BIOETHICS AND THE HUMANITIES:

ATTITUDES AND PERCEPTIONS

R.S. DOWNIE AND JANE MACNAUGHTON

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Bioethics and the Humanities

Many medical schools are now re-introducing the humanities (philosophy, literature, creative writing, medical history) with the aim of broadening the education of doctors. This book attempts to show how the humanities can extend the scope of bioethics beyond regulation, and how they can affect the attitudes of doctors towards patients and the perceptions of medicine, health and disease which have become part of contemporary culture.

The book rattles the medical cage by offering a critique of certain aspects of medical practice and research. For example, the idea that patient status or the doctor/patient relationship can be understood via quantitative scales is shown both to rest on a misunderstanding of numbers, and to create a distorted perception of human beings. The book offers an alternative way of understanding the qualitative research producing this distortion, an understanding akin to the sort we acquire from good literature. Again, much medical ethics would have us believe that doctors, unlike plumbers, teachers and the rest of us, are uniquely beneficent, indeed altruistic. This professional delusion diverts us from the real ethical achievements and problems of medicine. The central aim of this book is to expose the half-truths of contemporary medicine and to celebrate the Greek belief that Apollo was god of both medicine and the arts.

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Foreword

It is fascinating to watch the coming of age of an area of academic study. The history of the arts and humanities movement as it affects health care and health-care ethics is a good example of such a development. The process usually begins in a small way, for example, with a seminar or a series of lectures, and then a group of enthusiasts meet nationally or internationally, a journal appears and books are written defining the boundaries of the subject and its content. Both the authors of this book were in at the beginning of the arts and humanities in health and medicine movement and the book itself is a mature reflection on the process and the current state of play in relation to ethical issues in health care. If the regulation of practice is the central concern of medical ethics (or bioethics) this book greatly enlarges that concern. At its heart is the suggestion that 'the arts and humanities can perform both a critical and a supplementary function in the ethical education of at least some health professionals'. Philosophy sharpens critical perceptions and literature and other arts supplement by maturing attitudes. In this way the arts and humanities are relevant to making difficult judgements and to developing a broader perspective on human illness and suffering than can be offered by ethical regulation.

The authors are not suggesting that every medical or nursing student can benefit from the study of the arts and humanities, nor that such courses be essential parts of the curriculum. Others of course have argued differently. This book contends that logic and moral philosophy provide ways of thinking, arguing and justifying decision making, and that the loss of these subjects is to be regretted. At present, however, it would be almost impossible to add such subjects as compulsory components in an already overburdened curriculum. But it is an interesting thought.

A study of the arts and humanities enables us to see clinical issues in different ways, illuminating familiar problems and giving them new meaning. The arts can also arm health professionals and others working in community contexts with creative ways of thinking about and delivering public health messages. For health-care professionals such insights can provide the impetus for fresh thinking but can also give support and comfort to those in the front line of health care. In ethical decision making in clinical medicine and public health the issues are rarely

straightforward and therefore in most instances judgements are required. The arts and humanities provide three major ways of assisting such decision making in the field of bioethics. First, they can provide a framework (or frameworks) of ethics which can place a problem in a particular context and help with decision making. Second, using the processes of logic and argument they can help to clarify a problem and assist in justifying a particular decision to a patient or in a public forum. Third, specific illustrations from the arts and literature can illuminate a problem and suggest novel ways of dealing with it. This book is helpful in all these ways, but goes further and places bioethics in a wider cultural context.

Professor Sir Kenneth Calman
Vice Chancellor and Warden
University of Durham

Preface

There are many books on the subject of bioethics, both general and on specific areas of medical and nursing practice, and there are some, although not quite so many, in the area of what has come to be called the 'medical humanities'. But we know of no book which concentrates directly on the relationship between the humanities and bioethics. Of course, it is sometimes significant when no books exist in a given area – a cruel reviewer once said of a book that it filled a much-needed gap! But we think that there is a gap in the literature of bioethics which can helpfully be filled by some attention to the humanities. In particular, bioethics is now mainly concerned with the *regulation* of medical practice, but that focus leaves two areas in the shadows. These areas concern, first, the *perceptions* which doctors and nurses have of the practice of medicine, of its scientific credentials, and of the whole idea of health care as the paradigm profession. Such perceptions inevitably affect, second, the *attitudes* which doctors and nurses adopt towards their patients and themselves. Indeed, the public is encouraged by doctors' leaders and governments to have similar perceptions and to adopt similar attitudes to health care as a profession.

In discussing these perceptions and attitudes we shall suggest that the humanities have two main functions: a *critical* function and a *supplementary* function. The *critical* function is mainly fulfilled by the various branches of philosophy. Bioethics as a regulatory activity tends to accept medical practice and research as given and it attempts to deliver them to the public in an acceptable format. But it may also be enlightening to offer more radical challenges to medical practice and research. Are they quite as scientific as doctors would like to claim, and what ethical view of human beings do their assumptions imply? Are doctors uniquely altruistic, or even beneficent, as the dominant views in medical ethics suggest? Philosophical challenges of this sort will occupy us in Chapters 2–5, and they concern the perceptions which doctors have, and encourage the public to have, of the practice and scope of medicine.

Second, the humanities can have what we shall call a *supplementary* function in the broad church of bioethics. As we stressed, the main function of bioethics is to regulate, specifying the duties of doctors and the rights of patients. But complaints

about doctors do not always suggest that they have failed in their duties. Sometimes the suggestion is rather that their attitudes are less than desirable, that they are rude or unsympathetic, or that the letters they write are peremptory or arrogant. The failure here is attitudinal. Perhaps the attitude can never wholly be put right, because it is created by the total medical situation in which the patient is vulnerable (and easily takes offence), and the doctor is perceived to have the answers (and therefore to wield power). But if anything can improve attitudes it is the humanities. They are able to make us see ourselves as others see us and to make us vividly aware of what it must be like to be in the vulnerable position of a patient. This ability we shall call the 'supplementary' function of the medical humanities. In Chapter 7 we shall suggest that this supplementary function can even be fulfilled by placing artists in hospital or community settings.

This book is written with two hopes: that we can extend and enrich the scope of bioethics, and that the medical student who said in his evaluation 'I only read *The Sun* cos we are all different' can be encouraged to be more adventurous.

Robin Downie, University of Glasgow
Jane Macnaughton, University of Durham
Autumn 2006

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We gratefully acknowledge help from many quarters. Principally we must thank Sir Kenneth Calman for writing the Foreword. It is particularly fitting that he should do so since as Postgraduate Dean of Medicine at Glasgow University he was perhaps the first in the United Kingdom in recent times to see the importance of the humanities in the education of medical students. As Chief Medical Officer he continued his enthusiasm and organised several meetings on a national scale on the value of the arts and humanities in health-care education and in the wider life of the community. As Vice-Chancellor of the University of Durham he has been in a position to establish the Centre for Arts and Humanities in Health and Medicine (CAHHM), which has encouraged the use of the humanities in undergraduate medical education, and has organised many successful ventures in which communities have participated in arts projects. It is fitting that the collaboration between the Universities of Glasgow and Durham should continue in this book.

We are grateful to some colleagues who have commented on parts of the book or who have helped to clarify our ideas. We mention in particular Fiona Randall, Consultant in Palliative Medicine in Bournemouth and Christchurch Hospital Trust, Mike White, Director for Arts in Health at CAHHM, Martyn Evans, Professor of Humanities in Medicine at CAHHM, Emma Storr, Senior Tutor in General Practice at the University of Leeds and experienced organiser of Special Study Modules in the Humanities, Karen Elliott, who produced accurate documents from messy originals, and our long-suffering spouses Eileen and Andrew.

RSD
RJM

Introduction

There is the story of a young man who was cautioned by a policeman for his exuberant behaviour. The young man suggested (with what colourfulness of language history does not relate) that the policeman was being over-zealous. The policeman then said, 'You have an attitude problem', whereupon the young man (doubtless a student) replied, 'You have a perception problem'. We will not comment on the relevance of this anecdote to the Government's Anti-social Behaviour Orders, but it is highly relevant to the themes of this book. It will be our central contention that the humanities can contribute to the ethical improvement of health care in two main ways: by improving the attitudes of professionals, and by widening their perceptions. The humanities can also perform a similar function with respect to our perceptions of and attitudes to our own health. Let us explain.

Bioethics – health-care ethics, medical ethics (we shall use the terms interchangeably) – is now mainly concerned with the business of the regulation of professional practice, whether medical, nursing or related professional activity. The core of professional regulation is in medical law, and medical ethics represents an attempt to regulate those aspects of professional practice which are too detailed for the broad brush of the law. Indeed, it is common for university departments or textbooks concerned with these to have 'law and ethics' in their titles, thus linking the two and asserting their continuity. We shall not dispute that the regulatory function of bioethics should remain its dominant one. What then is left out?

To answer this question we shall refer to a novella by Graham Greene entitled *The Tenth Man*.[1] The story opens towards the end of the Second World War. The Nazis have taken hostages in a small French town, and intend to shoot three of them as a reprisal against murders by the Resistance. The Nazis leave it to the hostages to pick the victims. They draw lots and one of the unlucky ones is Chavel, a rich lawyer. The fearful Chavel offers his large house and all his wealth to anyone who will face the firing squad in his place. To everyone's surprise his

1 Greene G, *The Tenth Man*, 1985, Harmondsworth: Penguin Books.

offer is accepted, by a poor man, Janvier, who plans to leave all the wealth he will inherit to his impoverished sister and mother. The contracts are duly signed and witnessed, and the execution carried out. All this takes place in the first chapter, and the remainder of the story is concerned with events after the war, and especially with the attitude of Chavel to himself. In brief, he is consumed with guilt and shame.

The relevance of this story (and we have not mentioned its many subtleties) to our themes is this.[2] The regulation of professional practice through law and ethics lays down the duties of the professional and the correlative rights of the patient. For example, one of the central concepts of health-care ethics is consent. If treatment is to be ethically acceptable the patient must be given adequate information on its likely outcome and possible side effects, and in the light of that information the patient must freely agree to the treatment. The contract becomes even more stringent and formal where non-therapeutic research is concerned. In other words, there is a framework of rights and duties supported by information and free choice.

But these conditions are met in the case of Chavel – he made an offer which Janvier freely accepted on the basis of full information. The agreement was witnessed and formalised. So what has Chavel done wrong? Something serious, certainly, for we can all sympathise with his feelings about himself, his desire for concealment of what he has done and his subsequent haunted life. Indeed, he comes to see that his action, his offer of the deal, was the outcome of his long-term and ingrained attitude to human relationships. But if we perceive ethics as solely a matter of rights and duties Chavel's guilt and shame become irrational. It will be a central contention of this book that Chavel's guilt and shame are not irrational, because the mesh of rights and duties is too wide to catch all the nuances of ethics. As Chavel came to see, our attitudes to others are as important from the perspective of ethics as the performance of our duties. We shall argue that the arts and humanities are vehicles for developing and maturing our attitudes. They offer a condensation of life, and in their immediacy and intensity can affect our attitudes.

We spoke not just of the relevance of attitudes to bioethics but also of the relevance of perceptions. What are the connections between attitudes and perceptions? The answer is that attitudes logically depend on perceptions. Attitudes necessarily have a cognitive core, in the sense that they depend on beliefs, or on the way we see a situation, a person or a relationship. We have the attitudes we do because we perceive the world, including other people, in a certain way. For example, if we have a cynical atttitude to politicians it will be because we perceive them in a certain way, or have certain beliefs about them – perhaps that they are all self-seeking, or that all they want is a place in history or that they never admit to being wrong.

2 The relevance of this story to medicine is discussed in detail in Elliott C, 'Doing harm: living organ donors, clinical research and *The Tenth Man*', *Journal of Medical Ethics* 1995, 21: 91–96.

In the case of medicine there are many such perceptions which directly affect the attitudes which doctors have to patients, to themselves and to medicine itself. For example, many doctors believe that the practice of medicine is the practice of an applied science, and that randomised control trials are the 'gold standard' of such science. Now we have criticised this position in a previous work from the point of view of the philosophy of science,[3] but from the ethical point of view a less than desirable perception of human beings emerges. Human beings are seen as consisting of quantifiable elements which are generalisable and can be measured in 'scales'. (One size fits all.) Moreover, many doctors believe that in illness patients have the sole aim of prolonging their lives and 'fighting' disease. In terms of this perception patients are often provided with information consisting of dubious statistics, and accompanied by the assumption that the offered treatment will be accepted. For example, the information that chemotherapy has a 15% chance of prolonging your life may be provided with the assumption that the patient would be wrong-headed not to accept it. But 15% of what, for how long, with what accompanying discomfort? Perceptions of this kind – of medicine as simply an applied science with the quantification and generalisation which go with that, and of human beings as ones who above all want to be kept alive – create a common sort of attitude which doctors have to patients. Such perceptions are bound to affect the choices patients are offered and the manner in which they are offered. This is an unnoticed aspect of ethics on which we shall comment in Chapter 3.

The perceptions which the public have of their own health can also be affected by the arts. As we shall show, there is some evidence that attempts to write or draw can release creative energies in at least some patients, which they did not realise they had. The release of creative energy can be an important causal factor in healing or making whole, so it would seem to be an ethically good thing to employ artists where they can be helpful. Of course the employment of artists and writers in hospitals or general practices can give rise to ethical problems, for they are not bound by the regulations of medical ethics. Yet it is precisely because such artists are not seen by patients as part of the professional establishment that they can, sometimes, have a healing effect. This effect comes partly, as we said, from the release of creative energies, but it also comes from the idea of an equal partnership. The partnership between artist and patient or artist and community can be a model for an ethically good relationship between doctor and patient or public health doctor and community. There are ethical lessons to be learned here, as we shall show in Chapter 7.

In conclusion, we must stress again that we are not suggesting that the regulatory function of medical ethics should be replaced; it remains central. Moreover, we are not suggesting that every medical student, doctor or community can benefit ethically, or in any other way, from the arts and

3 Downie RS and Macnaughton J, *Clinical Judgement: Evidence in Practice*, 2000, Oxford: Oxford University Press.

humanities (as we shall see, p 167). But we are suggesting, more modestly, that the arts and humanities can perform both a critical and a supplementary function in the ethical education of at least some health professionals. They can provide a reasoned ethical critique of the nature of contemporary medicine and make suggestions about the directions in which it ought (and ought not) to go; and they can enrich the ethical judgements of professionals by assisting them to develop a broad and humane perspective. We have tried to capture these points in our sub-title: attitudes and perceptions.

Part I

Bioethics and the humanities