courses demonstrated that science is not a mechanical activity of reproducing knowledge but a critical, analytical and reflective challenge to the intellect. Medical students all over the country decided to combine the study of philosophy with that of medicine. When later, in 1982, the initiative was taken to establish the Dutch Society for Philosophy and Medicine, it turns out that there were approximately one hundred interested persons with a double degree.

Another professor of philosophy who motivated me to go specifically into the direction of philosophy of medicine was Marius Jeuken. Biologist, philosopher and Jesuit, he was teaching philosophy of biology in the Science Faculty. When I had to choose the main subject for my master in philosophy, philosophy of medicine had not yet attracted much attention. The discipline closest to it was philosophy of biology. Jeuken addressed many relevant

issues such as body and mind, science and values, nature and life, freedom and determinism. He also directed the Institute of Theoretical Biology with excellent library and study facilities. He encouraged me to address the interrelations between medicine and philosophy. As a result, in one of my first publications, published by the leading Dutch journal of philosophy, I argued that philosophy of medicine should be considered as a legitimate philosophical discipline (ten Have, 1980).

Under Jeuken's guidance I studied what philosophers like Plato, Aristotle and Kant have said about medicine or medical subjects. More or less by accident I discovered that Jeremy Bentham has had a considerable influence on contemporary medicine. He was one of the first to argue that there is a need for activities in public health and for deliberate health policy. He emphasized the importance of prevention and the utility of creating a separate Ministry of Health. As a philosopher, Bentham inspired the emergence of the sanitarian movement with disciples such as Thomas Southwood Smith and Edwin Chadwick. It was a perfect example of how philosophy and medicine have been interacting in the past. For Bentham, medicine was the leading model for reformation and modernization of society. What the physician is doing at an individual level, the lawmakers should do at the level of the 'political body'; they should address the 'political nosology' on the basis of experience, observation and experiment. On the other hand, his focus on social conditions promoted the view that major health problems such as epidemic diseases are not the result of individual behavior or contamination, but rather the sequel of poor and unhygienic living conditions due to the Industrial Revolution with overcrowding, bad air, pollution and insalubrious drinking water. In his view, individual patients should not be the target of medical intervention but the environment and social conditions as main sources of diseases.

My master thesis on the influence of Bentham on contemporary medicine and health care was later elaborated into a PhD dissertation (ten Have, 1983). The historic example however was located in the wider context of interaction between medicine and philosophy. The two disciplines have for most of their history been intimately related. Only recently, with the emergence of medicine as a natural science, they separated. The warning of the Swiss psychiatrist Eugen Bleuler (1921) that medicine and philosophy should be kept apart, otherwise one will end up with a mixture of chocolate and garlic, has been taken seriously. Medicine is nat-

ural science; philosophical speculation is not only useless but also dangerous for its development. Philosophy has only produced a graveyard of dead systems of ideasbook.

2. Re-appreciation of philosophy of medicine?

What started as a personal quest for philosophical reflection on medicine transformed rapidly, at different places, into a systematic and disciplinary exploration of a new field of scientific enquiry: philosophy of medicine. The appearance of specialized journals such as The Journal of Medicine and Philosophy (since 1976) and Metamed (1977; renamed Metamedicine since 1980; Theoretical Medicine since 1983) as well as the book series Philosophy and Medicine (since 1975) showed that in many countries in more or less the same period of time philosophical reflection on medicine has been emerging. But, as in other countries, there have been two streams in the development of medical philosophy: medical ethics practiced by theologians and moral philosophers, and philosophical studies focused on concepts, theories and methodologies of medicine, by physicians. Only in the mid 1980s these streams flowed together with a growing dominance of the ethical one. In my scientific work I have always tried to bring the increasing focus on bioethics back to the initial and fundamental context of philosophy of medicine. In fact, the intellectual movement towards bioethics was facilitated by two reductions. The notion of 'bioethics', introduced in 1970 has been reduced from its initial wide scope proposed by Potter to a more limited one, focused on an enlarged version of medical ethics. Furthermore, the fundamental and critical debate about health care was reduced to a discussion of normative issues, and primarily to the question what individuals ought to decide. Bioethics became 'pars pro toto' for the wider movement of philosophical reflection. These two reductions imply that important concerns and questions have disappeared from the agenda of bioethical debate. In this respect it is important to clarify the context of philosophy of medicine in which bioethics has been born.

a. Context of emergence of philosophy of medicine

Critical reflection was closely linked to the progress of medical science in the 1950s and 1960s. In the Dutch context the evolution of philosophy of medicine was related to the tradition of anthropological medicine and general practice, that both requested a focus on the patient as a whole person and thus a more holistic methodology, as well as the tradition of history of medicine (ten

Have and van der Arend, 1985). The first phase of criticism was characterized by the identification and critique of 'medical power'. Particularly influential was a booklet of Van den Berg (1969) scandalizing the unprecedented power of medicine. Within the medical discourse itself, it was argued that the role and efficacy of medicine is often overestimated (McKeown, 1976).

The second phase focused specifically on the negative impact of medical power. This power, exercised by professionals, is often associated with arrogant and paternalistic behavior as well as a tendency to expansion into other areas of human and social life. The concepts of 'medicalisation' and 'iatrogenesis', introduced by Zola (1973) and Illich (1975), appeared particularly fruitful. Many studies emphasized the interrelation between medicine, society and culture, and they could be easily connected with philosophical criticism from structuralism (Foucault) and critical theory (Adorno, Habermas). Such critique led to the third phase of counterbalancing medical power, either by imposing limits through legislation and emphasis on patient rights, or by articulating individual autonomy and decision-making, or by creating and utilizing alternative systems such as complementary, holistic, and humanistic medicine and self-help (Aghina, 1978, van Dijk, 1978; ten Have, 1980).

The various activities of critically analyzing present-day health care promoted a broader examination of the presuppositions, foundations, methods, concepts and values of modern medicine. The usual approaches and assumptions could no longer be taken for granted. Rethinking the philosophy of medicine was apparently motivated by the need to clarify the image of the human being, not only presupposed in medical activity but also stimulated and reinforced by medical science. As philosophy in action, medicine tries to remake man and reality (Pellegrino, 1976; Engelhardt, 1974). Medicine always proceeds with certain implicit ideas about what human beings are and should be. This motivation is connected with social movements to 'humanize' medicine and to make it more 'holistic'.

Another motivation for philosophical analysis was the need to clarify the scientific character of medicine, reflecting on the methods of clinical judgment and clinical decision-making (Wulff, 1980). Elucidating the so-called medical model was particularly imperative in discussions with protagonists of anti-psychiatry and alternative medicine. Kuhn's paradigm theory of scientific development was applied to medicine (Verbrugh, 1978), to determine

the demarcation between science and non-science but also to discover the special nature of general practice and family medicine. In connection to medical methodology, basic concepts such as health, disease, illness, normality, complaint and suffering were intensively discussed (ten Have, 1984). A third motivation to engage in philosophy of medicine was created by the moral problems of medical progress. It is not simply that there are new or different problems but medical ethics itself is in a crisis. A first proposal to redefine medical ethics, based on the concept of human dignity and on a broader image of man as a relational being, was published by Paul Sporken (1969) who was also appointed as the first professor of medical ethics in a medical school (in 1974 in Maastricht). During the 1980s bioethics rapidly institutionalized; all eight medical schools in the country created chairs and specific departments or centers in medical or bioethics with ethics teaching as mandatory component of the curriculum.

b. From internal to external morality

The rapid emergence of bioethics can be explained as the transformation from internal to external morality in the area of health care. Traditionally, medical ethics referred to the deontology of the medical profession. Deontology expressed the internal morality of medicine, i.e. the specific values, norms and rules intrinsic to the actual practice of medical care. They define implicitly good clinical practice and determine what a good professional is. The growing power of postwar medicine discredited this notion of internal morality and replaced it rapidly with values, rules and norms external of medicine. These normative determinants were prevailing in social, cultural and religious traditions that influence the context in which medicine is practiced. There was increasing consensus that these determinants should be more important in the regulation of medical practice than the usual internal ones. The new bioethics emphasized primarily external morality, with moral notions such as 'individual autonomy' and 'social justice' (ten Have, 2001).

This shift from internal to external morality had significant consequences. It has been instrumental in creating a distinct profession of bioethicists, but it also promoted the development of health care legislation (in some countries like France specifically labeled as 'bioethics laws'), separate institutions (bioethics committees) and educational and training programs (masters in bioethics). However, the primary emphasis on external morality also encouraged a particular view of medicine as a neutral transaction, an

enterprise, even trade or business, aimed at exchanging technological assistance and expertise with the demands and needs of autonomous persons (clients or consumers). By developing into an autonomous discipline assisting health practices, bioethics has at the same time become a component of the technological order. It has been dominated by an engineering model of moral reasoning using the idea of technological rationality in addressing a particular set of practical problems through the application of moral principles. In this approach, bioethics is a sophisticated technology to make a particular set of (potential) problems manageable and controllable. Usually the focus of ethical analysis is narrow and not too critical. For example, ethical review of research protocols is focused on informed consent, not on the social relevancy of the research; assessment of new technologies concentrates on safety, effectiveness, and costs, not on the social and ethical implications. If bioethics as a new scientific discipline and public discourse has emerged because of the development of moral problems due to the technologic advances that are changing medical care and treatment, then the outcome of this evolution is rather paradoxical (ten Have 2004). According to philosophers as Habermas, Foucault, and Illich technology confronts us with moral problems since our life-world has been penetrated, dominated, or even 'colonized' by science and technology. But when bioethics can be regarded as a specific technology itself, aimed at resolving or at least 'pacifying' the moral consequences of the use of medical technologies, it is obvious that the answer to such problems cannot be given by an ethics that is itself technologically orientated. In fact, a type of bioethics that is approaching moral problems in an engineering way, technically applying principles to cases and dilemmas, has become itself another manifestation of the same basic problem. Bioethics has become another expression of the technical rationality that has been the source of moral concerns in the first place.

c. Repositioning bioethics

This diagnosis of the development of bioethics implies that bioethics emerged as the predominant response to the criticism of contemporary medicine and the problems created by science and technology. But it also demonstrates that bioethics does not provide a cure but merely acts as a palliative. Instead of seriously addressing the philosophical queries raised within the critical movement, bioethics is primarily concerned with proposing practical answers and solutions.

The detachment from internal morality, as discussed above, was facilitated by the self-conception of bioethics as 'applied ethics'. Within the tradition of ethics this notion seems a tautology since ethics has always been considered as practical philosophy. Nonetheless, as Stephen Toulmin (1982) has argued in a famous publication, ethics has been marginalized as a sterile, academic, analytic discipline. Only through the emergence of moral problems in the medical setting it came to be revived. Emphasizing 'application' has a double connotation: it indicates that ethics is available for what we usually do, it applies to our daily problems; but ethics is also helpful, practical, in the sense that it is something to do, - it works to resolve our problems. The conception of bioethics as applied ethics not only demonstrates its usefulness (beyond mere theoretical and academic interest) but also its relevancy. It was canonized in the equally famous textbook of Beauchamp and Childress (1983) that defined biomedical ethics as the application of general ethical theories, principles and rules to specific problems which may arise in health-care delivery, research, and therapeutic practice. The aim of ethical contributions is to analyze these problems and to offer solutions that are morally justified. The main instrument of this approach is a set of moral principles. Usually three or four basic principles are used: respect for autonomy, beneficence, non-maleficence (which is sometimes included in beneficence), and justice. These principles are considered to be basic, because they are general judgments serving as justification for particular prescriptions and evaluations of human actions. Principles are normative generalizations that guide actions. From principles, ethical guidelines and rules can be derived. The advantage of the (four) principles is that they are defensible from a variety of theoretical moral perspectives. They provide an analytical framework, a universal tool, to clarify and resolve moral issues. The principles approach in analyzing moral issues is usually very helpful in identifying and mapping out the relevant moral considerations regarding medical technologies and services; it is also instructive because it points out where further studies are required. For example, in transplantation of organs from living human donors, three fundamental issues are identified: the risks and harms affecting the donor, and questions about voluntary consent, and buying organs harvested from the living. The principles of beneficence and non-maleficence generate moral concerns about justifying harm to the donor. Is it justified to remove somebody's kidney when the removal harms the healthy person without pro-

ducing any medical benefit to him or herself? Or is the donor more harmed by the loss of a family member or friend than by the loss of a healthy kidney? The principle of respect for autonomy generates concerns about consent. If an adult person is asked to give informed consent to surgery to remove a kidney for a family member, can the consent be truly voluntary in such circumstances? In the case of a child whose kidney is the best match for a sibling, can the parents give consent? A decision to "donate" is clearly not in the best interests of the child. Finally, the principle of justice generates concerns about the donation and transplantation systems. What criteria are used to allocate donated organs within a particular area? At the same time, it seems that commercial arrangements are increasingly used, although the sale of organs for transplantation is prohibited in many countries.

The moral issues identified by using the principles approach show that two methodological approaches need to be combined: empirical and theoretical studies. To know, for example, whether autonomy of potential donors is compromised in practice, ethicists need to engage in empirical research. To evaluate the probability and extent of harms and benefits, ethicists need to use or produce quantitative data. Insights into the factual dimensions of a technology are required before these can be assessed from normative points of view. The moral principles identify not only which facts are relevant for further consideration from a moral point view, but they also provide a normative framework for further assessment. Theoretical research here requires analysis of the philosophical and ethical literature, articulating, for example, the implications of deontologic and teleologic ethical theories with regard to the problems at hand. Usually, this is intensive and innovative work, because the existing literature has rarely foreseen or addressed the moral issues arising in present-day medicine. But apparently, even with applied ethics with emphasis on principles, there is a need to extend the ethical approach in two directions: empirical analysis of the practical context and critical philosophical understanding and justification.

d. Remedies

During the 1990s there was an intensive debate about the methodologies and approaches in bioethics. I repeatedly argued that the bioethics discourse could be richer if it explores the dialectics between internal and external morality (ten Have, 1994, 2001).

On the one hand, more attention could be paid to analyzing the internal morality of medical practices. Indeed, new approaches to

bioethics have developed with focus on the particularities of such practices, such as phenomenological ethics (Zaner, 1988), narrative ethics (Newton, 1995), and care ethics (Tronto, 1993). Furthermore, traditional conceptions have been revitalized, notably the new casuistry (drawing from the classical casuistic mode of moral reasoning) (Jonsen and Toulmin, 1988), and the virtue approach, emphasizing qualities of character in both individuals and communities (Pellegrino and Thomasma, 1993). What is particularly striking is the rising interest in so-called empirical ethics. The focus of ethical research is shifting from applying ready-made ethics toward studying ethics-in-action (Arnold and Forrow, 1993). A variety of research methods is used: participatory observation, questionnaires and interviews, decision analysis, quality assessment, preference polls. The common denominator is that qualitative and quantitative data are collected via the empirical study of ethical questions. Many of these studies are fascinating since they show the underlying value pattern of specific practices and in the intrinsic norms which are operative in clinical work, for example in surgery (Bosk, 1979), genetic counseling (Bosk, 1992), intensive care (Zussman, 1992), neonatal care (Anspach, 1993), and nephrology (Lelie, 1999). Especially the work of Bosk has been seminal since he introduced the methods of anthropology and sociology into bioethics (Bosk, 2008). Although empirical research in ethics can provide new and useful insights, and can be regarded as complementary to philosophical approaches, it is also troubled with fundamental problems (ten Have and Lelie, 1998). One of the basic questions concerns the moral relevancy of empirical data. Empirical research can help to explain and understand the attitudes, reasoning and motivations of the various actors in the health care setting, but empirical data in themselves can not justify how the actors ought to behave or what kind of decisions are morally justified (Pellegrino, 1995).

On the other hand, the external morality could not simply be assumed in bioethical discourse but should be critically revisited. In order to obtain a better understanding of the interaction of both moralities, internal and external, it is necessary to establish a theoretical framework relevant to medical practice in order adequately to take account of the norms and values inherent in the practice of medicine, but it requires at the same time sufficient detachment in order to provide a critical normative perspective on medical practice. This is not only true for the principles that are applied, such as the principle of respect for autonomy that is often

assumed as the basic notion for ethical discourse (with individual decision-making as antidote to medical paternalism). But is seems to be true also for the emphasis on application in general. When bioethical analysis concentrates on how to morally justify the application of science and technology in the context of health care, it is often so fully immersed in the object of analysis itself that it does no longer position itself at a critical distance of scientific and technological developments. We then no longer understand how they create moral quandaries. Critical reflection on the presuppositions and implications of scientific and technological developments can clarify how moral problems emerge, why some problems emerge and not others, and how such problems are addressed. Bioethics therefore needs to go beyond the framework of science and technology itself, questioning whether the new knowledge or the specific technology, as such, is justified in the light of moral values. Here, ethical analysis does not, a priori, take science and technology for granted. It starts from a critical perspective, assuming that for example technologies are not value-neutral but incorporate particular values themselves. Technologies are expressions of values, such as the values of searching for knowledge, having offspring, or relieving suffering. However, these values are often implicitly given and not articulated. Ethical research is now taking them as the starting point for a debate on (other) motivating values in society. This type of research focuses on values underlying or embedded in the development of technology itself. For example, studies in this category will not take for granted that the progress of transplantation technologies is beneficial. They will question the specific framing of notions such as personal integrity, altruism, death, and body, which is associated with these emerging technologies. They critically examine the implied notion of 'body ownership', where the moral principle of respect for autonomy is indeed helpful to facilitate organ donation but at the same time reiterates the traditional dualistic image of the human person: an autonomous subject with a material body as its property (ten Have and Welie, 1998). These studies will also explore the recent expansion of these technologies with cell and gene transplantation. They call attention to the claims of perfectibility and immortality, often implicit in the bewildering progress of stem cell technologies, and relate such claims to a philosophical, and sometimes utopian, body of knowledge (Gordijn, 2003). The methodology of such studies is historical as well as synthetic. They attempt to provide a diachronic and synchronic perspective: values embodied in

current technologies are explained in connection to similar values in history, but they are also clarified in connection to developments in other scientific disciplines, thus looking beyond the framework of present times and existing disciplines (ten Have, 1995). The presupposition of this type of ethics research is that ethics first of all is the philosophical effort to understand ourselves and our existence in terms of what is desirable or undesirable, supportable or reprehensible, good or bad.

e. From application to interpretation

The complex interactions between the internal and external morality of health care practices remind us that bioethics is first of all a philosophical activity. As a particular domain of philosophy, ethics proceeds from empirical knowledge, viz. moral experience. The moral dimension of the world is first and foremost experienced. Ethics is the interpretation and explanation of this primordial understanding. Before acting morally we must already know, at least to some extent, what is morally desirable or right. Otherwise, we would not recognize what is appealing in a moral sense. On the other hand, what we recognize in our experience is typically unclear and in need of further elucidation and interpretation.

Because of the importance of interpretation it is argued that ethics is best considered to be a hermeneutical discipline (ten Have, 1994, 2001). Ethics can be defined as the hermeneutics of moral experience. Bioethical problems in particular must be understood within the broader framework of an interpretive philosophical theory. More or less at the same time, philosophers of medicine argued that medicine itself has to be considered as a hermeneutical enterprise; it is not or not merely a natural science (Daniel, 1986; Leder, 1988; Svenaeus, 1999). The modern emphasis on information and empirical data has contributed to new understandings of diagnosis and treatment as the physician's interpretation of what concerns the patient and what can be done to help the patient. And metaphorically, the patient is conceived as a text that may be considered on different interpretive levels. Usually, the patient is understood through an anatomico-physiological model. The patient's body is made 'readable' by the use of technology. But the biomedical language of diagnosis and treatment reduces the overwhelming amount of information presented by the patient so that the standard medical case report reflects not the story of the patient's life but of the physician's relationship with the patient's illness (Poirier and Brauner, 1988).However, differ-

ent interpretative models should be re-activated to do justice to the patient's experiences.

Bioethics as interpretation rather than application concentrates upon four parameters: (1) moral experience, (2) attitudes and emotions, (3) community, and (4) ambiguity. These characteristics enrich the bioethics discourse.

First of all, for ethics, the fundamental question is not so much 'What to do?' but rather 'How to live?' What is important is praxis not poiesis. The moral relevancy of our actions should not be reduced to their effects; it is also determined by an evaluation of what we do in executing our actions. For example: the issue of experimenting with human beings should not be settled by reference to future results, but should also raise the question: Why are we interested in scientific research? This change of focus implies a re-orientation from activity to passivity, from acts to attitudes and emotions. Moral experience also involves primarily feelings, for instance, of indignation, confusion or contentment; these emotional responses should be made the object of moral thinking.

Second, the interpretive reading of a patient's situation is not an individual doctor's affair. The medical prior understandings that orientate the interpretation are the sediments of traditional cultural assumptions concerning the nature of the world and the body, and the results of a specific historical evolution of medical knowledge. Interpretation presupposes a universe of understanding. This is a consequence of the so-called hermeneutic circle; in order to interpret a text's meaning the interpreter must be familiar with the vocabulary and grammar of the text and have some idea of what the text might mean. For man as a social being, understanding is always a community phenomenon: understanding in communication with others. The continuous effort to reach consensus through a dialogue with patients, colleagues and other health professionals, induces us to discover the particularities of our own prior understanding, and through that, to attain a more general level of understanding. This seems to reflect the experience of hospital ethics committees: analyzing a case in terms of moral principles leads to a stalemate but interpreting the moral experience of the concrete participants involved in this particular case usually leads to a consensus. Since the interpretation of moral experience takes place within the context of particular social practices, intimate knowledge of the historical, medical and scientific components of those practices is essential to the task of moral criticism. Ethics can not be practiced without a high degree

of engagement in medical work neither without explicit attention to the social and cultural context.

Third, ethics primarily aims at interpreting and understanding moral experience. But moral experience is complex and versatile. It implies that every interpretation is tentative; it opens up a possible perspective. Definitive and comprehensive interpretation is non-existent. An interpretive approach always has an ambiguous status: more than one meaning is admitted.

Finally, interpretive bioethics will require a new rapprochement between ethics and philosophical anthropology (ten Have, 1998). From an historical perspective bioethics has emerged through various phases of philosophical criticism of modern medicine with very different manifestations: originally epistemological, then anthropological, now ethical (ten Have,1990). Particularly in health care, normative positions and moral theories are intimately connected with images of the human being. In the medical setting we cannot escape the question: what kind of human being do we want to realize in medical activities, what kind of person do we wish to respect, heal, inform, comfort in health care?

f. The need for philosophical anthropology

The image of the human person that underlies, justifies and stimulates much of everyday medicine is a universalistic and reductionist image. In this image, human beings are understood by analysing and studying anatomical structures, physiological functions, pathological aberrations, biochemical complexities or genetic locations and dislocations. The most dominant image in modern medicine is: man as mechanism. The mechanistic image of man underlying in a prototypical way clinical and curative medicine is in fact the Cartesian heritage. Considering the human body as part of material reality has been a fruitful paradigm for modern medicine. But it is important to recognise that present-day bio-ethics has emerged from criticisms of the human being as a mechanism (ten Have, 2000; 2005). It is the one-sided perspective of this image that gives rise to many bio-ethical problems. Moral issues arise from an almost exclusively technological orientation to the world and a predominant scientific conceptualisation of human life. Human beings resist the tendencies of medicine to focus primarily on their bodies and biological existence. They protest against the overwhelming power of health professionals and health care institutions, reducing patients to cases, numbers, and objects. They object to the lack of involvement of individual beings within decision-making processes, as well as to the lack of respect for in-

dividual authenticity and subjectivity. Bio-ethics has emerged as a movement to re-introduce the subject of individual patients into the health care setting, emphasizing patients' rights, respect for individual autonomy, and the need to set limits to medical power.

The paradox, however, is that we try to address the moral issues of medicine with a conception of ethics which is itself impregnated with scientific-technical rationality. The unique view of bio-ethics as 'applied ethics' or 'principlism' that has emerged during the last thirty years seems to reinforce the dominant view of human beings as mechanism, although bio-ethics itself has mainly developed from the criticisms of this image of man.

The dialectic interaction of anthropology and ethics, as emphasized particularly in the conception of interpretative ethics, may help us to regain a view of man as social being, and therefore restore the idea of moral community (Kuczewski, 1997). Our selves are constituted through the practices of the community. Cultural context and community are constitutive of the values and goals of individuals. Communal relatedness falsifies therefore the idea of the unencumbered self, the idea of self-ownership assuming that the individual as an entity exists prior to the ends which are affirmed by it. The idea that the self autonomously designs its life-project from an asocial or pre-social position, and subsequently participates in the community, is self-defeating. Without societal culture our potential for self-determination will remain empty. Ethical reflection is primarily needed to articulate the social and cultural embedded-ness of human beings and to interpret the narrative of each individual life

3. What obligations follow from studying medicine?

Studying medicine implies in the first place being immersed in internal morality, and in particular internalizing the virtues of being a good professional. The focus on the internal morality reiterates the view that medicine is a profession. Medical students should know that they are not just doing academic learning or scientific research, and, - as argued above -, for most of them this is precisely the reason why they have chosen to enter into this profession. In this view medicine is not a morally neutral body of knowledge and technique; its moral content cannot be derived from the general morality of society. A full account of the content of the internal morality of medicine requires further development of two constituents: the moral goals of medicine and the morally acceptable means for achieving those goals. The clinical practice of

medicine is directed on a set of particular goals, a coherent range of good healing actions. As Brody and Miller (1998) have pointed out these goals should not be too narrowly identified (interpreting 'healing' as 'curing a disease'); at the same time, even a comprehensive list of goals is limiting medical activities and requiring particular moral values rather than others. Medical practice also requires internal standards of appropriate performance. Promotion of a particular goal alone is not sufficient; it should go with morally acceptable means. Brody and Miller suggest four obligations for the practice of medicine, originating in the nature of medical practice: (1) The physician must employ technical competence in practice, (2) The physician must honestly portray medical knowledge and skill to the patient and to the general public, and avoid any sort of fraud or misrepresentation, (3) The physician must avoid harming the patient in any way that is out of proportion to expected benefit, and must seek to minimize the indignity and the invasion of privacy involved in medical examination and procedures. (4) The physician must maintain fidelity to the interests of the individual patient.

Second, the profession of medicine is special since it confronts us with the human predicament in all its variety, and more often than not, its misery, pain and despair. University education should prepare students for these essential characteristics of their future work. This requires not only psychological and moral sensitivity but also critical thinking. A hermeneutical challenge will always be there in order to understand and interpret the conditions and misfortunes presented to us. But this challenge also necessitates us to take a critical distance; not to be overwhelmed by emotions or subjected to the possibilities of technological interventions but to reflect on the conditions and circumstances in which human beings are living, the positive and negative impact of science and technology on human existence, and the particularities of the social and cultural context in which problems and questions emerge.

Studying medicine therefore not only implies moral obligations (due to the internal morality of medicine) but the relevancy of external morality also demands philosophical obligations particularly as critical reflection on specific issues and analyzing them within a wider historical and human context

4. What is the most interesting criticism?

Two interrelated critical debates concerning method and sub-

stance of ethics have been conducted, specifically within European bioethics. The first concerns the role and approach of ethics in health care, particularly as applied ethics. The 'engineering model', as described by Caplan (1983) has been advocated as the most efficient and practical approach in ethics. For example, van Willigenburg (1993) defines himself as 'ethical engineer': he has specific expertise in managing concrete moral problems. Practical ethics is focused on solving problems. It is illusory to argue that ethics should primarily be concerned with fundamental problems. Contemporary philosophy can no longer answer fundamental problems. Any distinction between fundamental and concrete problems has disappeared since concrete problems concern essential questions in real life situations asking concrete choices and decisions, not speculation and reflection. For van Willigenburg, practical ethics has emancipated from philosophy and is an effective, useful discipline of its own. Through analysis and rigorous methodology it can structure the process of deliberation and facilitate decision-making. This view of 'ethical engineering', however, seems to reduce the moral concerns of health care to problems that need to be solved. At the same time, it reduces 'living' to 'acting' as if life is one concatenation of decision to be made and actions to be performed. In fact this view illustrates that it is not detached from philosophy but has incorporated a specific philosophy (e.g. the philosophy of techno-science) as its hallmark. The theoretical debate about methodology and conception of bioethics as applied ethics or interpretative ethics is therefore a debate among two different views of philosophy. Another critique has addressed the distinction between internal and external morality. Reinders (1993) has argued that it does not hold water. First, the values internal to medical practice are plural; they are difficult to demarcate from external ones. Second, similar values are shared with other professional relationships. Third, external values determine what good medical practice is. Rather than being criticism, Reinders' arguments illustrate the interconnections between internal and external morality. They call in fact for more research into the internal values of care practices, and this is exactly what has happened since then.

The second critical debate concerns the substance of ethics: it is the debate between liberalism and communitarianism. Is the emphasis in ethical discourse on the primacy of the autonomous individual or on community values and perspectives? In the first two decades since the birth of bioethics, apparently the liberal

paradigm was dominant: each autonomous individual should determine what is valuable and good. This emphasis was understandable given the superiority of medical power and the need to create a strong counterbalance. However the emphasis became less strong due to the development of cultural sensitivity to the context of modern medicine and bioethics (Payer, 1988; Gordijn and ten Have, 2000; Stevens, 2000). Many studies showed not only that medical practices differ among countries and cultures but also fundamental notions and conceptions of disease, health and good life and death. There was growing awareness that respect for individual autonomy was recognized as fundamental principle in bioethics in western cultures but that its significance can not be assumed in other cultures. More or less at the same time, emphasis on individual autonomy became also problematic in the west. This has been an important issue in the efforts to articulate European dimensions in bioethics. In the analysis of ethical problems in care for the chronically ill or in the health care system in general, notions such as solidarity and justice traditionally play a more important role in the European than American context. But the role of the principle of respect for autonomy is also problematic in other bioethical controversies, for example the euthanasia debate or the ethics of genetic technologies and enhancement (ten Have and Welie, 2005). It makes an important difference in the ethical analysis whether the focus is on individual decision-making or on the social or communal context. Considering human beings are part of an encompassing community, - the community of all human beings (as 'cosmopolitan citizenship') or particular communities that locate us in the world (as argued by Sandel, 1996) will widen the scope of ethical discourse, often criticizing the emphasis on individual rights and liberties. For many however, this represents a conservative position since it goes against the liberalism of western societies.

5. The most important problems for future inquiry?

Bioethics currently is at a turning point. Because of the increasing internalization of medical research and the processes of globalization in general, the scope and agenda of bioethics is considerably enlarged. The adoption of the Universal Declaration on Bioethics and Human Rights, unanimously adopted by UNESCO in 2005, has earmarked this new stage in the development of bioethics as a really global bioethics. In a certain sense, the original notion of bioethics initiated by Potter (1971) is revived. Many 'new' issues

are now on the agenda, requiring analysis and research, such as corruption, violence, conflicts of interests, dual use, social justice, future generations, but also ecological problems such as pollution and climate change. Bioethical discourse can no longer focus on the quandaries of rich countries but has to focus on the problems of developing countries. This revival of global bioethics also underlines that bioethics no longer is solely an academic discipline but also public discourse and political concern. More reflection is needed on the transition between scientific research and decision-making in bioethics. The contemporary linkage with human rights has created new challenges and possibilities for bioethics.

The widening of scope furthermore implies a new focus on the ancient problem of universal values and principles. The adoption of the UNESCO declaration illustrates that there is now agreement about principles that form the basis of international, multicultural bioethics, itself firmly founded on international human rights, as predicted years ago by Thomasma (1997). However, the question remains whether the principles are universal as such or merely universally affirmed. It can be that they are gradually discovered to be relevant and justified everywhere, even if they have emerged in particular cultures. Or it can be the result of a gradual expansion, domination, or even imposition, of particular principles in the process of globalization. It has been argued, for example, that the UNESCO declaration gives primacy to individual interests (suggesting that it mainly reflects western perspectives). A closer look at the listed principles, however, shows that agreement was reached on a much broader range of principles, beyond the individually orientated ones. In fact, the principles can be ordered as orientated to individuals, to interaction between individuals, to society, to culture, to future generation, and to the environment. Ironically, the 'Georgetown mantra' has been complemented with social, cultural and ecological principles. It remains to be seen whether the right balance has been struck between universal human values and cultural differences, and what will be the relevancy of cultural diversity within the enlarged scope of global bioethics.

Another question that continues to return in global bioethics concerns the issue of application. Even if the search for universal principles will be successful, it remains true that from a communitarian perspective the universal human condition of existence as a communal-cultural being can only be realized in particular ways. The communitarian self is constituted by particular cultural characteristics. Even if principles are universally adopted, in

practice their application must be tailored in multiple ways to accommodate different types of research and health care, categories of patients and problems, and cultural settings and traditions. Specification will be particularly important for the application of relatively new principles such as the principle of social responsibility and health. It states that progress in science and technology should advance, among other things, access to quality health care and essential medicines, access to adequate nutrition and water, and reduction of poverty and illiteracy. How such principles can be applied in heterogeneous settings and what will be their practical implications, will require new and challenging research.

At the same time, the UNESCO declaration (and other possible universal statements of bioethical principles) contains an expression of a major characteristic of bioethics: the continuous need for interpretation. Bioethical problems commonly arise because conflicts exist between several competing ethical principles. Often it is not obvious which principle will prevail. Accordingly, a careful balancing of principles is usually required. The declaration states principles that may occasionally seem inconsistent. However, ethical decision-making in practice frequently requires rational argumentation and the weighing of the competing principles at stake. In order to advance decision-making, the principles are to be understood as complementary and interrelated. This means that even if universal principles are identified, on the basis of which global bioethics may be justified, the work of bioethics has hardly begun. The challenge then is how such principles can be translated and implemented within different contexts, cultures and traditions.

References

Aghina, M.J. (1978): Patiëntenrecht. Een kwestie van gewicht. Van Gorcum, Assen.

Anspach, R.R. (1993): Deciding who lives. Fateful choices in the intensive-care nursery. University of California Press, Berkeley.

Arnold, R.M. and Forrow, L. (1993): Empirical research in medical ethics: an introduction. Theoretical Medicine 14: 195-196.

Beauchamp, T.L. and Childress, J.F. (1983): Principles of biomedical ethics (2nd ed.). Oxford University Press, New York/Oxford.

Berg, J.H. van den (1969): Medische macht en medische ethiek. Callenbach, Nijkerk.

Bleuler, Eugen (1921): Naturgeschichte der Seele und ihres Bewustwerdens. Eine Elementarpsychologie. Springer, Berlin.

Bosk, C.L. (1979): Forgive and remember. Managing medical failure. The University of Chicago Press, Chicago/London.

Bosk, C.L. (1992): All God's mistakes. Genetic counseling in a pediatric hospital. The University of Chicago Press, Chicago/London.

Bosk, C.L. (2008): What would you do? Juggling bioethics and ethnography. University of Chicago Press, Chicago.

Brody, H. and Miller, F.G. (1998): The internal morality of medicine: Explication and application to managed care. Journal of Medicine and Philosophy 23(4): 384-410.

Caplan, A.L. (1983): Can applied ethics be effective in health care and should it strive to be? Ethics 93; 311-319.

Daniel, S.L. (1986): The patient as text: A model of clinical hermeneutics. Theoretical Medicine 7: 195-210.

Dijk, P. van (1978): Naar een gezonde gezondheidszorg. Ankh-Hermes, Deventer.

Engelhardt, H.T. (1974): Explanatory models in medicine: Facts, theories, and values. Texas Reports on Biology and Medicine 32 (1): 225-239.

Gordijn, B. and ten Have, H. (eds.) (2000): Medizinethik und Kultur. Grenzen medizinischen Handelns in Deutschland und den Niederlanden. Fromman-Holzboog, Stuttgart – Bad Cannstatt.

Gordijn, B. (2003): Die medizinische Utopie. Eine Kritik aus ethischer Sicht. Nijmegen.

Have, H. ten (1980): Wijsbegeerte der geneeskunde. Algemeen Nederlands Tijdschrift voor Wijsbegeerte 72: 242-263.

Have, H. ten (1980): Self-help. Backgrounds, postulates and problems of a new phenomenon. Huisarts en Wetenschap 23: 305-308.

Have, H. ten (1983): Geneeskunde en filosofie. De invloed van Jeremy Bentham op het medisch denken en handelen. De Tijdstroom, Lochem.

Have, H. ten (1984): Ziekte als wijsgerig probleem. Wijsgerig Perspectief 25: 5-12.

Have, H. ten & van der Arend, A. (1985): Philosophy of medicine in the Netherlands. Theoretical Medicine 6: 1-42.

Have, H. ten (1990): Verleden en toekomst van medische filosofie. Scripta Medico-philosophica, Schrift 7, p. 5-18.

Ten Have, H. (1994): The hyperreality of clinical ethics: A unitary theory and hermeneutics. Theoretical Medicine 15: 113-131.

Have, H.A.M.J. ten (1995): Medical technology assessment and ethics. Ambivalent relations. Hastings Center Report, 25:13-19.

Have, H.A.M.J. ten (1998): Images of man in philosophy of medicine. In: Evans, M. (ed.): Critical reflection on medical ethics. JAI Press, Stamford (Conn.), p.173-193.

Have, H.A.M.J. ten and Lelie, A. (1998): Medical ethics research between theory and practice. Theoretical Medicine and Bioethics 19: 263-276.

Have H.A.M.J. ten and Welie J.V.M. (eds.) (1998): Ownership of the human body. Philosophical considerations on the use of the human body and its parts in healthcare. Dordrecht, Boston, London: Kluwer Academic Publishers.

Have, H. ten (2000): The zapping animal. Oscillating images of the human person in modern medicine. In: A-T.Tymieniecka and Z. Zalewski (eds.): Life - The human being between life and death. Analecta Husserliana LXIV, Kluwer Academic Publishers, Dordrecht, pp. 115-123.

Have, H.A.M.J. ten (2001): Theoretical models and approaches to ethics. In: H.A.M.J.ten Have & B. Gordijn (eds.): Bioethics in a European perspective. Kluwer Academic Publishers, Dordrecht/Boston/London, pp. 51-82.

Have, H. ten (2004): Ethical perspectives on health technology assessment. International Journal of Technology Assessment in Health Care 20(1): 71-76.

Have, H.A.M.J. ten (2005): A communitarian approach to clinical bioethics. In: C. Viafora (ed): Clinical bioethics. A search for the foundations. Springer, New York, pp. 41-51.

Have, H. ten and Welie, J. (2005): Death and medical power. An ethical analysis of Dutch euthanasia practice. Open University Press, Maidenhead (UK).

Illich, I. (1975): Medical nemesis. Calder & Boyars, London.

Jonsen, A.R. and Toulmin, S. (1988): The abuse of casuistry. University of California Press, Berkeley, CA.

Kuczewski, M.G. (1997): Fragmentation and consensus. Communitarian and casuist bioethics. Georgetown University Press, Washington, D.C.

Leder, D. (1988): The hermeneutic role of the consultation-liaison psychiatrist. Journal of Medicine and Philosophy 13: 367-378.

Lelie, A. (1999): Ethiek en nefrologie. Dissertation, University of Nijmegen.

McKeown, T. (1976): The role of medicine. Dream, mirage or nemesis? The Nuffield Provincial Hospitals Trust, London.

Newton, A.Z. (1995): Narrative ethics. Harvard University Press, Cambridge (Mass.).

Payer, L. (1988): Medicine & Culture. Varieties of treatment in the United States, England, West Germany, and France. Henry Holt and Company, New York.

Pellegrino, E.D. (1976): Philosophy of Medicine: problematic and potential. Journal of Medicine and Philosophy 1 (1): 5-31.

Pellegrino, E.D. and Thomasma, D.C. (1993): The virtues in medical practice. Oxford University Press, New York/Oxford.

Pellegrino, E.D. (1995): The limitations of empirical research in ethics. Journal of Clinical Ethics 6: 161-162.

Poirier, S. and Brauner, D.J. (1988): Ethics and the daily language of medical discourse. Hastings Center Report 18: 5-9.

Potter, Van Rensselaer (1971): Bioethics. Bridge to the future. Prentice-Hall, Englewood Cliffs, New Jersey.

Reinders, J.S. (1993): Over de medische praktijk als uitgangspunt van ethische reflectie. In: F.W.A. Brom, B.J. van den Bergh & A.K.Huibers (eds.): Beleid en ethiek. Van Gorcum, Assen, pp.226-232.

Sandel, M.J. (1996): Democracy's discontent. America in search of a public philosophy. The Belknap Press of Harvard University Press, Cambridge (Mass.) and London.

Sporken, P. (1969): Voorlopige diagnose. Inleiding tot een medische ethiek. Ambo, Bilthoven.

Stevens, M.L.T. (2000): Bioethics in America. Origins and cultural politics. The Johns Hopkins University Press, Baltimore and London.

Svenaeus, F. (1999): The hermeneutics of medicine and the phenomenology of health. Steps towards a philosophy of medical practice. Linköping University, Linköping (Sweden).

Thomasma, D. (1997): Bioethics and International Human Rights. Journal of Law, Medicine & Ethics 25: 295–306.

Toulmin, S. (1982): How medicine saved the life of ethics. Perspectives in Biology and Medicine 25: 736-750.

Tronto, J.C. (1993): Moral boundaries. A political argument for an ethic of care. Routledge, New York/ London.

Verbrugh, H.S. (1978): Paradigma's en begripsontwikkeling in de ziekteleer. De Toorts, Haarlem.

Willigenburg, T. van (1993): Ik ben een ethisch ingenieur! In: F.W.A. Brom, B.J. van den Bergh & A.K.Huibers (eds.): Beleid en ethiek. Van Gorcum, Assen, pp.189-204.

Wulff, H.R. (1980): Principes van klinisch denken en handelen. Bohn, Scheltema & Holkema, Utrecht.

Zaner, R.M. (1988): Ethics and the clinical encounter. Prentice-Hall, Englewood Cliffs, N.J.

Zola, I.K. (1973): De medische macht. Boom, Meppel.

Zussman, R. (1992): Intensive care. Medical ethics and the medical profession. The University of Chicago Press, Chicago/London.