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Thomas Alured Faunce. *Pilgrims in Medicine: An Allegory of Medical Humanities, Foundational Virtues, Ethical Principles, Law and Human Rights in Medical Personal and Professional Development.* Leiden: Martinus Nijhoff, 2005. xxiv + 651 pp. $263.00, cloth, ISBN 978-90-04-13962-6.

Reviewed by Robert Darby

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The unpretentious medical school at the Australian National University can be approached along a meandering path which leads you past some of the most attractively landscaped corners of the campus. Plantings of elms, gingkos, pines, oaks, beeches and eucalypts provide welcome shade from the fierce Canberra heat, while native ground covers thrive in the patches of sunlight. It is not the most direct means of access, but the pathway takes you past many botanical features that you would otherwise miss, each of which has potential to make a contribution to the goals of education, whether broadening knowledge, sharpening perceptions or honing sensibility. Something of the same approach has been taken by Thomas Faunce, senior lecturer in both the medical school and the college of law, in this remarkable text. Like the pathway, *Pilgrims in Medicine* takes the reader on an unpredictable safari through the history, the schools of thought and the perennial issues of medical ethics, pausing here and there to contemplate an interesting or controversial growth, hurrying past the more common or less contentious questions, and enlivening the journey with references to novels, plays, films and paintings.

Although Faunce takes his literary conceit--the idea of pilgrims--from *The Canterbury Tales*, the book is not structured as a series of stories from different members of the band. Instead, we hear the voice of Dr. Corambis (surely a persona for the author) lecturing to his students; with names such as Legalism, Virtue Ethics, Political Correctness, etc., they embody moral principles in the manner of a medieval miracle play; their comments on the professor's discourse and reports of incidents from their clinical or personal experience reflect their differing outlooks and approaches to life. The chapters move through time as well as subject matter. The students graduate and take up their individual career paths, and one of them eventually succeeds Dr. Corambis as the lecturer: in the final chapter, as Professor Virtue Ethics, he attempts to draw together "all the strands of an integrated system of doctor-patient regulation." Although the book deals with fairly abstract concepts intended to have universal validity, an attractive and often amusing feature is

its firm location in a real place, the Australian Capital Territory, though it is referred to, rather playfully, as Uqbar, after a story about an imaginary country by Jorge Luis Borges. The somewhat remote principles discussed are brought down to earth by references to the smell of bushfires, currawongs carolling in the gum trees, possums scampering over the roof, splashes of mud from a bicycle tire, and the students' experience in the wards of Canberra and other rural hospitals. We are reminded that the objective of medical ethics is to safeguard the rights of real people, not just to provide debating points for those who enjoy philosophical discussion.

As Faunce tells the story, it is clear that the necessity for medical ethics arises from the disparity of power between doctors and those who consult them. While there is debate over whether the institutional power of the medical profession as a whole derives mainly from its expertise or its capacity to influence the organs of the state, there is general agreement that the power of doctors in relation to patients arises from their superior knowledge of the body, the disease conditions which may affect it and the possibilities of intervention.[1] The disparity of power, and the need for ethical rules, becomes more acute in situations where the individual lacks the capacity or competence to say yes or no--as is the case with children, or with patients etherized on an operating table. Although the Victorian era--when Dr. Paterson could fail to report that Dr. Ernest Pritchard was poisoning his wife because interference would have been a breach of professional etiquette--was perhaps the period in which medical ethics reached their nadir, it was also the moment when progressive physicians began to develop a conscience, as shown, for example, in the opposition of British obstetricians to the clitoridectomies performed by Dr. Isaac Baker Brown in the 1860s. In the course of the debate over the propriety of Brown's treatment, his opponents enunciated a number of ethical principles that have neither lost their relevance nor ever been wholeheartedly practiced.[2] Among these was one which Faunce takes as a foundational virtue: that a doctor's prime loyalty is to his patients, not to his colleagues, and certainly not to any "good" as defined by society or by a subculture.

Although various codes of medical ethics have existed since ancient times--most famously, the so-called Hippocratic oath--it was only with the rise of the medical profession as an influential social force in the nineteenth century that the ethical principles governing their *modus operandi* became a focus of concern, and only after the Second World War--in response to the abuses of medical power under the Nazis and Stalinism, the development of a constituency for human rights and the decline of medical dominance itself--that the question became pressing. Before this time you would be scratching to find more than a dozen texts devoted to the subject, while today we face such a flood of relevant literature that it is difficult even for those who call themselves bioethicists to keep up with more than a fraction of it. Like other forms of expert knowledge, medical ethics has become a specialization, and the likelihood that the average GP, intern or surgeon will have more than the barest acquaintance with its principles, much less its controversies, seems increasingly remote. It is to address this situation that Faunce has written *Pilgrims in Medicine*.

His aim in this long and ambitious text is to reconceptualize medical ethics as a system of doctor-patient regulation based on the fundamental premise that the role of the doctor--its basic telos--is "the relief of individual patient suffering." The wider aim is to formulate a system of medical ethics which integrates traditional principles stretching back to the Hippocratic Oath, modern ethical philosophy, law and human rights, especially as codified in the various conventions and other instruments that have appeared since the Declaration of the Rights of Man (1789). Although this approach is as radical as the style of the book

is unconventional, Faunce is no iconoclast: his aim is to retain all that is positive in past schemes of doctor-patient regulation and unite them with modern conceptions of individual rights, particularly the rights to autonomy and inviolability of person. Despite criticism of legal positivism, he regards at least one tenet of medical law--that any touching without consent is likely to constitute battery--as supremely useful.

Surveying the history of medical ethics, Faunce detects three persistent themes: that doctors must respect patient's autonomy and do them no harm; that all human beings have a right to physical integrity and must be informed of all material risks before any procedure; and, that all human beings are born equal in dignity. Although the Hippocratic Oath is often regarded as the foundation of medical ethics, particularly in its famous rule to do no harm, Faunce points out that it also posits loyalty to colleagues as a doctor's prime responsibility and pictures his/her relation to patients as one of command and obedience. Such a schema is clearly inadequate today, though there have been many attempts to bring it up to date. The crimes of the Nazi doctors gave rise to the Nuremberg Code, banning experimentation without consent, and this in turn led to the modernization of the Hippocratic Oath as the Geneva Declaration in 1948. Under this code doctors were required to put the patient first, rejecting "the relief of communal or public suffering as their primary telos," and not assuming that the interests of individual patients should be sacrificed "to the common good" (pp. 164-165, and see n. 271 and 272 for elaboration of the argument). Despite these efforts, neither the Nuremberg Code nor the Declaration of Geneva was formally adopted by any national medical body, and they have generally been interpreted narrowly as referring only to medical experimentation, not to everyday patient care. The problem since then has not been the absence of statements of principles, but lack of commitment towards putting them into effect, coupled with a corresponding tendency to find situations in which the rules do not apply.[3]

When medical ethics began to be taught in the 1970s, the key text became T. L. Beauchamp and J. F. Childress's ***Principles of Biomedical Ethics*** (first edition in 1979), which sought to create a common language for the identification, analysis and resolution of moral problems in biomedicine. At its core were four principles: beneficence, non-maleficence, autonomy and justice. The first two derived directly from Hippocrates, the others from later developments. Although this attempt at systematization was a step forward, Faunce notes that the first two principles have been emphasized, yet the second has been neglected: although "substantive ethical rules requiring voluntary consent from a competent patient prior to medical invasion of his/her physical integrity" were necessary to protect patients and ensure their capacity for autonomous choice, there have been many situations where this rule has not been followed, especially those involving children and the otherwise (either legally or actually) incompetent. The principle of justice (meaning access to medical care) has also been the focus of more lip service than realization (pp. 174-176, 188-189).

To overcome these problems--inadequate formulation and irresolute execution--Faunce proposes an integrated system of ethics which includes Beauchamp and Childress's four principles, international human rights, law and legal cases, philosophical ethics and conscience, developed by a medical education which regards knowledge of the humanities (particularly literature) as having nearly the same importance as knowledge of anatomy. The telos or good of the system is defined as "relief of individual patient suffering," while suffering is defined as a significant bodily discomfort which, by virtue of its severity and the impossibility of self-remedy, threatens the coherence of a person's life narrative. Although this last concept is central to the argument, it is not as

clearly defined as the others, though I take it to mean the sum total of a person's self-image and aspirations--the sort of person he or she considers him/herself to be or would like to become. Faunce insists throughout that an ethical (or virtuous) physician will take care to facilitate the coherence of a person's life narrative and do nothing likely to pre-empt or close off possibilities.

This is an ambitious program, but perhaps the most controversial aspect of ***Pilgrims in Medicine*** is the proposition that neither health (the "objective" good of the patient) nor the patient's subjective desires can be the telos of this system of doctor-patient regulation. Arguing the first point, Faunce rejects a dominant theme in modern discussion of the role of medicine, summed up in the influential view that "the most fundamental goal of medicine is the improvement of the quality of life of those who seek and need care," as a recent text puts it.[4] Faunce does not argue his position here with the detail it perhaps deserves, but his main points are the difficulty of defining objective good (he identifies four possible meanings of the expression) and that (good) health may either not need a doctor at all or may need much more. Beneficence cannot be the primary telos because it is more important to relieve suffering than to make healthy patients even healthier. Although he does not spell this out, I suspect that part of Faunce's caution in setting such an apparently modest (almost Oslerian) goal for medical care arises from awareness that so many utopian schemes for human betterment foster arrogance in their promoters and end up in coercion and tyranny. As he writes, "This primary telos of relief of individual patient suffering effectively demarcates doctor-patient relations from related regulatory systems, such as medical research, public health policies and research, or political activism against institutional barriers to health, where close involvement with individual patients is less prominent. Formulating the telos negatively is intended to discourage contemplative or 'bureaucratised' responses commonly produced by ideals such as health or objective patient good" (p. 552).

In much of this argument, Faunce's specific target is "legal positivism," the legal rules set by statute, regulation or case outcomes, which increasingly determine the parameters of what a doctor may or may not do. He attributes the rising influence of this approach to "a fascination with the social power of law," fear of liability and "an excessive reverence for evidence-based medicine," and he contrasts it with his own holistic approach, based on ethics, conscience and human rights. Under the legal paradigm, "the patient possesses power only insofar as he or she is surrounded by boundaries that the physician cannot cross without violating legal rules" (p. 28), while under his own proposals the patient would be protected by the training in ethics the doctor has received as a student. Such a vision may seem idealistic, but there is no denying the difficulties in the legalistic approach. If the rules are formulated broadly, they are subject to endless interpretation; thus, if the matter comes to court, it will be the party with the best barrister or the most sympathetic judge who has the advantage. Further, the issue becomes what the court will find, not what is morally right. Faunce might have added that legal redress is uncertain, expensive and, even when a case is won, retrospective. But his deepest objection to the legalistic approach is its tendency to impoverish the sensibility of the medical student; he describes it as conservative because "it marginalises human qualities such as virtue, emotion, aspiration and conscience," while relegating to "the outer circle of academic darkness" systems of regulation "that emphasise an active social and professional conscience, such as natural law and human rights" (pp. 31-32).

Faunce is particularly severe on physician involvement in state- or custom-sponsored violence. In this context he mentions the Nazi medical experiments, Soviet psychiatric institutions, torture of political prisoners, virginity testing in Turkey,

sterilization of criminals and mental defectives by doctors advocating surgical control of social problems in the United States.[5] He also notes that the World Health Organization (WHO) has condemned the participation of doctors in "female genital mutilation/circumcision as violating either the human right to health, a child's human right to develop normally, the human right to physical integrity, and the human right to non-discrimination as a woman" (p. 77). Faunce condemns the participation of doctors in capital punishment "especially through methods involving medical skill and technology, such as lethal injection," as "fundamentally opposed to the posited primary telos" of his system; lethal injection "cannot be justified ... on the basis that it is a humane method of execution which causes the least amount of suffering" (pp. 442-444).

In his stress on the importance of incorporating "international human rights" into medical ethics, Faunce takes the familiar list of grounds on which people should not be subject to unequal treatment (sex, race, color, religion, disability, perhaps age and sexual preference) very seriously, but these are social rights, exercised as members of a community, not rights relating to a person as a biological or corporeal entity. Does or should the body itself have rights? The constant emphasis on the right to autonomy and physical integrity suggests that it does, but the book does not delve deeply enough into the problem of possible collisions among the various rights. Faunce is aware that the right to physical integrity may conflict with other principles (such as the right of parents to follow practices authorized by their culture or religion), but the awareness is expressed in disappointingly partial (not to say discriminatory) terms. There are several references to female genital mutilation as a harmful cultural practice, and thus one that ethical doctors should not perform, but what about boys? Do they not also have rights to physical integrity and to construct their personal life narrative that might protect them from genital mutilation? Or which might at least discourage doctors from performing such procedures? The author's apparent blind spot here is surprising given the flood of literature on the question of "routine" (that is, medically unnecessary) circumcision of minors over the past decade, and all the more remarkable considering that he cites one of the texts that contains a seminal essay on this very issue--Margaret Somerville's "Altering Baby Boys' Bodies: The Ethics of Infant Male Circumcision," in her collection ***The Ethical Canary*** (2003).

It is all very well to appeal to the authority of international instruments requiring observation of named rights, the promotion of non-discriminatory policies in medical care and the supply of health services, but what does a doctor do when confronted by Somali or Sudanese parents who bring their little girl and boy along, and request that their genitals be altered in accordance with the traditions of their original home culture? Or Australian or American parents wanting their baby boy done because they had seen a newspaper article or TV program in which it was suggested that, if he was not circumcised, he would be sure to get phimosis and urinary tract infections as an infant, STDs and probably AIDS as an adult, and (in the unlikely event that he lived that long) would die an agonizing death from cancer of the penis in middle age? (The medical excuses for circumcision of minors make many of the cultural reasons seem rational by comparison.)

Here we have a sharp collision between the obligation to respect the culture or convictions of the parents, on the one hand, and the imperative to respect the bodily integrity of the child, on the other. What should the virtuous physician do in this situation? Taking the legalistic position criticized in the book offers an easy way out: since circumcision of boys is legal nearly everywhere, and still widely practiced in North America and (to a lesser extent) Australia, the doctor can perform the surgery without much fear of legal complications.[6] But, in relation to females, his hands are tied: he cannot touch the girl, because any form of

FGM is prohibited by law. Such a response might satisfy the conservative legal positivists, but it should not satisfy Faunce, because he has argued against the legalistic approach and sought a broader reach for medical ethics under the aegis of human rights. Nor could it satisfy those who believe that there should be no discrimination on the basis of a person's sex, since it is not clear why the girl should be protected, but not her brother. Nor is it clear why customs affecting males can be accommodated under the rubric "respect for cultural diversity," while those affecting females must give way to the superior principle (entirely Western) of respect for women's bodies.

I would like to think that a physician who has read *Pilgrims in Medicine* would decline to carry out the requested surgery on the ground that genital mutilation performed for no therapeutic purpose would be a violation of his fundamental duty to relieve patient suffering. The reply that if he does not do so, the parents will find a backyard operator who is likely to perform the operation crudely and with a greater risk of additional injury, infection, etc., is analogous to the argument that doctors should supervise torture of political criminals or perform executions by lethal injection because their expertise can ensure that the prisoner is not killed and that the condemned criminal can be despatched with the minimum pain and suffering. As we have seen, however, Faunce is highly critical of this sort of argument and regards it as fundamentally inconsistent with the ethical system he is advocating.

Despite the reticence on this controversial question, coupled with a rather disappointing discussion of the difficulties inherent in surrogate consent and the specific needs and rights of children, *Pilgrims in Medicine* is a comprehensive and stimulating text. Personally, I was as impressed by the author's range of references and vigor of discussion as I was tickled by the originality and freshness of his overall approach. The discursive style sometimes makes it difficult to follow the argument, but the compensation is that the book is far more readable than a systematic treatise, and even enjoyable in many places. I do not know how many students will read such a long book right through, but it is a text best taken in as a whole and not merely picked over (via the index) for the particular points in which the reader is interested. It has a cumulative impact greater than the sum of its parts. For educators in the health sciences, medical humanities, bioethics and human rights fields, *Pilgrims in Medicine* should prove an invaluable teaching and professional resource.

Notes

[1]. For the debates over the institutional power of the medical profession see Tony Pensabene, *The Rise of the Medical Practitioner in Victoria* (Canberra: Australian National University Health Research Project, Research Monograph No. 2, 1980); Evan Willis, *Medical Dominance: The Division of Labour in Australian Health Care* (Sydney: Allen and Unwin, 1983); and Peter Backhouse, "Medical Knowledge, Medical Power: Doctors and Health Policy in Australia" (Ph.D. diss., University of Adelaide, 1994).

[2]. For an analysis of the Baker Brown affair and its impact on the development of medical ethics, see Robert Darby, *A Surgical Temptation: The Demonization of the Foreskin and the Rise of Circumcision in Britain* (Chicago: University of Chicago Press, 2005), chap. 7.

[3]. Such as "routine" circumcision of male minors, still a fairly common practice in Australia and the rule rather than the exception in the United States. Among many critiques, see J. Steven Svoboda, Robert S. Van Howe and James G. Dwyer, "Informed Consent for Neonatal Circumcision: An Ethical and Legal Conundrum," *Journal of Contemporary Health Law and Policy*, 17 (Winter 2000).

[4]. A. R. Jonson, M. Siegler and W. J. Winslade, *Clinical Ethics: A Practical Approach to*

Ethical Decisions in Clinical Medicine (New York: Macmillan, 1998).

[5]. Philip Reilly, *The Surgical Solution: A History of Involuntary Sterilization in the United States* (Baltimore: Johns Hopkins University Press, 1991). In the 1890s, the San Diego physician Peter Charles Remondino vigorously advocated legally mandated circumcision of Negro males as a means of protecting white women from rape. P. C. Remondino, "Questions of the Day: Negro Rapes and Their Social Problems," *National Popular Review*, 4 (January 1894): pp. 3-6. For full text and commentary, see http://www.historyofcircumcision.net/index.php?option=content&task=view&id=63.

[6]. Though there have been cases of men successfully suing the surgeon who circumcised them as infants. For one such case in Australia, see Shane Peterson, "Assaulted and Mutilated: A Personal Account of Circumcision Trauma," in *Understanding Circumcision: A Multi-Disciplinary Approach to a Multi-Dimensional Problem*, ed. George C. Denniston, Frederick Hodges and Marilyn Milos (London and New York: Kluwer Academic and Plenum Press, 2001).