Medical ethics as the science of normative perspective in health care and its role to address ethical vulnerability

Laetus OK Lategan
Dean: Research and Innovation
Central University of Technology, Free State
Bloemfontein
llategan@cut.ac.za

Abstract

Literature reports on the ethical challenges health care practitioners are experiencing due to their working environment, personal circumstances and a growing need to deal with challenges pertaining to the care of war veterans, geriatric patients, abused children and women. These challenges contribute greatly towards the ethical vulnerability of health care practitioners. In order to assist health care practitioners to understand these challenges, a discussion is offered on medical ethics as the science of normative perspective in health care. It is proposed that ethics should be understood from a four quadrant perspective. In addition it is argued that ethics as growth and compromise in ethical dilemmas can contribute to a comprehensive understanding of ethics as normative perspective. This paper promotes the idea that in view of the four quadrant perspective health care practitioners, as with the priesthood, have a calling too. As such calling in this study is not reserved exclusively for the priesthood, but for all kinds of workers. Health care practitioners' calling is profiled by service, community, mercy and justice. The aims and objective of this paper are (i) to extend the scope of medical ethics to include the ethical vulnerability of health care practitioners, (ii) to propose an interpretation

model for medical ethics that can assist health care practitioners to identify and understand some of the ethical challenges and (iii) to pass ethical judgment on these challenges.

Keywords:

Ethics as normative perspective, medical ethics, bioethics, calling, compromise, health care practitioners

1. Introduction

Considering that the health care profession is often challenged by dwindling funds, declining resources, insufficient infrastructure and unfavourable working conditions, do we ever reflect on the fact that health care practitioners are ethically vulnerable or do we reserve ethical vulnerability for patients only?

Although many international medical codes commit health care practitioners to perform their work diligently and with the highest medical-ethical standards, it is disheartening to note that the absence of a supportive working environment challenges ethical standards and even the practitioners themselves to effectively perform their duties. A multitude of reasons may be put forward for this. Typical examples will include health care practitioners and the public who do not share the same opinion regarding care for war victims or military veterans, “bio-factories”, cloning, reproductive medicine, gene therapy, basic versus specialist care or the treatment of patients infected with HIV/Aids. To complicate matters even further, *religious challenges* can be added to the list – such as a faith-based understanding of medicine or ethical dilemmas such as the USPHS syphilis study on the poor men of Tuskagee.

Ideological, technological, economical, personal or religious reasons and motivations can be provided why ethical behaviour may be lacking in the working environment and why these circumstances contribute towards the ethical vulnerability of health care practitioners. Based on these comments, the emerging research questions are to understand ethical vulnerability and how health care practitioners can be supported to deal with this vulnerability. In order to do so, a deeper sense of contributing factors to ethical vulnerability in health care needs to be identified. These are subsequently discussed.

2. Contributing factors to ethical vulnerability in health care

The introduction to this paper suggests that health care practitioners are ethically vulnerable. Although some observational comments are offered as to the reasons why, a more detailed understanding is required in support of these comments. The following eight references can assist with this understanding.

UNESCO's Report on *The principles of respect for human vulnerability and professional integrity* (2013) is based on Article 8 of the Universal Declaration on Bioethics and Human Rights (2005) and according to which "respect for human vulnerability and personal integrity as a bioethical value of universal concern" (UNESCO, 2013:5) is emphasised. The Report is clear that although all humans are vulnerable, there are two kinds of vulnerability that deserves special attention, namely serious disabilities, and people who are vulnerable because of culture, religion, power, economics and natural disasters. It is for this reason that human vulnerability and personal integrity are essential concepts in bioethics. It must be acknowledged that social vulnerability is often neglected – primarily because of its complexity and the way it is imbedded in people's daily lives: "Social vulnerability is a phenomenon determined by the structure of people's and communities' daily lives. Situations of social vulnerability usually interfere with the self-determination of individuals and lead to significantly increased exposure to risks caused by social exclusion … Vulnerability is caused or exacerbated by a lack of means and the capacity to protect oneself" (UNESCO, 2013:14,15). The Report focused on the many manifestations of vulnerability such as the health care setting, human participant research and the development and application of emerging technologies. It remains a concern that vulnerability is never an isolated situation and impacts on many aspects of human lives. A specific comment that must be underlined is the enormous challenges associated with social vulnerability. This is a concern that is often neglected in health care and an issue that cannot be ignored when ethical vulnerability is addressed.

The challenges outlined by the UNESCO Report were also examined by Ten Have (2011). He explored the current context of bioethics and came to the conclusion that topics such as the commercialising of medical research, taking advantage of test persons – especially in developing countries – organ trading, brain drain, the migration of health care practitioners, research misconduct, the close link between science, care, and industry (especially the pharmaceutical industry) are all topics that should form part of understanding

modern bioethics. From these examples it is evident that the impact of ethical challenges on health care practitioners cannot be ignored. Medical ethics can never be reserved for patients only, but has an application to the health care practitioner, the patient, the family of the patient and the health care industry (as collective for [fellow] health care practitioners, hospitals, clinics, hospices, policy makers, health care administrators and managers).

In line with the need to understand the reasons for and context of ethical vulnerability, Bornstein (2013) raised his concern that doctors and medical students may lose their passion for the health care profession due to the limited time to spend with a patient, long working hours and indifferent circumstances. He asked the question *Who will heal the doctors?* – a concern related to the widespread burnout amongst doctors. Luckily there are training programmes to assist doctors and medical students to find meaning in their work and to stay committed. In his comments, Bornstein made reference to the "disastrous process of the MacDonaldization of healthcare". This mass production approach to health care impacts negatively on the doctor-patient relationship. Bornstein's concern, furthermore, is applicable to all health care professions.

In an earlier article, Du Preez, Pickworth and Van Rooyen (2007) raised the concern subsequently addressed by Bornstein and wherein they argue in favour of teaching and assessing professionalism in health care education. Teaching and assessing *professionalism* is an approach that must be developed and assessed. Du Preez *et al.* (2007) are mindful that although it is difficult to teach professionalism, a method such as the Golden Threads can assist lecturers to teach students and students to learn from simulation, imbedded examples in the curriculum and general discussions to enhance the students' understanding of professionalism. The Golden Threads method focuses on interpersonal skills, group and teamwork, professional attitudes, bioethics, problem-solving and critical thinking, research-based clinical practice, health and the law, economy and health and an epidemiological approach to health. Important aspects in teaching professionalism are to focus on patient autonomy, the context of the student and subsequent issues of vulnerability. Although role models play an important part in establishing and promoting professionalism, both observational research and case studies confirmed that role models do not always set a good example for professional behaviour. Part of professionalism will be to alert future medical students to the needs and humanity of patients, therefore a mindfulness for patients' vulnerability should be developed. Although this approach is directed at the education of the students, the question emerges concerning

the students' own needs and humanity. How do we address (future) health care practitioners' ethical vulnerability?

The same question can be addressed to Reid (2014) who outlined the important role of medical humanities in health sciences education. Reid described medical humanities as an interdisciplinary curriculum that focuses on the understanding of humans in health sciences. Medical humanities wants to understand the challenges the patient has besides his or her medical condition. He argued that medical humanities is important for health science education, since the importance of graduate attributes and the outcomes in the workplace are acknowledged. This too is applauded, but one should be careful not to limit the humanitarian understanding to the patient only, but also extend it to the health care practitioner. Health care delivery may have one focal point, namely the patient, but can never be removed from the impact this delivery has on the health care practitioner.

Understanding health care vulnerability as theme is further explored in a study by Vanlaere and Burggraeve (2013) showing that although it is expected from health care practitioners to be superhuman beings (i.e. almost perfect), their "imperfections" can be an advantage too. It is always expected from health care practitioners to be ethical at all times. This expectation is merited too. However, to be ethical at all times is not always doable. Health care practitioners can be challenged with their own ethical dilemmas or challenges in the workplace which may rule out the expected behaviour. Although this may have an impact on the expected performance of their duties, it cannot be evaluated outright as unethical. For example, disobeying an unethical system or practice cannot be labelled as unethical. In fact, it could be very ethical since this can be regarded as protest against an unethical system or practice. What can be interpreted as unethical behaviour is sometimes the only way to react to an unethical system.

Dealing with the medical industry requires a relook at medical ethics guiding health care. Schotsmans' (2009:33-39) comments on the development of medical ethics is very useful. He observed that originally the emphasis was on a fixed set of rules in medical practice. Lately there is a definite shift to move away from this (limited) understanding to include social and anthropological aspects in ethics, the doctor-patient relationship and human needs in medical care. The perspectives of, amongst others, Paul Sporken (*Ethiek en gesondheidszorg*) and Jan Hendrik van den Berg (*Medische macht en medische ethiek*) contributed to this broadened understanding of medical ethics. Schotsmans argued that all clinical decisions are mostly

linked to ethical decisions. He observed that the clinical engagement is an engagement between people. This necessitates a broader understanding of medical ethics than what is generally expected to be the case. He stated that there can be no medical care if the medical practitioner is not aware of ethical challenges or moved by these challenges. The conclusions drawn from his observations are that medical ethics must also guide the ethical needs and concerns of health care practitioners and that medical ethics should be part of all health care activities.

The ethical challenges outlined above are well reflected on by Phalime (2014) in her book titled *Postmortem: The doctor who walked away*. This book is an account of a medical practitioner who resigned from the medical profession since she could no longer see her way fit to work under conditions that is by no way supportive of what medicine should be about. She reflected on cases ranging from under-reporting HIV-related deaths due to the South African government's denial of the link between HIV and the disease profile that characterises Aids, an unemployed man who pleaded for a certificate to confirm that he was not fit to work and consequently be considered for a disability grant, patients demanding unwarranted sick leave certificates for personal reasons and staff requesting a prescription that is then turned in for toiletries. The pharmacist claims from the medical insurance but does not issue the medicine – the "patient" receives toiletries instead. These examples promote the view that health care practitioners have to deal with many more ethical challenges than what is normally covered by medical ethics. These observations are also specific that the ethical dilemmas confronting health care practitioners cannot be ignored and should be part of the scope of medical ethics.

It is therefore not at all surprising that there is a growing advocacy to promote medical-ethical consultation not only as *practice* but also as *profession*. The growing importance of medical consultancy is based on the important role that medical ethics consultants play in almost all aspects of health care decision-making. Medical ethics consultants can direct the focus to health care practitioners, patients and institutions (Scofield, 2008:95-96). One can, in addition, clearly state that understanding medical ethics requires a multidisciplinary approach (Schotsmans, 2009).

These references suggest that health care practitioners' understanding of medical ethics cannot be limited to the well-known discussions on life and death (normally closely associated with bioethics), palliative care and informed consent only. There are simply too many other ethical challenges that health care practitioners need to respond to in the workplace. A fair

conclusion is that unfamiliarity with the scope of ethical challenges or the inability to deal with these challenges can leave a health care practitioner with a feeling of ethical vulnerability and insecurity. This remark is well grounded in Schotsmans' (2012:17-22) ethical overview of health care. He found *human engagement* as the basis of all health care service. It means that health care practitioners reach out to patients, but also allow the patients to engage with them. Without this reciprocal approach there cannot be any reference to an ethical relationship. This approach by default implies a responsibility to other people – in the context of health care to the patient, the family and the medical industry. In return the patient, the patient's family and the medical industry also have an ethical responsibility to the health care practitioner. This mutual relationship should be built on trust. Schotsmans continued by arguing that all medical care is vested in a relationship. Although the aim of medical care is to promote the human dignity of the patient, it can never be limited to the patient only. The health care practitioner's dignity should be respected and promoted too. It is here that values play such an important role. Schotsmans' ethical framework is reflected in his understanding of care ethics. For him it is not so much about finding universal values and norms, but more specifically about the uniqueness of each person's situation. No one can lose sight of the fact that human life is vulnerable. Proper health care is to meet a patient in his or her specific and personal circumstances and vulnerability. Vulnerability calls on responsibility that should be reflected in all human interactions. Therefore, it cannot be stressed enough, an ethic of responsibility can never be removed from care.

In view of the above-mentioned analysis of contributing factors to health care practitioners' ethical vulnerability and the research questions posed (paragraph 1), the following comments can be offered. The medical industry at large is subjected to ethical vulnerability. Apart from the well-known medical-ethical challenges associated with health care, new challenges associated with the medical industry very often remain an unattended concern. Another concern is that medical ethics is very often directed at patients only, but the health care practitioner and medical industry are not included in the discussion on medical ethics.

These comments form the basis for my thesis that medical ethics requires a broadened understanding concerning its scope and application. This thesis will be discussed in consequent paragraphs.

3. Aims and objectives of paper

The first aim of this paper is to extend the scope of medical ethics beyond the general accepted categories of life and death, informed consent, do no harm and responsibilities of health care practitioners. The second aim of the paper is to propose a model that can assist health care practitioners to identify and understand the ethical challenges they experience in health care delivery.

The objective of the paper is to assist health care practitioners to pass ethical judgment on the above-mentioned challenges. In doing so, health care practitioners may be in a more secure position to deal with ethical dilemmas in the workplace. This objective will contribute towards dealing with the ethical vulnerability of health care practitioners.

The departure point for the discussion is based on the foundations of medical ethics as the *science of normative perspective in health care*. The next section will attend to these foundations.

4. Medical ethics as the science of normative perspective in health care

The concept “ethics” finds its origin in the Greek *èthos* and/or *êthos*. These words refer to custom, practice, attitude and motive and relate to universal principles and the subsequent identification and application of norms derived from these principles. Ethics refers to people’s behaviour following on a particular value system.

In this paper ethics is broadly defined as the science of *normative perspective*. This description suggests that ethics deals with the identification of a norm (for example, the protection, caring and improvement of human life and health) derived from a universal principle (no suffering, for example). A normative perspective can therefore be defined as the *application* of a universal principle required for a *responsible* and *respectful* life. This approach goes beyond the delineation of ethics as a matter of good or bad, right or wrong and just or evil. It links up with Schotsmans’ (2009:39-45) view of ethics as human actions in the context of compassion and dignity.

Ethics brings *perspective* to a situation on what the desired norm, action and behaviour should be. Ethics cannot be presented as a *fixed* list of what people can and cannot do. Ethics is about *creating* a rightful space where people are treated with compassion and that will, in turn, enable them to reciprocate in behaviour. Ethics is no fixed list of rules for normative

behaviour, but is rather a dynamic value system that must be applied to the uniqueness of each situation – notably ethical dilemmas. Ethics is a value system directing decision-making, the continuous review of a situation and the recurring question of how a situation can be improved on the basis of ethical decision-making. Schotsmans' (2012:141) view (almost poetic observations!) that ethics is to guide, orientate and to anticipate what could be, is therefore supported. It is the ethical responsibility of health care practitioners, patients, family and other support systems to make decisions that will promote human dignity (in health care). Ethics is therefore more than compliance and oversight. Ethics is commitment, action and application. Ethics is fundamentally what defines the character of different individuals and institutions.

I am mindful of the uniqueness of each situation and that no two ethical challenges are bound to be the same. Ethics is the gatekeeper, the whistleblower and guardian of any just society. It is continuous and creative action and not a one-time decision on the basis of a set rule book. Where ethical behaviour is absent, a society will fail – something that features prominently throughout history (cf. the Roman Empire), all unjust systems (slavery) and political ideologies (e.g. Communism, Apartheid, the Holocaust, the human tragedy in Rwanda).

Based on the above-mentioned outline, refers medical ethics to the normative perspective for the medical industry. This perspective is not limited to issues of life and death only, but drills down to the search for the best care for those who are fragile and vulnerable. It includes the health care practitioner (as service deliverer) and health care managers, administrators and policy makers who direct and oversee the implementation of health care.

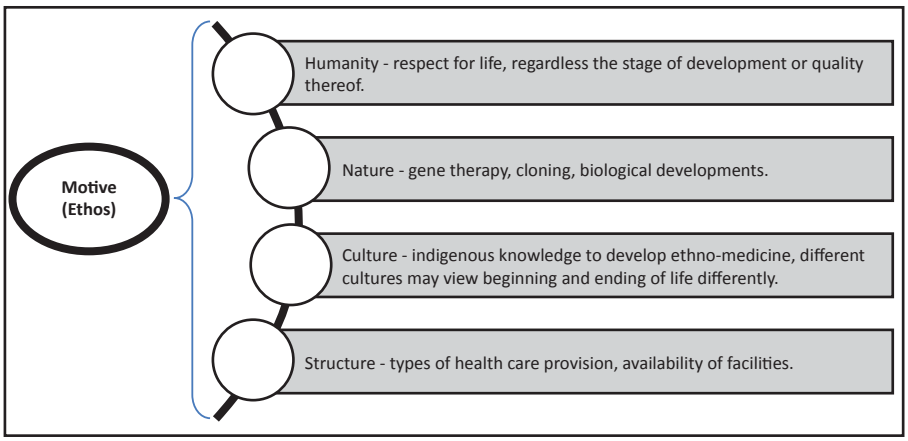
This understanding of medical ethics is further informed by what the present author frames as a *four quadrant normative model*. Here I am very much influenced by the South African scholar, J.A. Heyns, who referred to the different relations that man is operating in (see Heyns, 1982). Adapting his ideas, man engages with *humanity* (people), *nature* (environment including but not limited to animals and plants), *culture* (e.g. habits, traditions, customs) and *structure* (societal institutions like relationships or organisations such as a medical clinic or hospital). In the centre of these relationships is *personal faith* that reflects convictions such as humanity created in the image of God, religious orientation, confessions and church tradition. Personal faith influences people and their relations. This view is vested in the philosophy of science's idea that people's thinking, behaviour and actions are influenced by their deepest sense of purpose, meaning or orientation. The position taken

here is that no science is practiced “value-free”. This position is reflected and debated by, for example, René Descartes (*idea innate*), Nicholas Wolterstorff (three kinds of beliefs), Herman Dooyeweerd (religious ground motives) and John Thompson (ideologies).

The present author’s practice of the four quadrant normative model is influenced by Christian religion. This means that the Ten Commandments, the Sermon on the Mount and the central religious command of love will play a leading role in these quadrants. This orientation will influence how one views life, health care, patients, rehabilitation, how life is protected, how health care is provided and how health care systems impact on society. Christian-based ethics does not mean that selected topics are presented, but simply that analysis and discourse come from a *particular* perspective. This perspective is based on the Scriptures, confessions as well as church and ecumenical traditions. The views held by Schotsmans (2012) are helpful. He argues that although a Christian perspective can be regarded as a minority view in an increasingly secular society, it has an important role to play in understanding and dealing with ethical challenges. This statement is based on the history of Christian religion, its particular understanding of ethics and its application to ethical dilemmas. In addition Christian religion promotes human engagement on the basis of neighbourly love, care, and compassion.

The four quadrant normative model emphasises the diversity and complexity of human relations, interactions and services and how other spheres of reality informs the interconnectivity of human existence within reality. With regard to its meaning for the health care profession and medical ethics it is evident that it enriches one’s understanding of the context for health care, that health care is challenged by more aspects than life and death only and that ethical dilemmas cannot be limited to patient care only. Following on this view is the directive conclusion that medical ethics should cover all aspects associated with health care. This model further contributes to health care practitioners’ comprehension of the complexity of ethical dilemmas and how these dilemmas could be addressed.

This model's meaning for medical ethics can be illustrated in the following way:



From this illustration it is evident that the four quadrant approach directs the motive (ethos) the way in which health care practitioners should perform their ethical behaviour in the context of health care. The following four perspectives can give direction:

(1) The *motive* (ethos) why the health care industry is doing something or acting and behaving in a specific way. Ethos questions what it is that an individual or system hopes to gain from a particular activity. A typical example is basic health care – is it to promote health, to secure easy access to primary health care services and facilities, a cheaper option if money for infrastructure and medicine is not available, an alternative to enough health care practitioners or a political strategy? Depending on the outcome, the follow-up question is whether a better alternative for the current motive can be provided.

(2) Service (*koinonia*), community (*diakonia*) and hope (*evangelium* as a new perspective) as drivers for ethical behaviour. This will bring mercy and well-being (*hesed*) to humanity and society. No health care can exist without compassion and dignity. Important ways to accomplish compassion and dignity are to engage respectfully with patients, family and fellow practitioners and to bring an alternative to their current situation (hope).

(3) Responsibility and respect for the quadrant relations, an expression of one's attitude towards the proverbial "other" and the "world". In typical Emmanuel Levinas tradition, meeting *other* people is an encounter with oneself. This engagement should therefore be unplanned, not forced, but a spontaneous way of going about with the "other".

(4) Ethics requires action and pro-action. An enormous limitation in ethical thinking is that ethics should identify a dilemma and indicate a possible way out of the dilemma or that ethical guidance means to occasionally, or as a one-time occurrence, seek ethical guidance or clearance. Ethics is not incidental. It is something that should be considered during all stages of health care. Ethics should also be used to monitor and evaluate responsiveness to ethical dilemmas. At the same time ethics is also the normative protest against an unjust world. Ethics should constantly remind us how things should be and not how they are.

Lips (2006) is correct in stating that ethics also means to take responsibility for one's own actions and behaviour. In addition, ethics must also create meaning in a person's life. These comments change the perception that ethical behaviour is only directed towards the other and not the self. Lips continues by arguing that people cannot be isolated from the "other". It is therefore not only the "other's behaviour" that deserves attention, but one's own behaviour as well. All people have the responsibility to engage with their own understanding of an ethical matter. This cannot be delegated to someone else. It is not only part of human freedom, but essentially forms the basis of everybody's own life and world orientation.

Applied to medical ethics, the imperative will be to preserve life, never to put any patient at risk regardless the treatment and/or therapy, to respect unborn life (e.g. the debates on abortion and the beginning of life) and life (the debate on active, passive and slow euthanasia), to consider if doctors should do what they are able to do (the debate on cloning), to question the necessity of health care (*Is basic health care sufficient in developing countries or are expensive therapies required as well? Do sophisticated health care techniques make a difference to a patient's life or are these techniques simply contributing to the growing medical cost?*), to evaluate the quality and cost of health care and health care provision (technological developments, the medical economy, health care legislation and the public, and the provision/availability of care providers), to review the development of new medicine (ethno-medicine [plant-based medicines based on indigenous knowledge]), and to address health care training (sensitivity towards own

needs but also that of others, humanities training integrated with medical, health and clinical training).

In addition to what was argued so far, two more perspectives will be added in order to present a more detailed picture of the breadth of medical ethics as the science of normative perspective in health care. These perspectives, *ethics as growth* (par. 5) and *compromise as ethical figure* (par. 6), will assist the health care practitioner with developing a more inclusive understanding of ethics. At the same time it will support health care practitioners to understand their ethical vulnerability and, by doing so, grow their own ability to deal with ethical challenges.

5. Ethics as growth

Flemish ethicist Roger Burggraeve promoted the concept of a "growth" ethic (Burggraeve, 1997). He rightly argued that ethics cannot be limited to simply pointing out what a situation or dilemma is. Ethics has the task to assist people (read health care practitioners) to what the ideal situation should be. He referred to the principle of *minus malum* (*the lesser evil*) and the principle of *minus bonum* (*the lesser good*). When decisions are passed in ethical dilemmas, a decision is based on choosing the *minus malum* (i.e. when facing two unpleasant options, choose the one which is least harmful). But one should rather interpret the decision as the *minus bonum*. This attitude should raise the awareness that this decision (*minus bonum*) is not the ideal situation and that one should always aspire to grow to the desired situation (*vere bonum*). This view should be understood in association with an *ethics of possibility* – a situation can be better.

Schotsmans' (2012:136-138) appreciation for the concept of growth ethics lies in the fact that ethics should continuously search for new meanings of a situation and ways how one can grow in personality to deal with ethical dilemmas.

This approach can be coupled with Egnew's (2009) advocacy that health care practitioners should assist patients to transcend pain and experience healing through new "illness narratives". Such an approach can assist contemporary medicine to maintain its tradition as a healing profession. He reflects on a number of approaches to health care and concludes that "healing is stimulated through the medium of close, caring interpersonal relations" (Egnew, 2009:174).

This understanding of ethics is important for health care practitioners since it embodies what health care stands for: *care* during illness/trauma and *growing* to a new situation post the illness/trauma. Such an approach is in line with the general accepted view on *palliative care*. Palliative care requires patient-centred care and relates to sensitivity for patients (cf. Richardson & Tookman, 2004). Deriving from Latin, the word palliative originally hails the meaning of a raincoat to protect a person from a storm. Thus the emphasis is to *protect*. Symbolically it likens the cloth to a manner of protecting the fragility of a fellow human being. This is particularly evident in military patients, men and women abused or raped, homeless patients and geriatric patients.

In the context of medical ethics as the science of normative perspective in health care, growth ethics will contribute towards the continuous awareness that medical ethics should be creative in dealing with ethical challenges and that it should also contribute towards the ability of the health care industry to deal with ethical challenges.

6. Compromise in ethical dilemmas

Compromise in ethical dilemmas is an underrepresented ethical figure in medical ethics. One of the reasons is that the compromise is traditionally associated with politics. In this domain compromise refers to a *balance* or *middle road* between two opposing views. It is very often a matter of give and take. The ethical meaning of compromise, however, refers to a borderline situation where only one possibility is doable. In a borderline situation, the simultaneous realisation of two norms creates ethical conflict. By nature these norms may not be conflicting at all, but due to the situation there may be a conflict between the realisation of these two norms. The classical example in medical ethics is where the continuation of a pregnancy will jeopardise both the life of the mother and that of the unborn child. A choice has to be made between either the protection of the mother's life or that of the unborn child. In this situation only one option is possible. This choice and its outcome are known as the compromise.

The importance of the compromise for medical ethics is informed by the fact that very often tough ethical decisions have to be taken. The challenge is not the fact that a decision has to be taken, but also that there is limited scope to take the decision in. The compromise is not a dual decision – *and* … *and* but a limited decision – *either* … *or* …. In these borderline situations health care practitioners and patients are reminded that sometimes limited ethical

options may be available. The compromise reminds one of the inevitability to act regardless the limitation of choices or options. What must be remembered is that the aim is not to avoid normative behaviour, but to secure that in a borderline situation one is still ethically responsible. The compromise is therefore an indication that the ideal choice is not always possible. The decision taken relates to a search for meaning due to loss, suffering and moral injury. The compromise is not only about decision-making, but also about how one will deal with a situation once a decision has been made.

It needs to be added that the compromise is ethically speaking also a sign of responsibility to act in the best way possible given the limitations of a situation and to do what is best despite the situation.

Although still a relevant concept, but no longer in demand due to the influences of a postmodernist and post-religious society, the compromise is also an act of *ethical responsibility*. The present author's initial judgmental comment is based on a human rights culture where there is often an overemphasis of *rights* instead of *responsibilities*. A normative ethics makes it clear that the responsibility to act can never be waived – regardless the complexity of the situation.

Having stated the role of the compromise in medical ethics, it subsequently sparks the question of how health care practitioners should approach ethical dilemmas. One option is the health care practitioner's calling.

The discussion on calling will support the aims of this study, namely to broaden the understanding of medical ethics and to support health care practitioners to deal with their ethical vulnerability.

7. Calling – A concept that extends beyond ministry

Burger (2005) completed an extensive study in which he concluded that calling cannot be reserved for the ministry alone. He builds a convincing argument that all people can have a calling regardless their profession. This is based on his claim that calling is of a religious nature and influences all aspects of a person's life. The value of his study is that man's deepest orientation could (re)direct his commitment to a particular profession. This will also secure a particular work ethic. Such a work ethic should be qualified by service delivery, quality of work and value adding. The value of calling for the health care practitioner is the acknowledgment that an individual can commit him- or herself to seek meaning that supersedes a professional

commitment. A professional commitment alludes to meeting the minimum standards of a profession and to comply with the professional code of that profession.

In the context of this paper, calling is presented as one's commitment to a work ethic that is aligned with a person's ultimate personal commitments. This can be closely associated with the four quadrant perspective presented in this paper, namely that the health care practitioner's religious conviction will influence his or her participation, attitude and approach to the four quadrants.

Four metaphors can be employed to contextualise calling for health care practitioners.

Firstly the health care practitioner is like a *priest* serving a community through personal commitment, availability, dedication and care. These compassionate characteristics are of an anthropological nature and assume a patient-centred approach in health care.

Secondly the health care practitioner is an *architect* designing a new understanding for the patient's situation en *route* to healing. Architectural design symbolises a new approach. This is linked to the concept of a growth ethic presented in this paper.

Thirdly the health care practitioner is a *farmer* who is assisting the patient to harvest a new beginning. This too is linked with the growth ethics promoted in this paper.

Fourthly the health care practitioner assists a patient with his or her *exodus* from the current situation to a new situation. Although a growth ethic is evident, here it relates specifically to borderline situations where tough decisions should be made in an ethical dilemma and then the ability to move from where one is to where one ought to be.

Following from this perspective on calling is the question how it will contribute towards the ethical well-being of health care practitioners. A perspective from service, community, mercy and justice can provide directives.

The role of service is well articulated in for example the (new) *Oath of Hippocrates* (namely that one will exercise one's art solely for the cure of patients), the *Nuremberg Code* (1946-1949) (namely that through one's superior skill and careful judgment no medical experiment should result in injury, disability or death), and the *Helsinki Code* (which points out the limitations of research in health care [the well-known distinction between *therapeutic* and *non-therapeutic research*]). The aforementioned oath and

codes commit health care practitioners to improve the life of patients through their health care services. Service is aimed at the needs of others and how the needs can be addressed.

The Greek word *diakonia*, as used in the New Testament, adds to our understanding of service in health care. Service is not only about addressing the needs patients may have, but also to reach out to patients as human beings. A patient's needs could never be understood in isolation from the patient and his or her context. Here we find that the case of a patient and his or her condition cannot be isolated. Treating the patient's needs requires an engagement with the patient too. It is for this reason that I am advocating that *diakonia* should be understood in juxtaposition to *koinonia* which symbolises the *community* with other people. Symbolically one can argue that it is not only the *hand* (outreach and help) but the *heart* (community through help) too. This approach can be linked to the *mercy* (the Old Testament concept of *hesed*) one should have for those in a weaker position. Mercy (*hesed*) becomes an expression of the health care practitioner's outreach to and care for patients as part of the health care environment. Mercy's primary concern is to bring *justice* (Hebrew: *mispat*) and *righteousness* (Hebrew: *sedek*) about. The health care environment can easily be challenged through *power play*. Power play is evident in cases of a strong and a weak party. This kind of power play does not only refer to the uneven interaction between people, but also to a situation or environment that is not supportive of human well-being. From the perspective of a developing country, this can very easily be the case. Consider the following South African examples. Patients are very often far away from a clinic and has no or limited transport to the clinic. Basic medicine or basic health care may not be available. The same could apply to specialised treatment such as cardiology therapies. Different languages can create a problem too. If one does not understand a health care practitioner's language (or are unable to use the local *lingua franca*, say English), one may not be able to express one's needs if one is not in command of the same language. (In South Africa there are no less than eleven official languages.) Besides the human factors, one should also be mindful of the impact technology may have on patients. If one is used to limited technology only, then high-tech treatment and therapies can be quite intimidating. It is in these and similar situations that justice and righteousness should prevail. Related to mercy, one can conclude that unethical behaviour should also be prevented. Ethics is not only about rectifying what is wrong, but also very much about preventing situations and behaviour that may become or may prove to be unethical.

8. Conclusion

This paper has promoted (i) a view on medical ethics that goes beyond the traditional understanding thereof, namely ethical challenges addressing questions surrounding life and death, informed consent and research on human subjects and (ii) a quadruple context within which medical ethics can function. It was further argued that such an approach can support health care practitioners to understand the complexity of ethical dilemmas as well as their own ethical vulnerability.

What is evident from the discussion in this paper is (a) the complexity of ethical behaviour due to the quadruple relations health care practitioners are functioning in, (b) that ethical behaviour is informed by the needs experience in different situations – thus no two situations are the same, and (c) a core of ethical pointers that should always be evident/present in one's behaviour. What was also outlined in this paper is the role that context, calling and mercy can play in health care ethics.

Applied to the context of health care, health care practitioners are often confronted with ethical challenges in their working environment. To optimise effectiveness in the working environment whilst recognising the ethical responsibility of health care practitioners as well as their own vulnerability, the health care practitioner requires multiple normative perspectives on a specific situation. The ethical armour and preparedness of a health care practitioner is important. What is required, is an understanding of a situation, the perspectives from which the situation should be evaluated to arrive at a workable ethic for the situation and to couple ethical behaviour with an attitude of service, community, mercy and justice. This attitude also transmits to health care practitioners. No health care practitioner can go without the reality that in borderline situations a decision should be taken that ethically fits the situation best. Health care practitioners should always aspire to grow to the ideal situation. Ethics is therefore not only to seek the common good and secure normative behaviour, but a continuous aspiration to improve the health care environment. This understanding can ultimately assist the health care practitioner to deal with his or her own ethical vulnerability.

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