Creative Dialogues

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Narrative and Medicine

Edited by
Isabel Fernandes,
Cecilia Beecher Martins,
Amândio Reis
and Zuzanna Sanches

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TABLE OF CONTENTS

List of Tables and Figures x

Acknowledgements xi

Introduction 1

Part I: Framing Narrative in Medical Practice

On Clinical History... 10
Diego Gracia

Confronting the Other: The Interpersonal Challenge in Literature and Medicine 21
Isabel Fernandes

Venatio, Vexatio and the Subduction of Meaning in Medicine 40
Manuel Silvério Marques

The Third Culture 67
João Lobo Antunes

Part II: The Relevance of Communication and Narrative in Medicine and Healthcare

Can You Die from Not Being Listened to? 80
Teresa Casal

Narrative Medicine: The Essential Role of Stories in Medical Education and Communication... 95
Rita Charon

Lessons from a Brain Disease 112
António Martins da Silva

Selves, Holding Their Own with Illness 120
Arthur W. Frank

Dissonance and Decision 130
Richard M. Zaner

Part III: Illness and Trauma in Literature

Representations of Illness in Contemporary Short Fiction: Some Portuguese and British Examples 144
Ana Raquel Fernandes

William Shakespeare and the Representation of Female Madness.......... 150
Maria Isabel Barbudo

Poetics of Trauma: Modes of Narration in Contemporary Fiction 156
Fernanda Mota Alves

Don't Look Back: Aesthetics of Survival.. 164
Gerd Hammer

Fiction as Healing: Memory, Trauma and Forgetting 170
Luísa Afonso Soares

Mary Shelley's *Frankenstein*: Writing a Way out of Trauma? 179
Cecilia Beecher Martins

Part IV: On Pain and Suffering

Variations in Suffering According to Different Contextual Pressures..... 196
Lambros Couloubaritsis

Affecting the Body and Transforming Desire: The Treatment of Suffering as the End of Medicine... 211
Hillel D. Braude

The Narrative of the Man Who Suffers 234
Maria Luísa Couto Soares

Part V: The Limits of the Verbal

Being-in-Stories: On the Symbolic Efficacy of Self-Narratives.............. 244
Paulo Jesus

On the Limits of Knowing Suffering and Pain.. 259
Smadar Bustan

Screams, Shouts and Silences: The Noise of the Wor(l)d
and the Impossibility of Narrative... 274
Marijke Boucherie

Contributors.. 286

Index.. 294

LIST OF TABLES AND FIGURES

Table 1.1-1 Private Deliberational Relationship
Table 2.1-2 Public Deliberational Relationships
Table 5.3-1 Image categories
Table 6.3-2 From Mertonian science to post-academic knowledge
Table 7.3-3 Herba/Verba
Table 8.3-4 Evidence-Based Medicine/Narrative Medicine
Table 9.3-5 The System of Medical Negations (a sketch)

Figure 1.3-1 Science, Epistemic Plurality and the Unity of Medicine
Figure 2.6-1 A Concept Map of the Movements of Narrative Medicine

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INTRODUCTION

ISABEL FERNANDES

This volume is the outcome of work done in the groundbreaking field of Narrative Medicine by an interdisciplinary research team based at ULICES – University of Lisbon Centre for English Studies – and devoted to the international project Narrative & Medicine since 2009. It corresponds to research work carried out in its launch phase, which came to an end in 2012, when the project was approved for funding by FCT – the Portuguese Foundation for Science and Technology – under the name: Narrative & Medicine: (Con)texts and Practices across Disciplines (PTDC/CPC-ELT/3719/2012). In the following paragraphs I will summarise the theoretical premises underlying this project and briefly present its contents.

In the last two decades, the field of the humanities in general, and of literary studies in particular, has witnessed deep changes, both in terms of the disciplinary boundaries previously set and inherited from a rational model of university, and of new methodological approaches and a self-reflexive praxis (Fernandes 2011a, Belsey 2011). This bursting out of disciplinary constraints was already apparent in the field of English Studies in the 1990s, when the new place of literature in the university was seen as having "negotiate[d] a transition or a displacement into the almost unlimited domain of cultural studies, media studies, communications, etc." (Kamuf in Bissell 2002). The move away from disciplinary conformity was to evolve even more decisively into the field of the so-called hard sciences, and promote a significant movement of convergence recently recognised by Ceserani (2010). By adopting Gillian Beer's perspective of the *open fields* and the presuppositions concerning interdisciplinarity, Ceserani showed the relevance and adequacy of literary concepts and instruments in domains such as philosophy, mathematics, biology, anthropology, economics, and medicine, among others.

Similarly, Davis and Morris favoured a blurring of boundaries between the sciences and the humanities, arguing for the emergence of "biocultures" which aim at building "a community of interpreters, across disciplines, willing to learn from each other" (Davis and Morris 2007) – a view based on the belief that "the biological without the cultural, or the cultural without the biological, is doomed to be reductionist at best and inaccurate at worst" (Davis and Morris 2007).

It is our belief that literary studies have achieved a phase of maturity (Fernandes 2011a), and thus become particularly apt for training in any hermeneutical practice or interpersonal relationship. Besides, literary studies can be seen as used to dealing with the uncertainty of an object whose meaning defies stabilisation (Gusmão 2010) with relevance for the uncertainty and singularity attending clinical decision-making (Danou 2007, Hurwitz 2009). The emergence of reader-oriented criticism and theory and, more recently, of ethical criticism (Attridge 2004, Fernandes 2011b) have focused on reading as an ethically charged dialogic co-creation. Attridge argues for "literary reading" (vs. instrumental readings) as capable of raising readers' awareness and increasing the potential for a complex and generally quite demanding exchange, evoking the emotions, knowledge and values called for by the forms of life literarily represented. This exercise presupposes on the reader's part a double attitude of passive awareness and radical hospitality (Derrida 1997) towards the text as "other", which entails the acquisition of "[a] disposition, a habit, a way of being in the world of words" (Attridge 2004) which may correspond to a liberating gesture for the other and for oneself (Ricoeur 1990). Literary studies can/must promote these processes of opening up, receptiveness and (self-)questioning, this response-ability (Levinas 1986), which is unpredictable and non-programmable at the outset, through this reading practice, carried out across disciplines. A comparative view of ethics also plays a crucial role (Hervé 2008). In the case of narratives, the development of the relatively new fields of narratology (Pier and Landa 2008) and socio-narratology (Frank 2010) has promoted a heightened awareness of narrative devices and forms of construction and allows those involved in communication to better "read" their encoding. Authors, methodologically focused, highlight the importance of narrative – in sociology, anthropology and psychology (Riessmann 2008) – and the strengthening of bonds among phenomenology, narrativity and medical ethics (Wiggins and Allen 2010).

Such contributions have been acknowledged in medical training (Coulehan 2003), and the incorporation of literary training in medical schools' syllabi has been in place in the US since the early 1990s. In this context, Charon argues that "narrative training in reading and writing contributes to clinical effectiveness" (Charon 2006). She even adds that "the kind of therapeutic decisions we make can be remarkably different from conventional decision-making as a result of narrative deepening of doctor-patient relationships" (Charon 2006).

The hegemony of the EBM paradigm in clinical practice in a context where "a culture of profit, consumerism, and mythical adulation of 'science' has invaded and complicated the mission of real medicine" (Newman 2008) requires a critical redressing and a readjustment of the praxis (Tauber 2009) so as to offer a richly contextualising and humanising framework for appreciating and responding to human illness, dilemmas and suffering (Hurwitz 2011, Marques 2003).[1]

It was in this context, and bearing in mind such presuppositions and constraints, but also the prospects opened up by an interdisciplinary venture of this kind, that we decided to launch the pioneering Narrative & Medicine project in Portugal in 2009.

Rita Charon's role as advisor was crucial from the start: a medical doctor and literary critic, she directs the Narrative Medicine program at Columbia, is an international reference in the field and an inspiring figure for us. Also noteworthy and deserving of our gratitude was João Lobo Antunes's invaluable support and advice throughout the process.

No less decisive was the joint collaboration of three European Research and Development units that have pursued work in this area: the Centre for the Humanities and Health, King's College, which has promoted research and initiatives in the field since 2002; the Laboratoire d'éthique médicale et de médecine légale, Univ. Paris Descartes, which introduced advanced training in 'Médecine et Humanités' in 2011-12, and ULICES – University of Lisbon Centre for English Studies, the centre that hosts the project and has promoted various initiatives in the area since 2009, in collaboration with other national Research and Development units, but especially CFUL – Centre of Philosophy of the University of Lisbon and CHC UNL – Centre for the History of Culture of the New University of Lisbon.

Since 2009, all the members of our interdisciplinary team (most of them authors in this volume) have done work in the field by taking part in joint initiatives, namely by attending the European Science Foundation Exploratory Multidisciplinary Workshop on Pain and Suffering in November 2009 at the University of Luxembourg, and organising: an International Conference in September 2010 at the University of Lisbon; two cycles of lectures, one in 2011, with nine (inter)national guest speakers and one in 2012, with eight (inter)national guest speakers; two workshops, one in July 2011, lectured by R. Charon (Columbia University) and A. Radley

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[1] This introductory section follows parts of the texts prepared for presenting our interdisciplinary Project *Narrative & Medicine: (Con)texts and Practices across Disciplines* when submitted for funding.

(Loughborough University) and one in July 2012, lectured by K. Hammerschlag and J. Whitehead (both from CHH, King's College), and the first interdisciplinary post-graduate optional curricular unit in Narrative Medicine at the University of Lisbon (in progress). Moreover, CHC–UNL successfully concluded the project "Medicine and Society" and published a book: *Arte médica e imagem do corpo: de Hipócrates ao final do século XVIII.* Lisboa: Biblioteca Nacional de Portugal, 2010 (Cardoso 2010).

The contributions in this volume are either from a selection of papers presented at the International Conference *Narrative and Medicine: Illness and Dialogue* or at the "Workshop on Pain and Suffering" (Bustan, Braude and Couloubaritsis), or else lectures delivered during the two cycles that took place in Lisbon in 2011 and 2012 (Antunes, Gracia, Fernandes, Frank). They have not yet been published, except for H. Braude's and L. Couto Soares's texts (we acknowledge permission for publication from Johns Hopkins University Press and *Journal des psychologues*, respectively). We are convinced that these articles and essays, heterogeneous as they inevitably are (coming as they do from different disciplines and perspectives), are not only of high caliber when read individually, but also an invaluable contribution to the field of Medical Humanities when taken as a collection. They will no doubt appeal and be highly beneficial to a general audience, encompassing first and foremost doctors and medical students, as well as other professionals in the field of health care, such as nurses and therapists, but also people in the Humanities, where there is a growing interest in this disciplinary interface, as seen at recent conferences on this and other related topics around the world.

The contributions to this volume are organised into five sections, according to the different emphases, subjects and points of view present in each of them. The first section, "Framing Narrative in Medical Practice", is of an introductory nature, starting with an historical overview concerning the presence and pertinence of narrative in clinical practice (Gracia) and followed by a text where the hermeneutical demands inherent in medical practice are highlighted by similar demands as exemplified in the literary reading of fictional texts (I. Fernandes). Marques addresses questions pertaining to the complex process of how meanings emerge in medicine, while Antunes argues for a third way or "third culture" as a means of redressing the much needed balance between an exclusively scientific approach in medical practice and a more narrative- or patient-oriented attitude.

The second section, "The Relevance of Communication and Narrative in Medicine and Healthcare", starts by giving voice to a patient whose extreme experience in hospital calls for an awareness of the intersubjective aspects of clinical practice and of the underlying assumptions that shape the therapeutic relationship (Casal). Charon highlights the importance of narratives in medical education and in clinical practice, while Silva illustrates their impact when dealing with particular diseases. Frank calls attention to the contribution given by socio-narratology to the area of Narrative Medicine, and Zaner illustrates all the preceding issues by giving the reader a true medical case where the narrative dimension is inescapable.

"Illness and Trauma in Literature" is the most literary of all the sections in this volume in that it deals with representations of illness and trauma in literature. The authors addressed vary from Shakespeare (Barbudo) to contemporary fiction, both British and Portuguese (A. R. Fernandes), American (Hammer), Hungarian (L. A. Soares), and German and American (Alves). Mary Shelley's famous *Frankenstein* is also here, invoked by Martins.

"On Pain and Suffering" addresses issues generated by extreme experiences both in psychological and/or physical terms. Drawing on philosophical ideas about suffering and neurobiological research on pain, Braude analyses the question of suffering as a clinical entity, while Couloubaritsis calls attention to the importance of moral suffering in human life. The section closes with a piece by Couto Soares suggesting that narrative can be a "cognitive operational tool" that integrates the heterogeneous and incommensurable discourses generated by suffering.

The final section in this volume addresses "The Limits of the Verbal" as a means of questioning the volume's departing premise of the relevance of narrative and the verbal. In their very different ways, the three contributors to this part draw attention to a pre-verbal dimension which impacts human experience, as in the phenomenological approach by Bustan to explaining the resistance of pain and suffering to conceptualisation or in Boucherie's argument for the impossibility of narrative in specific psychological conditions. Jesus, on the other hand, argues for the "storied creation of selfhood", while nevertheless calling attention to the "continuous task of producing embodied intelligibility at the intersection of semiotic saturation and nonsense, and phenomenological inarticulacy and silence".

I feel confident that the reader of this volume will find much food for thought in the diverse contributions gathered together, which ultimately converge in a creative dialogue between narrative and medicine.

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PART I

FRAMING NARRATIVE IN MEDICAL PRACTICE

ON CLINICAL HISTORY

DIEGO GRACIA

Introduction

Clinical history is the fundamental document of clinical practice. It collects all the interesting health data of a patient or person, hence its enormous importance, well matched by its complexity. As documentary support of information on patients, clinical history raises many problems. Currently it is the object of strict legal regulations, which are not our main subject. We will focus on the analysis of the ethical problems that it raises, that is, the conflicts of values which it gives rise to.

In this paper we will analyze the following points. First, the historical evolution of this extremely important document and its current situation. Next, the ethical problems that this document raises and, finally, special cases, that is, its various uses as regards the patient (scientific, legal, forensic, epidemiological, etc).

A Millenary Document

Clinical history is as ancient as the introduction of writing in medicine itself. In other words, from the time that physicians learnt to write, they began to take notes on their patients. It is common knowledge that writing appeared for the first time in the basin of the Euphrates and Tigris rivers sometime before the year 3000 B.C. The first people who used it were priests, and that explains why the first oral traditions to be set down in writing were religious. But the Mesopotamian High Priests also had medical duties, as was the case amongst many other primitive peoples, for which reason they had to take notes on the diseases of their patients. There remain some testimonies of this, but they are few and of scarce relevance.

Where clinical history becomes a true medical document is in Greece, by means of the Hippocratic physicians. This is what is demonstrated to us in the collection of clinical histories collected in the book named *Epidemias*. It is the first collection of clinical histories that we know of (Tratados hipocráticos, 1989), and as that book was written circa the 4th

Century B.C., it means that physicians have been writing up clinical histories for at least 2,500 years.

Since then, clinical history has become the document in which the the main data of any clinical interview are collected. That is why we now need to raise the subject of the clinical interview (Laín Entralgo, 1998).

The clinical relationship is a special type of human relationship, but so characteristic and paradigmatic that it suffers from all the problems of any other kind of relationship between rational human beings. There have been extended debates over what kind of relationship it is. It is a classical theme in literature on bioethics (Childress and Siegler, 1984; Emanuel and Emanuel, 1992). The models that have been used to try to understand it are many: paternalistic, social, alliance, friendship relationship, etc. I submit that it is a relationship of deliberation, and that the entire process of the clinical relationship has to be one of deliberation on facts, values and duties, in order to be able to make a decision that both physician and patient can consider wise, reasonable, responsible or prudent (Gracia, 2004). All human relationships probably have to be, in one way or another, of deliberation, but naturally not all in the same way. Deliberation is particularly important when the aim of the relationship is to make a decision, and more specifically, as in this case, a decision binding to both parties, that is to say, that is common to both. In what follows, therefore, we shall deliberate first on the facts, then on values, and finally on duties (Gracia, 2001b, 2011a, 2011b).

The Clinical Relationship: Facts

The concept of “fact” as we understand it today is very recent. We have to almost completely change our categories if we wish to understand what happened in the days before the modern liberal and scientific revolutions. In the ancient world there was no awareness of individuality. This is something that is so foreign to us, contemporary human beings, that we do not understand it. For us, the beginning of the clinical relationship is a fact, an objective fact: someone detects something that is not working properly in his own body and goes to the physician or to the health system to ask for help.

In classical times this was not so. The clinical relationship was one more interpersonal relationship, and these were not the result of the initiative of individuals, who established relationships with each other and constituted a social group. This explains why contractualistic theory is contemporary, not ancient. For the classical mindset, contractualism was simply incomprehensible. It is not that the individuals, autonomously, constituted by an act of will a social or political reality; it is rather that they were already naturally constituted in this way. So says Aristotle in the beginning of his *Politics*: all *pólis* is a *koinonía* (Aristotle, 1821, 1252 a 1). We often see the term *koinonía* translated as "association". This is an error. It is not that human beings associate with one another by means of an act of will. The *koinonía* is a "natural community" that has the characteristic of existing before the individual and is superior to him. This has extremely important consequences. The most important of them is, undoubtedly, that the idea of "individual" is meaningless. One is only an individual within a natural community, and therefore the community is the true individual. This explains, for example, why the term *autonomy* is only applicable in Greece to the *póleis,* not to individuals. These are not autonomous. The autonomous being in Greece is the *idiótes,* the de-classified, the one who lives outside the *pólis.* He acts against himself, because no-one can achieve his natural perfection unless he is within the *pólis,* which is the only autonomous structure. This explains why, for Aristotle, for example, ethics were part of politics (Aristotle, 1821, 1094 a 26-b 11). This is often interpreted as a watered-down version, as if ethics is individual, but integrated into a higher unit, the city. But that is not the meaning; rather it is another, stronger one: ethics is not individual, but common. The purpose of moral life is the *eudaimonía,* and this cannot be achieved unless one is within the community. The role of ethics is precisely to adapt the individual life to that purpose that is communitarian, common.

Another consequence of this is the logic of practical reasoning, and in particular, ethical and political reasoning. It is common knowledge that this reasoning is dialectic, according to Aristotle (Aristotle, 1821, 100 a 15-101 b 4). Therefore, its premises are not self-evident truths but "opinions". And here we see once again that the community is the only self-sufficient or autonomous unit, because these opinions have to be shared by all or by the majority. It also says that, if they are not shared by all or by the majority, they must at least be shared by the wisest or most prudent. And from this follows another fundamental consequence, which is that there are persons who have a greater capacity to understand that viewpoint which is not individual but higher than the individual, that is, common. They are the *áristoi,* the best, not because they are the best individually, but because they are the best from the viewpoint of what is common or of the community. These are the natural rulers of the others. That explains why, for Aristotle, as well as for Plato, they should be the rulers. Aristotle says that, if it is not them, then the best option will be the democratic system, precisely because it yields to the common or communitarian opinion (Aristotle, 1821, 1281 a 39-1282 b 14). Let it be said that democracy is not meant in the modern sense of the word, as a conflict of private interests that require the search for a common minimum, but as a search for the common good. Between one position and the other, there is the same difference that Rousseau established between the “volonté générale” and the “volonté de tous” (Rousseau, 1782). The ancient thesis is that it is necessary to rule by seeking the general will, not the will of all, which is instead the modern thesis.

Only in this framework can social and interpersonal relationships prior to modernity be understood. One is an individual within the group and only in relation to it. Identity is bestowed by the group, the community, be it by blood or political. From there, it follows that the value of the community is higher than that of the individual, and consequently, the life of the individual is subordinated to the group; furthermore, within the community relationships are vertical, of the mandate-obedience type. Obedience is moral and political virtue by antonomasia. This was the conceptual framework of all human relations, both religious and civil. Those who know how to find the perspective of the common good rule, and their mandate consists precisely of saying what is good, what good consists of. They define, therefore, what is good, and the rest have no other duty than obedience. This was the case in the religious, civil, political, and familial spheres, and obviously also in the medical one. When the ruler of any one of the natural communities seeks his own benefit instead of the common benefit, then he is called “despot”. So says Aristotle in his treatise *Politics* (Aristotle, 1821, 1278 b 32-37). Being a despot means treating others as slaves. This is not how a ruler should behave; rather he should treat his subjects like a father treats his children. This is “paternalism”, the model that has ruled social relations, at least in theory, during the greatest part of western history (Aristotle, 1821, 1278 b 37-1279 a 10).

It goes without saying that the clinical relatioship also established itself according to this model. The physician is the ruler, therefore he has the power of saying what is “good” for the patient, and this is not because he includes his own values and not those of the patient in the process of decision-making (this is a completely modern view of the old scenario), but because he knows the order of the *phýsis*, which is what determines what is correct and incorrect. That order, in classical Greek culture, was understood more as a “framework” than as a “natural law” which prescribed with total exactitude the correct conduct of human beings. This permits us to understand why Aristotle said that it has to be “prudently” managed. Only later, with stoicism, was a strictly ethical character ascribed to it, and therefore this normative framework was interpreted as an absolute and immutable order, a source of universal obligations, with no room for exceptions. It is the theory of natural law, which gave rise to the modern reaction. Modernity reacts against all that is held to be a "fact" in the ancient and medieval conceptions of life. The natural order does not have an ethical character. If it has one, this order has to be in reason, and the reason is not common but individual. This is where the process of the "emancipation" of individuals began, and consequently the term "autonomy" took on a new meaning, one which was no longer common or political, but individual or ethical (Gracia, 2001a).

This emancipation was achieved initially in the political sphere. This is the modern contractualist theory, and its logical consequences, the so-called liberal revolutions. The creation of the state is a free and voluntary act of individuals, therefore a moral act. From this one can deduce that the primary moral subject is the individual, not the community. Individuals have a diversity of values, and therefore one goes from the axiological "uniformity" to "pluralism". This pluralism began with the Protestant Divide and the modern religious wars. In order to get along, therefore, a principle was imposed, and that principle is "axiologic neutrality". The state was no longer the one to define the good, but it had to remain neutral in questions of value, at least in those which were discussed between individuals, and therefore in those where there was pluralism. It is this need to remain neutral in questions of value which led to the slow emergence of a value-free space or territory. This is what would begin to be called "fact". And as this phenomenon coincided with the birth of modern experimental science, it makes sense that a fact by antonomasia was now "scientific fact", not only distinct from value but absolutely neutral in matters of value.

Scientists, therefore, have to devote themselves to the management of pure facts, without going into questions of value. This is what must be done by the physician, as either a technician or a scientist. Neutrality becomes for him a duty, since otherwise he is not respecting the plurality of values. But from here arise ethics which have been the hallmark of medical ethics, and in general of the ethics of all social and interpersonal relationships. The point is that the scientist wants to be neutral in matters of value, but without renouncing the definition of good. The good is defined by science, in such a way that that there is a gap between the facts and the duties. It is, once again, the naturalistic fallacy, now fostered to an extreme by axiological neutrality. The physician, as a scientist, does not renounce the definition of good, and nor, therefore, the declaration of what is good and what is bad, what should be done and what should not be done.

This means that, the liberal revolutions having led to the respect of pluralism in the sphere of political decisions notwithstanding, this did not happen in other fields, such as the management of the body, life and death. In this field, the revolution has been very recent, happening in the last 50 years. Until then, relations continued to be vertical, authoritarian and paternalistic. There has been no respect of axiological pluralism in the definition of the good, but an attempt has been made to define it objectively, by means of a neutral knowledge called science.

This is the revolution that we are witnessing today. It is a question of extending to the world of the management of the body the same pluralism that has already existed for centuries in the management of public affairs; in other words, introducing axiological pluralism in the definition of the good into the sphere of body and life management. The facts are not sufficient to establish the goodness of any practice. Values must also be considered.

The Clinical Relationship: Values

It is not possible to be completely neutral in questions of value, and therefore there are no decisions that do not include values. The sought-after neutrality is always fictitious. This can be clearly seen in the case of medicine. What the physician has always done is to include, generally unconsciously, values in his decisions; in concrete terms, his own values.

In the case of the management of the body. it is clear that our societies have not been neutral, amongst other reasons because they could not be neutral. The values in this kind of question have been imposed by the most powerful ideological institutions. For example, in countries with a catholic tradition, these values were set by the Catholic Church, which laid down which practices were correct and which were not. The catholic tradition has not spoken so much of “values” as of “duties” and “laws”. The overriding criteria has been “natural law”, which is also “divine law”. From that point on, moralists established duties. This was so much the case that “ethics” was considered a speculative and philosophical discipline, since “morality”, the discipline related with he normativity in life and the practical conduct of human beings, was taken as an intrisic part of of theology.

The phenomenon of secularization has meant that the strength of ecclesiastical institutions in this kind of matter has drastically decreased, but only to be replaced by other institutions, now civil ones. Hence from ecclesiastical law we have moved to civil law, and nowadays the duties of the majority of people are established by what is laid down by law. There has been, in effect, secularization, but it has continued to be assumed in a heteronomous way.

This tendency of the human being to jump from facts to duties without passing by values is very significant, and its consequence is the belief that duties should be defined by others and not by oneself. It is an attempt to avoid responsibility for our actions, instead letting them be endorsed by others. In this way, we renounce autonomy and convert ourselves into heteronomous entities. This is paramount to renouncing being moral subjects, ending in ourselves, as Kant said, by converting into mere media, that is, instruments of the decisions of others. It is the phenomenon of "reification", so frequent in moral life. In this way, we continue in the paternalistic line. In order to avoid it, it is necessary to begin with the facts, but give space to the analysis of values, of the values of each individual, and of the values shared intersubjectively by all or by many. Only then can duties be determined.

In the case of the clinical relationship, it is necessary to start from the finding that disease is not a mere fact, but also a value, and that only bearing this in mind can we manage it adequately. The dimension of value is so important in the clinical relationship that, with unreasonable values, the clinical relationship not only becomes very difficult, but can even become impossible.This applies not only to the individual clinical relationship, but also the health system itself. Irrational or inadequately deliberated values lead to irrational decisions.

The problem of values is that they are in conflict among themselves. Conflictuality is an axiological category, and a daily phenomenon in human life. It is much more frequent in clinical practice. Hence a necessary capacity of the health professional is to be capable of identifying with precision the values in conflict, for only in that way can he then analyze the possible courses of action, and establish his duties or duty (Gracia, 2013a, 2013b).

A value that is always at stake in the clinical relationship is health, or life. It is what creates the relationship between the professional and the patient. But there have to be other values: those which qualify the relationship as such. Based on these values, the clinical relationship will take on distinct characteristics. *On the other side of the conflict there may be very different values***.** In the case of a Jehova's Witness, it will be religious values; in the case of a person with few resources, financial ones. In other cases, it will be aesthetic values, or culinary, or patriotic etc. All these values can be grouped into one, the value of *liberty,* or *liberty of* *conscience,* meaning that there are values that are as important or more important than life, for which one can risk, or even sacrifice one's own life. In traditional societies, the values for which one could give one's life were religious, patriotic, etc. Today, some of them, like patriotic values, seem to have lost amongst us much of their former strength. But others have replaced them. For example, the avoidance of pain, quality of life, not spending resources, not depending on others, etc.

Therefore, the basic conflict is always between *life* and *liberty.*

Ethics of the Clinical Relationship: Duties

The usual procedure has been to resolve the conflicts between these two values incorrectly, choosing only between the two most extreme courses of action, which are always the worst. The extreme courses are, in the conflict between the two values described before, the following: the first is what can be called the *impositive model*, the imposition of the professional's viewpoint on the patient, which will entail also the uncompromising defense of human life. The second is the *purely informative model*, neutrality, accepting whatever the patient decides, without further inquiry.

These two forms of action are clearly incorrect. They avoid the conflict of values by cancelling out one of the two values. In the first case, there is the imposition of the value of biological life as defined by medicine. In the second, the winner is the other value, the decision of the patient. They are extreme courses, which as we already know are always bad, because they utterly jeopardize a value. Hence the need to seek intermediate courses, since they will be more respectful of the values in conflict and jeopardize them to a lesser extent. Intermediate courses are, amongst other possibilities, the following: to adequately inform about the risks and benefits without manipulating the information; to evaluate the capacity of the patient, and to avoid all kinds of external coercion; to avoid internal coercion, giving time to accommodate the bad news and providing emotional support until the patient is able to master his defense mechanisms and make a prudent decision, and to analyze the authenticity of the values that are related to this process, elaborating on the history of values and deliberating on them, so that they are reasonable and prudent.

It goes without saying that the optimal course is to decide between these intermediate courses, and that our moral obligation consists of choosing this course, because any choice of a course worse than the optimal is by definition wrong. In ethics, only the optimal is good.

By Way of Conclusion

In what was said before we have considered that the relationship is between an isolated physician and his patient. But reality is much more complex, because they are never alone. Hence it is a plural relationship, where there are different moral roles (Gracia, 2004). These social and moral roles can be thus summarized:

PRIVATE DELIBERATIONAL RELATIONSHIP	
FIRST PART IN THE RELATION **PRINCIPLE OF AUTONOMY**	***SECOND PART IN THE RELATION*** **PRINCIPLE OF BENEFICENCE**
ETHICS OF THE ELECTION • Informed Consent • Capacity	ETHICS OF THE PROFESSION • Excellence • Diligence
	ETHICS OF THE ATTACHMENT • Relatives • Close ones • Friends

Table 1.1-1