DO WE NEED ETHICS AND BIOETHICS IN CLINICAL MEDICINE?
The science of medicine, the art of medicine and physician-patient relationship

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ABSTRACT
A few (Many) thinkers have provided important insights into the physician-patient relationship. The practical use of medical knowledge (diagnosis, therapeutics, prognosis) is by no means accidental to modern science and theory more generally – and, it seems perfectly clear, to medicine as well to the very extent that it has allied itself with that science. Theory and power are integral to one another. The vision of theory and practice becomes inseparable in ways which the mere terms pure and applied science fail to convey. Effecting changes in nature as a means and as a result of knowing it are inextricably interlocked. Hence science is technological by its nature. At the same time, to the very extent that medicine’s theory and practice is ordained to the diagnosis, therapeutic assessment, and prognosis of specific patients, it is a matter of practice as well. This understanding of the close alliance between theory and practice – that practice informs and shapes theory – is medicine’s own creation and its original contribution.

The art of medicine and the science of medicine are not antagonistic but supplementary to each other. Good practice presupposes an understanding of the sciences which contribute to the structure of modern medicine, but it is obvious that sound professional training should include a much broader equipment. The treatment of disease may be entirely impersonal; the care of a patient must be completely personal. Thus, the physician who attempts to take care of a patient while he neglects those factors which contribute to the emotional life of this patient is as unscientific as the investigator who neglects to control all the conditions which may affect his experiment. The physician must always have a reasonably clear-cut indication for the administration of any drug. There are several important principles in the selection of drugs. First, the physician should employ drugs with he is familiar, both in terms of beneficial effects and possible side effects or reactions. The physician should select a small number of agents to handle the various therapeutic problems, read about them, and use them primarily. Application of the scientific method to experimental therapeutics is exemplified by a well-designed and well-executed clinical trial.

The sine qua non of any clinical trial is its control. Selection of a proper control group is as critical to eventual utility of an experiment as the selection of the experimental group. There are several special considerations in the design of clinical trials if they are to be used to compare the relative effects of alternative therapies:

1. specific outcome of therapy; 2. the accuracy of diagnosis and the severity of the disease; 3. the dosages of the drugs; 4. placebo effects; 5. compliance; 6. ethical considerations may be major determinants of the types of controls that can be used must be evaluated explicitly.

Now finally, we must not only study the factual basis of clinical diagnosis and treatment, but at the same time work toward an equally difficult goal: CULTIVATION OF A PROPER RELATIONSHIP WITH EACH OF OUR PATIENTS.

Key words:

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1. INTRODUCTION
Medical knowledge and practice are continually changing. We live, therefore, in an atmosphere of doubt and uncertainty, and make our decisions and take our actions on the basis of probabilities. Advancement in knowledge of clinical medicine is now mainly accomplished by full-time clinical scientists in medical schools and research institutes throughout the world (51, 53, 54, 55, 67, 69, 75)

Disease do not always present themselves in pure culture, and indeed the perspective of the clinical scientist can sometimes be skewed. Disease often tells its secret in a causal parenthesis (51, 53, 54, 55, 67).

The practice of medicine combines both science and art. The role of science in medicine is clear. Science-based technology and deductive reasoning form the foundation for the solution to many clinical problems; the spectacular advances in genetics, biochemistry, and imaging techniques allow access to the innermost parts of the cell and the most remote recesses of the body. Highly advanced therapeutic maneuvers are increasingly a major part of medical practice. This combination of medical knowledge, intuition, and judgment defines the art of medicine, which is as necessary to the practice of medicine as is a sound scientific base. The practice of medicine in a managed care setting puts additional stress on the classic paradigm of the patient-physician relationship (51, 53, 54, 55). The profession of medicine should be inherently linked to a career-long thirst for new knowledge that can be used for a good of the patient. The practice of medicine is dependent on the sum total of medical knowledge, which in turn is based on an unending chain of scientific discovery, clinical observation, analysis and interpretation. Physicians frequently confront ethical issues in clinical practice that are perplexing, time consuming, and emotionally draining. Experience, common sense, and simply being a good person do not guarantee that physicians can identify or resolve ethical dilemmas. Knowledge about common ethical dilemmas is also essential. Physicians are expected to maintain mastery of their rapidly advancing fields (the science of medicine) while considering their patient’s unique needs (the art of medicine) (51, 53-56).

2. THE ART OF MEDICINE AND THE SCIENCE OF MEDICINE

2.1. Introduction
Every student and practitioner of medicine should familiarize himself with the classic essay on The Care of the Patient by Peabody: “The practice of medicine in its broadest sense includes the whole relationship of the physician with his patient. It is an art, based to an increasing extent on the medical sciences but comprising much that still remains outside the realm of any science. The art of medicine and the science of medicine are not antagonistic but
supplementary to each other. There is no more contradiction between the science and medicine and the art of medicine than between the science of aeronautics and the art of flying. Good practice presupposes an understanding of the sciences which contribute to the structure of modern medicine, but it is obvious that sound professional training should include a much broader equiment. The treatment of disease may be entirely impersonal; the care of a patient must be completely personal. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for an extraordinary large number of cases both diagnosis and treatment are directly dependent on it, and failure of the young physician to establish this relationship accounts for much of his ineffectiveness in the care of patients. What is spoken of as „clinical picture“ is not just a photograph of a man sick in bed; it is an impressionistic painting of the patient surrounded by his home, his work, his relations, his friends, his joys, sorrows, hopes, and fears. Thus, the physician who attempts to take care of a patient while he neglects those factors which contribute to the emotional life of this patient is as unscientific as the investigator who neglects to control all the conditions which may affect his experiment. The good physician knows his patients through and through and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in carrying for the patient“ (61).

2.2. the physician and the patient
These beautifully expressed thoughts about the physician and his relationship to the patient are even more important to emphasize today than when they were written more than 75 years ago. Medicine has become, and will continue to become, much more a science, not less, so that the physician of tomorrow will have to be more a scientific, not less (51, 53-56). Nevertheless, the art of medicine remains, and the physician must continue to be wise and understanding with a deep respect for the patient as a human being. The secret of success in the care of the patient is still in carrying for the patient.

The physician must always have a reasonably clear-cut indication for the administration of any drug. This implies that he knows what is wrong with the patient and which drug is the most effective. There is little room in therapeutic technique for the shotgun approach to drug administration. The haphazard administration of a large number of drugs is more likely to harm the patient than to benefit him (51-56, 59). If the physician does not know what is going on, he is better advised to
follow a course of watchful waiting. There are certain exceptions, usually related to life-threatening diseases, which do not permit sufficient time to reach a final diagnosis. For example, the patient with findings suggesting septic meningitis is treated with several antibiotics while awaiting bacteriologic confirmation of the presumptive diagnosis (52, 53, 57). No drug should ever be given until the physician has determined whether or not the patient is sensitive to it. If a drug sensitive exists, the fact should be noted prominently. The careful physician also avoids drugs which might further complicate his patient’s problems (51-56, 58, 59).

2.3. The selection of drugs
There are several important principles in the selection of drugs. First, the physician should employ drugs with he is familiar, both in terms of beneficial effects and possible side effects or reactions (53, 54, 55, 58, 59, 67).

The physician should select a small number of agents to handle the various therapeutic problems, read about them, and use them primarily. Over a period of time, he can develop a broad background of experience with a small number of drugs, rather than fragmentary knowledge of many drugs.

If a new preparation clearly provides a therapeutic effect which has not been obtainable with drugs already available, its use is indicated at an early date. On the other hand, if the drug appears to do no more than older medications, it is good judgement to use the older preparations, which are likely to be both cheaper and safer. With most drugs, as experience accumulates, the therapeutic claims become more modest, and various kinds of toxicity, previously unsuspected, become manifest. One legitimate situation for using a new drug, however, is when older preparations have failed to produce the desired results in a given patient.

The physician must satisfy himself that a drug’s claim of superiority to others already available are justified by the evidence at hand (51, 52, 53, 55 67).

2.4. Experimental medicine, therapeutics and bioethics
Over a century ago Claude Bernard formalized criteria for gathering valid information in experimental medicine, but application of these criteria to therapeutics and to the process of making decisions about therapeutic has until recently, been slow and inconsistent. At a time when the diagnostic aspects of medicine had become scientifically sophisticated, therapeutic decisions were often on the basis of impressions and traditions. Historically, the absence of accurate data on the effects of drugs in man was in large part due to ethical standards of human experimentation. “Experimentation“ in human beings are precluded, and it was not generally conceded that every treatment by any physician was and should be designed and in some
sense recorded as an experiment (52, 53, 55, 56, 59 67).

Although there must always be ethical concern about experimentation in man, principles have been defined, and there are no longer ethical restraints on the gathering of either experimental or observational data on the efficacy and toxicity of drugs in adults. Therapeutics must now be dominated by objective evaluation of an adequate base of factual knowledge.

2.5. Scientific methods, experimental therapeutics and clinical trials
Application of the scientific methods to experimental therapeutics is exemplified by a well-designed and well-executed clinical trial. To maximize the likelihood that useful information will result from the experiment, the objectives of the study must be defined, homogeneous populations of patients must be selected, appropriate control groups must be found, meaningful and sensitive indices of drug effects must be chosen for observations, and the observations must be converted into data and then into valid conclusions. A number of excellent, critical summaries of the scientific requirements for clinical trials have been published (6, 7, 8, 36, 51, 52).

The sine qua non of any clinical trial is its control. Selection of a proper control group is as critical to eventual utility of an experiment as the selection of the experimental group.

There are several special considerations in the design of clinical trials if they are to be used to compare the relative effects of alternative therapies:

1. Specific outcome of therapy that are clinically relevant and quantifiable must be measured.
2. The accuracy of diagnosis and the severity of the disease must be comparable in the groups being contrasted; otherwise, false-positive and false-negative errors may occur.
3. The dosages of the drugs must be chosen and individualized in a manner that allows relative efficacy to be compared at equivalent toxicities or allows relative toxicities to be compared at equivalent efficacies.
4. Placebo effects, which occur in a large percentage of patients, can confound many studies – particularly those that involve subjective responses; controls must take this into account.
5. Compliance to the experimental regimens should be assessed before subjects are assigned to experimental or control groups.
6. Ethical considerations may be major determinants of the types of controls that can be used must be evaluated explicitly. For example, in therapeutic trials that involve life-threatening diseases, the use of a placebo is unethical, and new treatments must be compared with „standard“ therapies (7, 36, 30).
2.6. Clinical diagnosis and the cultivation of a proper relationship with the patient

The physician should be aware, that exciting advances in medicine sometimes create serious new problems. Our therapy makes use of powerful drugs, all of which can harm. Few hospital patients receive less than half a dozen different medications. In addition to intrinsic toxicity, these can interact with each other to produce unwanted effects. Knowing when to stop a certain treatment is as important as knowing when to bring it into use. One of the most important qualities needed by today’s physician is ability to restrain curiosity. We should adhere to the rule that a potentially injurious diagnostic and therapeutic procedures should be carried out only when its possible benefit to that patient justified the risk. A test should never be done just for the sake of „thoroughness“ ...

Now finally, we must not only study the factual basis of clinical diagnosis and treatment, but at the same time work toward an equally difficult goal: Cultivation of a proper relationship with each of our patients.

Concluding our few remarks to some ethical problems of pharmacotherapeutics we would like to recall a great ideas of Albert Schweitzer (51):

„These is no higher religion than human service. To work for the common good is the greatest creed.“

3. DISCUSSION

Since the beginnings of the Bioethics movement, a plurality of ethical theories have been used as a foundation for medical ethics. One approach just beginning to be examined is the grounding of medical ethics in a philosophy of the physician-patient encounter (63-66). On this view the phenomena of being ill, being healed and promising to heal are taken as the starting points for ethical reflection. An ethics based in the clinical encounter promises to be more closely related to the concrete experiences of doctor and patient than the application of pre-existing ethical theories (65, 62).

Medical ethics, the ethics of the physician as physician, has been the subject of systematic philosophical inquiry for only a quarter of a century (64). Before that, medical ethics was grounded in a set of moral precepts freely and unilaterally asserted and derived from Oath and Ethos of the ancient Hippocratic school. In recent years, philosophers have begun intensively to question these moral groundings and each of the precepts drawn from there (78). As a result, many today question whether any enduring moral foundation for medical ethics beyond societal or professional consensus is tenable.

To be sure, there have been proposals aplenty to substitute for, or replace, the traditional groundings. They vary with the particular philosophical stance one
takes as the analytical tool—
deontology~ consequentialism~
prima facie principism~ Aristotelian
or Thomistic virtue theories~
feminist, caring, narrative, or
casuistic philosophies~ etc. (16).
These theories and others have been
applied intensively to medicine,
clinical dilemmas, and professional
conduct. The resulting moral
diversity is simultaneously
salubrious and confusing, but also
philosophically interesting (6, 11, 2,
1, 3).

On the salubrious side is the
opening of the previously protected
sanctuary of physician-patient
relationship to moral scrutiny (9, 5,
10, 13, 8). This was inevitable in an
era of self-determination when
medical ethics has become
everybody’s concern. How
physicians conduct themselves in
the face of the universal human
experiences of illness and healing is
of universal interest. Medical ethics
cannot responsibly ignore the
unprecedented scientific, societal,
and political challenges posed in our
times to the traditional accounts of
physician-patient interrelationships
(13, 16, 12, 15).

On the confusing side are the
conflicting moral precepts, divergent
answers to moral dilemmas and
variant justifications so many
different theories of ethics can
generate. The fact of moral diversity
and philosophical pluralism
notwithstanding, can so many
opposing views all be true? Or, must
we, as the post-modernists insist,
give up any notion of a generalizable
foundation for medical ethics and
settle for what eventuates from the
practices or social constructions of
the moment? (18, 17, 16, 20, 24).

Few would argue for the traditional
method of free moral custom found
in professional codes. But not all
would agree that there is no need for,
or deny the possibility of, a durable
philosophical foundation for medical
ethics or the philosophy of medicine
(62-66). For many the question
remains: Now that the moral
assertions of the past have been
challenged, how do we deal with the
fractured foundation? The questions
posed by today’s moral
philosophers cannot be ignored. But
there are too many perils in an easy
acquiescence to coherence, social
constructivist, or dialogical ethics to
justify them as the only or the best
answers (25, 32, 29, 22, 21, 23). In the
long term, foundations cannot be
avoided. However we designate it,
some philosophical theory will be
used to justify particular moral
choices – even if that theory holds
that no foundation is conceptually
tenable (41, 26, 19, 37, 28, 45, 44).
The central problematic is how to deal
with the fragment of the fractured
foundation. Can the insights of a
quarter of a century of philosophical
inquiry be assimilated without
following that inquiry to its current
decompositionist conclusion?
Beneath and beyond the skepticism
of contemporary moral philosophy
so far medical ethics is concerned,
there is an undeniable reality (25, 31). That reality is the encounter between one human person who is ill and seeks assistance and another person who freely professes to be able to heal. The patient’s predicament and the professional’s response to that predicament center in another reality – the intersection of the life-worlds of doctor and patient within which the acts of medicine take place. If we can understand something of this intersection, we can grasp more firmly the origins and essence of the moral encounter which makes medicine the special kind of human activity it is or should be (35, 31, 32, 36).

In the Life-world of doctor and patient, two persons encounter each other in a specific way distinct in part, though not wholly, from other types of personal relationship. The patient comes to the physician because he feels “sick”. He has detected some aberration in his body or psychic functioning that he considers “abnormal”, i.e., a deviation from his usual or expected functioning. Whatever that aberration may be – some symptom, some sign, some affective state – the person’s perception of health, well-being or normality is put into question. The patient may for a time minimize, deny, or try to cope with, or treat, this new predicament but if it persists, worsens or causes anxiety, that predicament effects a change in the existential and experiential state of the sick person (61, 34, 43, 46, 60).

From a state of well-being, the person enters a state of illness whether demonstrable disease is present or not. To be “sick” is literally a statement of dis-ease – a loss of well being characterized by a constellation of changes in Life-world and lived body (61, 47, 49, 62). Anxiety about the meaning of the sign or symptom takes place of “ease“. What does this encounter mean? It is serious? Will it mean death, disability or inability to do what I want to do? Immediate and future plans are put on hold, or if pursued, they are approached warily and fearfully, with uncertainty that they will be fulfilled as anticipated. How the patient’s life world will be reassembled is an open question neither patient nor physician can fully answer in the first stages of their encounter. The person altered by illness asks if he is the same person who become ill. He does not know if he will ever be again that person (48, 50, 38, 40, 39).

By “going to the doctor” the patient is now dependent on the doctor’s authoritative knowledge and his perception of the patient’s experience of illness. Indeed, the patient invites the physician to enter his life-world, just as the physician offers to enter that world by his offer to heal. The life-worlds of doctor and patient inter-penetrate each other. Their relationship is conditioned henceforth by intersubjectivity. This is the moment of clinical encounter, the confrontation of one human person bearing the burden of illness seeking to be healed by another human person possessed of the knowledge and skill needed by the
sick person in search of healing. This is an encounter between the life-worlds of two persons who up to the moment of confrontation were strangers independent of each other. Now, they are intimately enmeshed with each other in the most intimate and special sorts of ways, some of which may make for a healing relationship and some for a harming one. How each of these perceptions is manifest in any particular person is a reflection of the uniqueness of that person. Yet this location can never be complete (72, 70, 68).

The patient’s life-world is lived in intersection with the life-worlds of all who live in relationship with him. Family, friends, other clinicians also become enmeshed in the patient’s world via the reality of sickness and disease. The meaning of illness to each person therefore will differ as it is interpreted in the infinity of variations possible in individual life-worlds. No two persons experience the predicament of illness exactly the same way. No life-world is exactly congruent with any other (73, 71). Nevertheless, there is a sense in which the alterations in life-worlds can be generalized, as a universal human experience. For even as there is uniqueness there is also commonality, since the life-world is a human creation and certain responses in that world are typified as “human” responses (77, 74, 79).

When we turn to the life-world of the physician, we begin with a very different perspective horizon. The physician is well and therefore occupies a radically different world from the patient. Even if he is ill himself, he prescinds, at least in part, from that illness when he acts a healer. He retains his freedom to act, limited by the science and ethics of medicine but not by his own disability. The disabled physician remains able to heal – sometimes even more sensitively than the non-handicapped. If he were disabled or ill to the point that he could not exercise his healing functions the physician would be disqualified as a healer. The physician’s conduct is held within bounds by an ethical commitment that requires a certain suppression even of his legitimate self interest (80, 81, 83). The physician’s life-world is constituted by all those things that derive from his private and personal life as they are transmuted by being a physician, as one committed to healing the sick. For every physician there is a unique mix of personal and cultural realities with the ethical, social and cultural meaning and requirements of being physician. How each physician balances these personal, professional and psycho-social modalities is just as unique as the patient’s balance (80, 82). The physician differs from the patient in that the balance he has struck is not at issue as it is with the patient. In their shared world, he is not in the vulnerable, exploitable, dependent, relatively powerless state of the patient. He is the professional freely offering to “help” the patient. It is true that he may be a “wounded healer”, but he is a healer nonetheless – even when his own vulnerability is part of his life-world
In making this profession, the physician also invites trust - in his knowledge, his competence and his character. The physician invites this trust and makes his promise of competence in the presence of another human person who is in the altered existential state we call sickness, with all the alternations of life-world. The patient is not just playing a „sick role“, he is now fashioning that role, creating it as he re-creates his whole life world. That person is vulnerable, dependent, anxious and eminently exploitable should the physician be a vicious and not a virtuous person. The patient, for his part, is forced to trust the physician even if he wishes not to do so. At least he must submit even if he does not trust – if he wishes to be healed by this doctor.

The doctor and patient’s life-worlds intersect in countless, complex ways, each of which may affect the success of the healing relationship. In an effective healing relationship these two different life-worlds must somehow interact positively around the common intention of healing which is the end or telos of their mutual clinical encounter. Both physician and patient expect healing to be the intentional focus of their encounter. Each share intencionality with reference to healing – the telos of the encounter. For both this means making the patient „whole“ again, repairing the damage to bodily or mental integrity, restoring the state of well-being or, if this is impossible, ameliorating the impact of sickness and disease. This healing is the „act“ of medicine in which patient and physician come together. In a sense they heal together since the patient’s cooperation with technically right and morally good clinical decision is essential. What is technically right derives from whatever there is of science and manual skill in medicine. What is morally good is a far more complex aim. It is the intersubjective apprehension of what is healing and what is harming to this patient that is crucial. Then, knowing what medicine is, some statement can be made about the moral obligations of those who profess to practice it.

The telos of medicine is healing, and medicine qua medicine is that set of human activities that has as its end and purpose – both for doctor and patient - that act of healing, of „making whole again“. In the clinical encounter, the telos is a right and good healing action for this patient. The doctor needs privilged access to the life-world of the patient, a truthful rendition of the impact of sickness, if he is to heal. In the same way, intellectual honesty, truthfulness, courage, suppression of self-interest, and compassion can be shown to be virtues entailed by the telos of medicine as well as by the interplay of life-worlds of doctor and patient. These virtues are always understood implicitly and intersubjectively. Just how they are understood in a particular physician or patient encounter lies in the intersubjective world – patient and
doctor enter in the intimacy of their unique clinical encounter (35, 65, 43, 38, 36).

Thus, through the telos of medicine - the defining point of a philosophy of medicine - and the virtues entailed by that telos, a philosophy of medicine and an ethic of medicine are joined. Once apprehended, a philosophy and ethic of medicine can be grounded „internally“ – i.e., in recognition of the nature of medicine as it is revealed in its essential form in the phenomena of the clinical encounter. As suggested elsewhere, we can then also grounded the prima facie four principles of beneficence, justice, non-maleficence and autonomy in clinical realities, as well as the duties and obligations of both doctor and patient (60).

4. CONCLUSION
Medicine is the most revolutionary of human technologies. It does not sculpt statues or paint paintings: it restructures man and man’s life. In short, medicine is not merely a science, not merely a technology. Medicine is a singular art which has as its object man himself. Medicine is the art of remaking man, nor in the image nature, but in his own image—medicine operates with an implicit idea of what man should be. The more competent medicine becomes, the more powerful it is, the more able it is to remake man, the more necessary it consequently becomes to understand what medicine should do with its competence.

The relationship between patient and physician is unique in a number of ways, and is among the most intimate and certainly most delicate among persons (51). Because of its inherent inequality (of condition and awareness) and structural asymetry (of power, knowledge, resources, legitimation), the relationship is especially fragile and exposed to constant dangers and temptations: manipulation and coercion, improper intimacies, and therapeutically compromising forms of remoteness, among others. Whatever else may be said about the interpretive disciplining of medical intelligence, therefore, it must suraly include its being understood and practiced as a fundamentally moral discipline.

REFERENCES


