Bioethics, Medicine and Society: A Provocative Trilogy

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Contemporary technological innovations and social developments have led to enormous changes in human fate and freedom. With ethical complexities and challenges emerging in modern medicine, bioethics seeks ways in which people in societies can work together under the provision of medical care and research. The argument is conducted by means of a brief history of bioethics. The field is supposed to provide an insight into the issues of moral community, and into how society understands political authority and its appropriate exercise. As a social movement, bioethics developed in the mid-20th century as a critical discourse, a response to felt inhumanities in the system of healthcare and biomedical research.

There is a general awareness that contemporary technological innovations and social developments have led to enormous changes in human fate and freedom. They possess cultural and commercial capital and are among the most visible and influential fields of the globalised world. Recent biotechnological breakthroughs which are considered the fountainhead of innovations are the mapping of the human genome to successful construction of the first self-replicating, synthetic bacterial cell. It is considered that the synthetic cell is the proof of the principle that genomes can be designed in the computer, chemically made in the laboratory and transplanted into a recipient cell to produce a new self-replicating cell controlled only by the synthetic genome. Chemical messages presented in right order and put in right chemical context can produce life. These latest developments have tried to resolve the age-old debate about reduction of life to the sum total of its parts. This vindicates the view that the gestalt is the outcome of actions and motives of distinct individuals. This, of course, ignores the fact that the individual is located in a complex system with structures and emergent powers, and, therefore, cannot be fully understood by merely disaggregating it into its component parts. This raises multiple questions ranging from the mundane practical – how will this be useful? – to the profoundly philosophical. (Will we have to redefine what life is?) Depending on one’s ideological viewpoint it is either a powerful testament to human ingenuity or a terrible example of hubris – and the first step on a very dangerous road.

Yet these gains have come at a cost, for many modern medical practices raise troubling ethical questions: Should life be sustained mechanically when the brain has ceased functioning? Should foetal stem cells be experimented upon in an effort to eventually palliate or cure debilitating diseases? As medicine turned to philosophers to help grapple with these types of questions, a new discipline – bioethics – emerged. Bioethics has its main task, the determination, so far as that is possible, of what is right and wrong, good or bad, about the scientific development and technological deployment of biomedicine. These are weighty duties and responsibilities of scientists that theologicians and philosophers have been wrangling over in the face of those developments.

At the Crossroad

The word “bioethics” is the intersection of ethical issues and life sciences. In tandem, the investigations of biology, scientific technology and ethical issues combine to form a new science called “bioethics”. For this multidisciplinary science, Van Rensselaer Potter at the University of Wisconsin in 1971 coined the term “bioethics” stating that it is “biology combined with diverse humanistic knowledge forging a science that sets a system of medical and environmental priorities for acceptable survival” (Potter 1971).

Potter’s definition establishes the premise that we operate through “humanistic knowledge” – the rejection of superstition; where humankind is in control of its own destiny; that our actions are based on moral principles and ethical thinking (Kieffer 1992). It provides a “system” approach (scientific methodology) to medical and environmental priorities and also, an overarching context of survival. But Potter points out that survival without qualification is meaningless. Influenced probably by humanist psychologist Abraham Maslow’s (1970) hierarchy of needs, Potter offers five categories of survival: mere survival, miserable survival, ideal survival, irresponsible survival and acceptable survival (Potter 1988). “Acceptable survival” refers to a sustainable society within a healthy ecosystem.

Bioethics is considered useful in promoting critical thinking. It allows greater accessibility to the content through connectivity rather than stand-alone units. It engages the content and process of real-life situations (present and future) where decisions have real consequences, seldom with risk-free outcomes. Finally, it promotes a focusing framework that places the biology in a fully integrated form.
Faced with new ethical challenges emerging as a result of technological developments in modern medicine, bioethics seeks ways in which people in societies can work together under the provision of medical care and research. The field is supposed to provide an insight into the issues of moral community, and into how society understands political authority and its appropriate exercise. Bioethics also involves social philosophy because the basic concepts of healthcare (concepts like “health” and “disease”) are socially constructed categories. Finally, the connection of bioethics to social philosophy is cemented by the fact that the central questions in clinical medicine – questions concerning the allocation of resources, for instance – are those of social philosophy and ethics. Thomas Kuhn (1962) has tried to sketch a different, deeper and richer conception of bioethics that can emerge from a historical analysis. The moral world of medicine sketched here is one of continual debate, of reformers and reactionaries, of revolutions and reactions, of progress and regress. It is a world that philosophers have played a pivotal role in shaping, and that they can shape best if they understand the historical contexts in which their ideas have proven influential and successful.

Bioethics is a multidisciplinary field which emerged to address the normative ethical issues in medical practice, research and policy. However, it can be stipulated that bioethics is distinct from traditional “medical ethics” which was primarily concerned with the conduct of physicians. The emergence of bioethics, as distinct from traditional medical ethics, was due in part to medical advances and the realisation of the important roles of non-physicians in the ethical choices present in medicine. The ethics of the guild were no longer adequate to address the ethical questions involved in medical practice and research. For example, industrialised and developing countries which pursue globalisation and privatisation of their economies can view the contemporary questions concerning managed care as one instance of controversy about the authority of healthcare resources and patient care. However, these questions raise, in turn, more fundamental questions about how medicine and health are understood within a society. Bioethics is a complex and potentially revealing subject for empirical investigation. Discussions of bioethics can sometimes make it seem as if there was no ethical reflection before the emergence of the field. As a social movement, bioethics developed in the mid-20th century as a critical discourse, a response to felt inhumanities in the system of healthcare and biomedical research. As a response to specific abuses, bioethics has remained practice-oriented; society expects bioethics to solve or at least ameliorate visible problems.

But Daniel Callahan asserts that bioethics is “less wayward and more establishment” (1999), and finds that four developments were important: the opening up of once-closed professions to public scrutiny, which happened strikingly with medicine; a fresh burst of liberal individualism, putting autonomy at the top of the moral mountain; the brilliant array of technological developments in biomedicine, ranging from the pill and safe abortions to control the beginning of life to dialysis and organ transplantation to hold off the end of life; and the renewed interest within philosophy and theology in normative ethics, pushing to one side the positivism and cultural relativism that seemed for a time in the 1940s and 1950s to have spelled the end of ethics as a useful venture.

While the emergence of medical knowledge and technology was essential for the development of bioethics, it does not by itself explain the emergence of the field. To understand other elements that contributed to the field’s emergence, it is important to recall that traditional medical ethics had relied on two sources of moral guidance. One was the tradition of professional physician’s ethics (McCullough 1999), the other was the teachings of the theological ethics. Furthermore, there have been extensive theological reflections on ethics and medicine in many religious traditions (Fletcher 1996).

In the past there has been no shortage of ethical reflections regarding medicine. This being the case, one might ask why there was a need to develop this new area of ethical reflection that has been named bioethics. Why not rely on the various traditions of medical ethics that already existed? The claim is that traditional medical ethics is really “physician ethics” (Veatch 1981) and that bioethics emerged as a result of the recognition that there are other people besides physicians who are involved in medical decision-making. This means that the field of bioethics emerged as a response to social dimensions of medicine and healthcare.

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Why were these sources no longer able to guide medicine once it reached its modern scientific phase? To understand why neither of these sources is sufficient for contemporary medicine, one must take into account the phenomenon of “moral pluralism”, according to which people not only hold different moral values, views on topics (e.g., abortion), but work out different moral frameworks and with different moral methodologies (Wilds 2000).

As it has been mentioned traditional medical ethics had been focused on physician ethics (Veatch 2000). The development of scientific medicine gave patients so-called choices and options concerning courses of treatments to be pursued or refused. If a physician and patient share the same moral value and way of thinking, such choices may not be all that problematic. However, when patients and physicians hold different views, the understanding of medical ethics must not be seen as reflecting the judgment of the physician alone (Veatch 1981).

Determining what is in the patient’s best interest cannot be done solely by the physician. The physician may speak in the best interests of the patient medically, but not necessarily the overall best interests of the patient. To make judgment concerning the patient’s best interests, the patient needs to be involved. Furthermore, in secular societies there are likely to be different religious views that shape people’s judgments about what is morally appropriate. This is why procedures like informed consent have come to play such a central role in both clinical and research ethics, such procedures allow people to exercise judgment about what is in their best interest.

Moving beyond Religion

Moral pluralism affects not only patients and physicians, but also the medical profession in general. A key part of the classical notion of a profession was that professionals had distinctive moral dimensions. Many people still assume that professionals act in ethical ways and that it is reasonable to have fiduciary expectations of professionals. However, with the development of the medical knowledge and technology, one finds a wide span of views among physicians – on issues ranging from abortion to euthanasia and the economic structure underlining medicine – about what is not appropriate behavior. As a result, it becomes more and more difficult to sustain claims based on the internal morality of medicine; the notion of an internal ethics of physicians, a cornerstone to traditional medical ethics, becomes less and less tenable.

Life in a pluralistic society is full of flux; one cannot assume that theological ethics will supply the type of guidance that is needed. In several religious traditions, there have been long, well-developed reflections on medicine, its uses and ethics. As the field of bioethics began to emerge, it became easily understandable why many theologians felt interested in these broader questions. Given their long-standing reflections of medicine and healthcare, these traditions were able to understand easily the changes that were taking place in medicine.

Yet fairly quickly, theology came to play less and less of a public role in bioethics. As Daniel Callahan has argued, bioethics became acceptable in America because it “pushed religion aside” (1993). Callahan does not argue that religious thought became irrelevant to medical questions. Rather he argues that as bioethics became a form of public discourse (Caplan 1993) it moved to the more “mortal” language of philosophy and law and away from the “closed” languages of the medical profession and theological discourse (McCullough 1999).

The process of secularism in western societies helped the non-theological orientations. There appeared a new system of secular-moral experts who could act independently. The philosophy of bioethics was drawn into this vacuum, transforming the philosophy of medicine from an endeavor into a socio-politically endorsed and influential profession containing socially and politically authorized ability.

In plural societies, where there are often many cultures, moral pluralism is found and valued. As a result, the traditional sources of reflections are limited in their effectiveness and are thus much less helpful. Traditional professional classes will be limited in their moral authority in these societies, and religious tradition will have far less claim on the lives of men and women.

It is also important to understand that the field of bioethics has emerged in the era of civil rights and choices and mounting emphasis on the protection of individual freedom and liberties. Minorities and women were arguing for, and achieving, greater and greater legal protections. Thus at a time more and more options for medical treatment for privileged classes were emerging, patients of this class were becoming more and more aware of their own liberties and protections. During this time period, many groups, such as women and minorities, found a voice in society and in their lives, patients found a voice there as well.

Social Construction

Bioethics has emerged as a result of several developments and complexity in medicine and society; two in particular stand out. First, the development of medical knowledge and technology created “choices” in medical care. Second, the moral pluralism and multiculturalism in societies led to the existence of different moral voices and views. This, in turn, meant that there would be differing views on appropriate medical care. Bioethics arose as a way to help people from different moral views navigate these choices and cooperate together. The field provides a window into the social and cultural settings of medical practices and as such provides a way to understand a society. It can help a society or culture examine basic questions of health, disease, sickness and death. It can also enlighten the way a society thinks about moral authority and how it is exercised. There are other reasons beyond those that emerge when one considers the development of bioethics as a research field, to conceive bioethics as a form of social philosophy. One such additional reason is the nature of medicine itself. That is why physicians and healthcare workers apply scientific and medical knowledge that has been discovered in the laboratory. There is little, if any, acknowledgement that science, especially medical science, is not value-free. Medical science is embedded in values of the society or culture. The scientific norms of medicine, such as health and disease, are often influenced by the social and moral values involved in their specification.
If medicine is a social construction, then bioethics should be thought of as a form of social philosophy. The term “social construction” has multiple meanings and should be used with caution; philosopher Ian Hacking has pointed out that the term suffers from overuse and is incoherent (1999). Given the ambiguity and confusion surrounding the term, one might ask what value it will have for understanding medicine. The term “social construction” is helpful because it recognizes that the practice and goals of medicine are contextualized and specified by the society’s values. The specification of meaning of key medical concepts like “health” disease, and “standard of care” is socially influenced by many instances. While here are universal elements in medicine, such as healing and health, there are many local elements involved in specification of universals. It is in this sense that one can speak of medicine as social construction.

However, to think of medicine as a science, or as a scientific one, needs the articulation of the assumptions that one holds about the different models of science. Medical knowledge is scientific in that it is statistically based, empirical, verifiable and generalised. A scientific model alone, however, does not capture our experience or expectations about medical practice, for such a model does not appreciate sufficiently how medicine acts as a social structure and set of practices within a given society. The relationship between the values of a society and its medical practices can be discerned by examining how the concepts of medicine such as the concept of disease, are specified in that society.

Some thinkers understand medicine only through the lens of the physician-patient encounters (Pellegrino 1998). However, contemporary model of medical care cannot be fully understood if one only looks at this relationship. Such a “physician-patient model” is too narrow in that it ignores the reality that medicine is set in a social context. The horizons in which the physician and patient encounter one another are shaped by important social forces. For instance, when societies often define what medical procedures will or will not be allowed (e.g., abortion or physician assisted suicide), and insurers generally decide what procedures will or will not be paid for when they meet in the clinic, then the physician and the patient are not alone (Buchanan 2000).

It is in this very encounter in the clinic that one finds the discussions of social construction in the contemporary medical practice, with its research and technological infrastructure. The physician-patient encounter involves other healthcare professionals, nurses, clinical or hospital administrators, legislators and regulators. This means we must reject the physician-patient model of the practice of clinical medicine for a more expanded view of the practice, one with a very different sense of medicine. Medical practice cannot be adequately explained as the encounter of the physician and patient, nor can medicine be adequately explained as the application of scientific knowledge. Medical knowledge is deployed in a set of social circumstances where the circumstances and values that help people to interpret reality and society is involved in establishing the norms of medicine (Hare 1993). Medicine is shaped by the values of a culture, and medicine then helps to reinforce and control the values of that culture.

Most physicians and patients would agree that medicine is not just a set of technical skills. Understanding medicine as a practice opens a set of philosophical questions about the nature of the practice. As Alasdair MacIntyre argues that a practice is a coherent method of achieving socially established goods that are internal to the practice (1981).

Practices are public and in the public domain. They are not the habits of abstract individuals, nor are they to be confused with the place and role of institutions that support practices but also support goods external to those practices. So, for example, while medicine is a practice, hospitals and delivery networks, institutions that support medicine and other goods as well, are not. A practice is considered a part of a way of life. As Steen and Thung write “any attempt to completely divorce medicine from other domains of culture would be futile, even foolish” (1988). To say that medicine is socially constructed is to recall that medical practice is influenced by the values, moral and otherwise of the culture and society in which it is situated. This influence is evidenced again and again in bioethics, where the issues and controversies of the field often reflect differing

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assumptions about health, disease, illness and goals of life. Some thinkers worry that if one holds the view that medicine is in part a socially constructed practice, then the door to relativism and the “Nazi problem” is wide open. That is, if medicine is constructed socially, how can it be argued that the medical practice of the Nazi physicians was wrong. However, there is a response to this criticism. Medical practice, like all practices, has moral boundaries. These boundaries are not unique to the profession or part of any special morality for professionals generally. What the Nazi doctors did to patients and research patients were normally incorrect for anyone to do so. One therefore does not need a morality unique to the medical profession to criticise ethically the practice of the Nazi doctors. One can argue, for instance, that the Nazi doctors, irrespective of their profession, had no moral authority to do what they did. The Nazi doctors never got consent from the people they acted upon and in many cases were consciously attempting to do harm (Engelhardt Jr 1996). As a result, we can, holding this sort of ethical perspective, claim that the actions of the Nazi physicians were wrong. Yet, we understand that medicine is a social practice with socially constructed elements.

If one takes the social and cultural turn in trying to understand medical practice, then one will have to accept a more expansive understanding of bioethics. This is because bioethics is not a field devoted only to the resolution of moral controversies. In many cases, the underlying issues in bioethics are issues in philosophy of medicine and provide insights into the social context of medical practice. From this more expansive view, it can be argued that bioethics can be a coherent and increasingly important field in helping to understand the social context of medicine.

In contemporary medicine, the scientific aspects of medicine have become increasingly important for medical practice. The development of scientific research and treatment along with the use of statistical and scientific knowledge to determine guidelines for treatment, reimbursement and allocation of resources, has accentuated the scientific side of medicine and limited the role of the physician’s judgment. This emphasis on the specific model contributes to a view of medicine as being transcultural and objective. The quantitative and qualitative developments of the scientific dimensions of medicine have led to a forgetfulness of the art of medicine.

It is this art of medicine that guides the interpretation of scientific facts in individual cases. Facts need to be understood in relation to other facts and assumptions. These relationships are what give the facts meaning and structure. Philosophers such as Paul Feyeraband (1978), Thomas Kuhn (1962), Imre Lakatos and Allen Musgrave (1970) brought to an understanding the formation of facts, a deeper awareness of both sociology of knowledge and the role of cultural values and social customs. Medicine is not just a set of techniques or skills. It is “philosophy in action”, as Engelhardt Jr argues that medicine seeks to remake the human in certain ways and certain purposes (1996). As one thinks about medicine, one is well advised to remember the words of Rudolf Virchow, a 19th century figure in the philosophy of medicine who said that “medicine is social science in its very bone and marrow” (1971). In his analysis of the Silesian typhus epidemic of 1847, Virchow said that its causes were as much economic and political as they were biological and physical. He later generalised this view in a series of articles on public health, in which he discussed the relationship of medical problems to social and political developments. Virchow conceived the scope of public health as broadly as possible indicating that one of its major functions was to study the conditions under which various social groups lived and another was to determine the effects of these conditions on their health.

In the past, the art of medicine essentially involved the physician’s judgment in relation to individual patients. However, in an age that is increasingly aware of cultural and moral pluralism and of the role of patients in medical decision-making, there is an expanding dimension for medicine’s artistic side. The very concepts like health, disease, and normality are greatly influenced by the surrounding cultural and social assumptions, and those assumptions are in need of interpretation. The art of medicine helps the physician apply scientific medical knowledge to particular contexts and patients. The relationship between medicine and social values is borne out in many issues in bioethics. For example, one way to examine certain issues about end of life care and physician-assisted suicide is by treating these as bioethical issues that involve scientific facts as well as moral and cultural attitudes concerning the meaning of life and death. These also raise further questions about the purpose of medicine and the appropriate role of healthcare professionals. The different responses to these distinct bioethical issues reflect differing views as the philosophy of medicine, which are influenced in turn by the cultural views of those involved.

**REFERENCES**


