Between Jerusalem, Athens and Rome – Ethics, Law and the Medical Arts

Table of Contents

Literature: *W. Arndt*, *F. Longchamps de Bérier*, *K. Szczucki*, Dobro wspólne. Teoria i praktyka, Warszawa 2013; *W. Biegański*, Myśli i aforyzmy o etyce lekarskiej, Opole 2013 (reprint of 1899, Warszawa); *T. Biesaga*, Elementy etyki lekarskiej, Kraków 2006; *J. Borówka*, Polska etyka lekarska w ujęciu dziejowym. Studium filozoficzno-historyczne, Toruń 2012; *T. Brzeziński*, Etyka lekarska, Warszawa 2002; Deontologia lekarska. Wybrane materiały do seminariów (ed. *A. Tulczyński*), Warszawa 1983; *Z. Gajda*, Do historii medycyny wprowadzenie, Kraków 2011; *P. Góralski*, Prawne i społeczne aspekty eutanazji, Kraków 2008; Historia medycyny (ed. *T. Brzeziński*), Warszawa 2014; *T. Jasudowicz*, *J. Czepek*, *J. Kapelańska-Pręgowska*, Międzynarodowe standardy bioetyczne. Dokumenty i orzecznictwo, Warszawa 2014; *P. Kaczmarek*, Awerronizm łaciński na Uniwersytecie paryskim w XIII wieku, Warszawskie Studia Teologiczne 2013, vol. XXV, No 1; *G. Majano*, The Healing Hand. Man And Wound in The Ancient World, 1991; *J. Makarewicz*, Kodeks karny z komentarzem, Lwów 1932; *O. Nawrot*, Ludzka biogeneza w standardach bioetycznych Rady Europy, Warszawa 2011; *P. Owidiusz*, Przemiany. Poema w XV pieśniach z oryginałem obok i z przypisami objaśniającemi, vol. 1, Warszawa 1825; *J. Parandowski*, Mitologia. Wierzenia i podania Greków i Rzymian, London 1992; *Platon*, Państwo, Prawa (VII Ksiąg) (translated by *W. Witwicki*), Kęty 1999; Prawo międzynarodowe publiczne. Wybór dokumentów (ed. *A. Przyborowska-Klimczak*), Lublin 1996; *B. Prochowicz-Studnicka*, Kontrola pracy oraz kompetencji lekarzy i aptekarzy w świetle wybranych podręczników hisby (Egipt, XII–XV w.). Fikcja czy rzeczywistość?, in: Kultura medyczna islamu (ed. *B. Płonka-Syroka*, *Ł. Braun*), Warszawa 2015; *E. Savage-Smith*, Medycyna, w: Historia nauki arabskiej, vol. 3, Technika, alchemia, nauki przyrodnicze i medycyna (ed. *R. Rashed*), Warszawa 2005; *A. Sikora*, Pojęcie, rozwój i struktura polskich kodeksów etyki lekarskiej na tle etyki zawodowej, Poznańskie Studia Teologiczne 2002, vol. 13; *R. Skeczkowski*, Pomniki prawa, Koszalin 1996; *A. Szarszewski*, Etyka lekarska w okresie późnego antyku i wczesnego średniowiecza – ideał a codzienność, Forum Medycyny Rodzinnej 2013, vol. 7, No 2; *A. Tulczyński*, Wzory osobowe polskiej deontologii lekarskiej, Problemy Higieny 1993, No 41; *E. Wiesel*, Bez sumienia, in: *V. Spitz*, Doktorzy z piekła rodem. Przerażające świadectwo nazistowskich eksperymentów na ludziach, Zakrzewo 2009.

1. Introductory Remarks

1 **1.** The history of the development of medicine is one of the most beautiful tales, accounts of the triumph of human thought and spirit over suffering, weakness and the limitations of the body. It is an account of man's departure from the world of unsullied nature – through a gradual learning of its laws, and liberating himself from its dictate. Already in the Ancient World, people associated medicine with the sphere of *sacrum.* For example, according to the ancient Greeks, the art of medicine was directly associated with the figure of Apollo, who was known as "The saviour, for he helped people in suffering, saved them from misfortune, brought them back from death and absolved criminals from their sins."[1] Ovid placed the following words in the mouth of the deities: "The science of healing began with me, I am versed in herbs and no one comes to seek my help in vain."[2] The god Asclepius was also a doctor. He was the son of Apollo and the nymph Coronis, though the tale of the love between them was tragic. After Coronis was with child, the obsessively jealous Apollo accused her of betrayal and had her killed. While the unfortunate Coronis was already lying on the pyre, Apollo cut her child from her womb, which came to be known as a caesarian section. This mythological account contains the first description in history of *sectio caesarea* conducted *post mortem martis*.[3]

2. Antiquity

2 **1.** The view that the origins of medicine were supernatural was commonplace in the Ancient World. Doctors were gods who, when needed, offered their help to people. For example, the Roman equivalent of Asclepius – Aesculap – was reported to have saved Rome from a tide of disease that broke out in 293 BC. The high priest Im, who became an Egyptian god-doctor in the 27th century BC was deified, receiving the name Imhotep. In the third millennium BC in Mesopotamia, the gods that were called upon to heal became Gula and Ninurta, husband and wife. The former dealt with "pharmaceutics", while her husband was associated with psychological counselling (charms and amulets). Moreover, religion, holy books, hymns praising deities, epic poems and commentaries constituted an important source of knowledge for medicine. In this context, Diodorus made an interesting remark, describing the practice of Egyptian doctors: if the doctor followed the regulations contained in the so-called holy book and took action accordingly, and despite this if he were not able to save the patient's life, he was considered innocent. If, however, he broke the regulations, he would risk his own life.[4] A departure from the letter of the holy books, namely from the wisdom of medicine, could therefore directly turn into the doctor's liability. In papyrus scrolls we can find

[1] *J. Parandowski*, Mitologia, p. 72.
[2] *Owidiusz*, Przemiany, vol. 1, lines 529–530.
[3] *Z. Gajda*, Do historii medycyny wprowadzenie, p. 93.
[4] As cited in: *J. Borówka*, Polska etyka lekarska, p. 69.

directions concerning the formulation of a diagnosis, including a departure from medical treatment in cases without hope, psychological help, prophylactics and hygiene, and even the growth and loss of heart muscle, depending on age (on this basis, the conclusion was formulated that man can live up to a maximum of 100 years).[5]

2. Similar comments, relating to the broadly understood process of healing and maintaining health, can be found in the Old Testament. Norms relating to the hygiene of the body, sexual customs, medicines protecting against infectious diseases, choice and means of making meals were not, however, only of a ritual nature. For example, Isaiah, commenting against religious hypocrisy instructs: "[16] Wash yourselves, make yourselves clean; Put away the evil of your doings from before My eyes. Cease to do evil, [17] Learn to do good; Seek justice [...]."[6] In the writings of the father of medicine – Hippocrates – we can find bitter comments addressed to the unethical pupils of Asclepius: "The art of medicine is the most noble of all, though the consequences of ignorance in its practice, as well as the consequences of the superficial opinion of the public, mean it remains behind all others. The cause of this retarded state of affairs is, according to my view, the following: there is no punishment in states for abusing the art of medical treatment, apart from infamy, which does not harm those that it affects. They are similar therefore to extras appearing in tragedies: they play a role, they have robes and the actor's physical presence, though they are not actors as such and that is the case for many doctors by name only, though in essence – only a few."[7] **3**

Galen, doctor and scholar, goes further: "Between robbers and doctors there is only one real difference – the former practice their culpable deeds in the mountains, while the latter do so in Rome."[8]

3. The impotence and helplessness of the patient, both in respect to illness and at the same time, the doctor, who often became almost "master of life and death", led to the appearance of mechanisms and instruments with the aim of safeguarding the patient against potential medical abuse from a doctor. Thus, in ancient Egypt the doctor in the practice was often bound by "principles of the healing art" as recorded in the holy books. Divergences from their letter, in the therapy undertaken did not have positive effects, could lead to criminal responsibility on the part of the doctor, with one of the possible sanctions being a death sentence. Similarly, punitive sanctions for "a mistake in the art" were foreseen by the Code of Hammurabi, originating in the 18th millennium BC. In chapter 65 *On the Responsibility of the Chirurgeon*, and in chapter 66 *On the Honorarium of the Physicker for Treating a Bone Broken or Poor Tendon.* The former contains six regulations, of which three relate to the doctor's honorarium and three, responsibility for mistakes. If, therefore, (§ 215) "a doctor conducted a serious operation with a knife of bronze on a citizen with full rights and returns that citizen to health, or with the aid of a bronze knife opens the eyebrow of a citizen with full rights and returns that eye to full health, he shall take 10 shekels of silver."[9] If the operation **4**

[5] *Z. Gajda*, Do historii medycyny, p. 47.
[6] Iz 1, 16–17.
[7] As cited in: *T. Brzeziński*, Etyka lekarska, p. 23.
[8] *Ibidem*, p. 25.
[9] Text of the Code of Hammurabi cited in: *R. Skeczkowski*, Pomniki prawa, *passim*.

concerned a member of the serving class, the honorarium would be five shekels of silver (§ 216), and if a slave – "the slave's master shall pay the doctor two shekels of silver" (§ 217).

The doctor's responsibility was also directly tied with the status of the patient and if, therefore, (§ 218) "a doctor conducted a serious operation with a knife of bronze on a citizen with full rights, and as a consequence that citizen dies, or with the aid of a bronze knife opens his eyebrow and destroys his eye, he shall have his hand severed." If, however, (§ 219) "a doctor conducted the operation with a knife of bronze on a slave, and as a consequence that slave dies, he shall replace the slave with a slave." Finally, (§ 220) "if he (a physician – *O.N.*) had opened a tumor with the operating knife, and put out his eye, he shall pay half his value." In respect to § 221, for healing a broken bone or tendon of a citizen with full rights, the honorarium amounted to three shekels of silver, or two shekels if the patient was a slave. So, in order to assess the proportions of the doctor's honoraria, it should be noted that the price of a slave was between 15 and 30 shekels, while the rental of a house for an entire year was about five shekels.

5 **4.** Already in the first millennium BC, the profession of doctor was closed to outsiders – a doctor was "initiated." So as to reach this particular honour it was necessary to undergo schooling, which took place in special centres situated near temples. The schooling was conducted by one or several masters and its effects were subject to verification during an exam. It was only after passing the exam that the apprentice gained the status of *ummanu* – an expert – and after taking an oath, the new doctor became a member of the medical fraternity. Similarly in ancient Egypt, membership of the medical profession was tied to the obligation of previously gaining particular qualifications and, having gained them, the positive results of ongoing inspections. The appropriate performance of medical standards was subject to the scrutiny of the "Medical doctor General of Lower and Upper Egypt" by means of an elaborate organisational structure. Every patient was diagnosed free of charge – any cost on the part of the patient was tied to the purchase of medicines.[10]

In ancient India, candidates for the medical profession came from noble families and had to distinguish themselves both in subjects on the human body (good health), as well as on the mind. Studies began at the age of 12 and continued up to 18. Education entailed both theory and the training of practical skills. After becoming familiar with recommended reading, apprentices of medicine would visit the ill, dispense medicines and practise conducting surgical operations. They would sew wounds using the skin of dead animals and make surgical incisions on cucumbers or melons, also extracting teeth from the jaws of dead animals. After finishing their studies, students would take the appropriate oath and apply to the king for permission in respect to practising in the profession.

The king, besides granting these rights, monitored the appropriate conduct of responsibilities on the part of doctors. As in the case of Mesopotamia, doctors received an honorarium for their services, where the sum was dependent upon the social status of the patient. In this case as well, doctors bore liability for mistakes in the art

[10] *J. Borówka*, Polska etyka lekarska, pp. 68–70.

of medicine. In the event that, as a result of an operation, a patient died or was harmed, then depending upon his social status, the doctor paid a fine or paid with his head. In ancient Greece, both the process of education and the nature of the doctor's profession underwent evolution. At first, the high priests of Asclepius were responsible for healing the ill. They were considered the heirs of the god and became known as Asclepiads, while the treatment itself took place primarily in temples. At this time, disease was considered the consequence of sin, and therefore of key significance in the healing process was the discovery of its causes.

The religious aspect did not dominate over the purely medical. According to Pindar: "Asclepius healed with the word, the elements and the knife" – in addition to religion, which certainly also fulfilled a psychotherapeutic function, Asclepiads used pharmaceutical medicines and carried out surgical operations. Access to the profession was limited, and as the high priests of Asclepius were not celibate, it was generally the children of Asclepiads who carried on the profession. This constituted a particular guarantee of the quality of services, for Asclepiads were therefore educated by having contact with the ill and learnt the art of medicine from the youngest age. After finishing studies in the "family" Asclepeion temple, the medical catechumen was required to complete a practicum in other, most often, distant centres of medicine. In this way, the catechumens of Asclepius were afforded the opportunity to become familiar with unknown previously or rarely occurring diseases, and to learn additional skills. Just how appropriate this was confirmed almost 20 centuries later when Phillippus Aureolus Theophrastus Bombastus von Hohenheim, commonly known as Paracelsus, noted: "if one wishes to become familiar with a good many illnesses, then one should venture far and wide."[11]

A similar evolution in the teaching of medicine occurred in ancient Rome. From the medicine of the high priest, tied to the cult of Aesculap, and peasant folk, through to medical associations and to state schools. Together with the changes, the significance of doctors themselves grew. Still at the stage of medical associations, created mainly by Greek medics, the status of a doctor did not differ from that of other artisans (and a doctor was considered as such), though his position began to grow in importance, which is directly tied with the needs of the Roman Empire. Proof of the rise in doctors' importance was their exemption by Emperor Augustus from paying taxes. Emperor Hadrian exempted doctors from the obligation to serve in the army and the related professional studies were simplified, as well as the introduction of easier conditions relating to the principles of practising medicine. With time, in the largest towns there began to appear so-called Collegia Medicora, which united and protected the interests of doctors themselves. The change of policy in the education of doctors and medical practice occurred at the turn of the third century AD. Family medical schools were liquidated and in their place state academies were introduced. The state took control over the education process, which entailed toxicology, physiology, pathology, surgery and midwifery, as well as the practice of the medical profession itself (Emperor Septimus Severus introduced a prohibition of practising medicine without the permission of the state).

[11] As cited in: *Z. Gajda*, Do historii medycyny wprowadzenie, p. 102.

6 **5.** Next to the system of legal norms – organising the teaching of the art of medicine – was that of medical ethics, a factor defining the relations that appear between the doctor and patient (as well as having an impact on the protection both of the patient's welfare and interest on the one hand and the interest of the doctor on the other). Already in the ancient world, this system of ethical norms, in principle, covered all aspects of the art of medical treatment. Proof of this are the principles relating to the practice of medicine functioning in ancient India, which were tied to both general issues (relating to the profile of the doctors traits), as well as those in particular (responsibility for professional development and doctor-patient relation etc.). In relation to these, "the doctor should be handsome, of imposing physique, kind, serious, unaffected, pleasant and intelligent, speak mildly and give comfort, as well as being a friend, which meant having a pure and noble heart, being a paragon of virtue and sobriety), love the ill more than siblings, friends or parents. It is possible to experience fear of one's brother, mother and friend, but never before a doctor."[12]

The text of the Indian *Oath of Initiation* outlines a series of important points relating to the doctor's ethical approach, as sworn by students of medicine after finishing their education. Thus, according to the above, a doctor should "live" in celibacy (it should be emphasised that the doctor was a priest), not cut his hair or beard, speak only the truth, not eat meat, eat only pure food, be free of jealousy and not be armed. Moreover, the doctor should, throughout his life, continue to develop his grasp of the medical arts – "learn practical medicine from those better, without demonstrating small-mindedness in this case." In visiting the ill, a doctor should be "appropriately dressed, head lowered, measured in manner and act only after serious reflection." His "speech, mind, intellect and senses should be completely devoted to the thought as to how to help the ill." In addition, the doctor was bound by medical confidentiality – "the particular customs of a home should not be made public."[13]

Already in the period when the beginnings of the art of medicine were beginning to form, its main determinants became legal norms, the organisation of the process of educating medical doctors and medical ethics. These three distinguished factors overlapped then, and continue to do so to the present day. The system of ethics translates into the system of law and the organisation of teaching, law in turn regulates the code of conduct belonging also to the sphere of morality, as well as the system of education of future doctors, while education and the development of science influence the sensibilities of doctors themselves, as well as forcing changes in legislation.

At various stages of the development of civilisation, the meaning of the above particular factors waxed or waned, and to this very day their significance for the nature and form of relations between doctor and patient have remained fundamental. To a large extent, this framework reflects a triad that constitutes the pillars of European civilisation – Jerusalem, Athens and Rome. Jerusalem is a symbolic concept of ethics and, in the case of European civilisation, first and foremost Christian ethics voicing the paradigms of European axiology. Athens is a symbol of science, open both to the factual world and one making use of elaborate theoretical models. It is also a symbol

[12] As cited in: *J. Borówka*, Polska etyka lekarska, pp. 78–79.

[13] *Ibidem*, pp. 78–79.

of the significance of knowledge and the organisation of the transmission of knowledge. Rome remains a symbol of "a good and just" legal system, giving the individual instruments that afford it protection of its goods and interests.

Similarly, the practice of the medical arts has to take into account ethical principles, scientific standards and legal frameworks. The omission of any one of these elements would lead to catastrophe. Without ethics there remain science and the system of legal norms – the patient becomes less important and at the same time the therapeutic effect – if it is at all possible to achieve – becomes significantly limited. The marginalisation of law strips the patient of real instruments of protection over his goods and interests, while also, in the spirit of paternalism, gives him over completely into the power of a doctor and the doctor's conscience. The limitation of science, even with the highest morals of a doctor and the most perfect system of legal norms, in essence represents the end of medicine.

The situation becomes even more of a concern when one of these mentioned elements becomes subject to hypertrophy. Thus, placing science first and marginalising law or ethics may lead to a complete objectification of the patient, as indeed took place during World War II. Highlighting ethics at the expense of guaranteeing a patient the legal and scientific norms can lead to creating medicine as an instrument of a doctor's power, whereby the practice of medicine ceases to serve the interests of man, but becomes a form of imposing a given system of values from on high. An excess of legal regulations turns a doctor into an official, regardless of whether they are rational or serve the welfare of the patient.

6. A similar vision of medical ethos developed in ancient Greece. Its greatest achievement, which to this very day illustrates the essence of the profession of doctor, sets the boundaries for his work and determines its aim, is the *Hippocratic Oath*. The concept of the medical profession in the categories of a mission draws its essence from the pragmatic level (artisan), which should first and foremost be regulated by legal norms, onto the axiological level, in which the key role is played by a faithfulness to defined values, often independent of the law. **7**

In this context, it becomes possible and at the same time appropriate to speak of professional honour, and on that basis to make an assessment of particular forms of medical treatment, as well as the doctor's approach itself. Apart from reference to the gods (beginning of the *Oath*) and a plea for blessing (closing of the *Oath*), it contains six responsibilities that every student of Asclepius undertook. Four are of a positive nature (instructions), two negative (proscriptions).

The positive responsibilities were:

1. The instruction to ensure the teaching of the medical art – respect for the master and dissemination of knowledge to future generations of medical doctors (and no one else)
2. The instruction to apply the medical art 'for the benefit of the ill, protecting them from personal loss and harm'
3. The instruction to practice the profession of doctor purely for the good of the patient
4. The instruction to keep medical confidentiality.

Among the negative responsibilities were:

1. Proscription as to making available poisons and abortive substances
2. Proscription as to exceeding a medical doctor's competencies ('not carrying out surgery on those with gallstones, leaving it to specialists who by profession carry out this operation').

It is worth noting two maxims attributed to the work of the father of medicine, which became paradigms of medicine and the most important forms of a medical vade mecum: *primum non nocere* (first and foremost do no harm) and *salus aegroti suprema lex* (the good of the patient is the supreme law).

3. The Middle Ages

8 **1.** During the Middle Ages, the above outlined framework in essence was not subject to far-reaching modification. On the one hand, this is due to the significant slowing of the tempo of development in the medical arts, while in the first few centuries after the fall of the *Imperium Romanum* in fact it became a regression, while on the other it represented a repetition of mechanisms that had taken place in the previous epoch. In Europe at the dawn of the Middle Ages, the art of medicine developed on two parallel tracks: one path was that of folk medicine, and the other was that of the monasteries, tied directly with the activity of holy orders. It was this latter form that, with time, came to dominate the practice of medicine up to the 12th century. To some extent, monks and the cult of holy figures filled the void left by ancient high priest-medical doctors and worshipped deities. Examples of this include St. Luke and Sts. Cosmas and Damian, to whom pleas were brought for help in the case of illness.

According to *Tadeusz Brzeziński*, the temple founded by Justinian in Constantinople and dedicated to the brothers Cosmas and Damian, functioned along similar principles to the ancient Greek temple of Asclepius, as well as the formulation of diagnosis on the basis of dreams.[14] Models of systems relating to care over the ill in the context of monastic medicine, were provided by the Benedictines. The monastery founded by St. Benedictine of Nursia in 529 AD in Monte Cassino, was built on the site of a former Temple of Apollo, while Benedictine regulations directly imposed on monks, among others, the responsibility of helping the ill. This help was primarily of a religious nature and entailed related spiritual support.

The words of St. Jacob should be recognised as significant: "When someone is ill, let him call the eldest of the community so that prayers are said and have oils applied in the name of God. And the parish shall help him and God shall raise him."[15] The religious aspect of care over the patient translated into an interest in every person who is ill, regardless of their social status, wealth or state of health. As much as doctors in the ancient world often took leave of treatment in cases that showed little promise, the Christian faith directed – in the example of Christ – that everyone be subject to care.

[14] *T. Brzeziński*, in: Historia medycyny (ed. *T. Brzeziński*), p. 46.
[15] As cited in: T. *Brzeziński*, Etyka lekarska, p. 26.

The last great "heretic" – Emperor Julian the Apostate – said outright: "Pagan priests are indifferent to the poor while the despised Galilites devote themselves to charity, and through the demonstration of a false empathy are wont to commit pernicious mistakes."[16] Apart from religious care and spiritual support, nuns also carried out typical medical help. At the monasteries, modelled on ancient temples, *hospitali pauperum* began to be organised, where help was given to all those in need, such as travellers, pilgrims to the Holy Land, the poor and the ill. The development of the art of medicine at monastic hospitals was aided by the fact that the nuns became the depositories of knowledge from the ancient world. Thus ancient writings were collected and translated in monasteries, including those relating to medicine.

2. With the passing of time, the fundamental point of helping the ill moved from being ecclesiastical to laic. The first lay school of medicine was established in Salerno in the middle of the ninth century, which maintained the tradition of Hippocratic medicine. The level of education at the Collegium Hippocraticum would have had to been high, for its operation came at a time when there was a return to regulations in the profession of medicine. According to the Assizes of Ariano issued in 1140 by Roger II, King of Sicily, Calabria and Apulia: "every individual – from this moment on – who wishes to practice the art of medicine should present before our court official and royal physicker so as to undergo an exam assessment if, however, the individual concerned in their disregard desires to claim this right before undergoing an exam he should be punished with incarceration and confiscation of his entire estate in this manner we give proof of foresight so that in our land chirurgeons with no experience cannot inflict injury onto those seeking their services."[17] **9**

The responsibility of gaining state permission by those desiring to practice medicine was also foreseen by the *Constitution of the Kingdom of Sicily* promulgated in 1231 by Emperor Frederick Hohenstauf II.[18] This constitution also established standards in relation to the education of doctors. A condition *sine qua non* of commencing studies in medicine was therefore the completion of at least three years of study in the field of logic. In addition, the study of medicine had to be begun within five years of finishing studies in logic. The fundaments of teaching were the writings of Hippocrates and Galen, while the education itself covered theory and practice. An important element of the teaching programme was surgery.

After finishing studies, sitting the exam and gaining permission to practise medicine, a physicker could be "sworn in according to the thus far binding regulation of the Royal Court, with the addition that he shall provide consultations free of charge to the poor." Another condition that was essential in order to practice his profession was to gain vital experience. In accordance, therefore, with the wishes of the emperor, "a physicker even after a period of five years (studies) may not as yet practise his profession if he does not complete a one-year practicum under an experienced physicker." Models of teaching, as well as practising the profession of doctor, were formulated

[16] As cited in: *Z Gajda*, Do historii medycyny wprowadzenie, p. 188.
[17] As cited in: *J. Borówka*, Polska etyka lekarska, p. 114.
[18] *Ibidem*, p. 114–115.

in Salerno and the kingdom of Sicily, and in southern Italy, and went on to be disseminated shortly thereafter throughout Europe in the 13th century.

10 **3.** In addition to legal norms regulating matters tied with the practice of medicine and demanding a system of education, the source of medical responsibilities developed into a system of ethical norms. These very norms, taking into account the ancient models of behaviour in respect to the patient, became established on a completely different foundation – that of the Christian vision of the world and man. The welfare of the patient was no longer assessed in a complex manner and objectively, but was entirely subjugated to a defined eschatology that imposed a means of viewing man. Placing the pillars of ethics on the Christian view of the world also meant a focus now on the person of the medical doctor, in particular their personal qualities. The supreme moral value was the figure of Christ, and thus a good doctor should model himself on the Saviour and act accordingly.

11 **4.** Arabian medicine, which developed on the basis of Graeco-Roman traditions, as well as Indian developments in medical science, had a significant impact on the means of practising the medical arts, as well as the organisation of medical help in Europe during the Middle Ages. This is because the common development of hospitals is tied with the world of Muslim civilisation. As in the Christian world, Muslims treated the instruction to help those in need as a particular imperative in medical work. As a result, medical care was given to all those that were in need, regardless of their social or material status. Hospitals were, in this context, lay institutions and, apart from typically medical functions, they were places of convalescence, care for the mentally ill, the elderly or the disabled, and those without relatives who would be able to offer them care and shelter.

At the beginning of the 10th century, those in jail were also afforded medical care and an itinerant dispensary was organised that offered care over the inhabitants of villages in lower Iraq.[19] The means of organisation and the extent of the work of hospitals suggest that they had significant budgets at their disposal. This is confirmed from documents preserved, where the budget of the hospital, for example in Al-Manṣūrī in Cairo, exceeded the sum of all the other public institutions in the city. The work of hospitals was, to a significant extent, financed from the monies of charity institutions and the work of the hospital was managed by an administrator delegated by the authorities. Most often, despite the fact that not only typical management issues were part of his responsibility, there were also those tied to the function of medical teams, and while the administrator in question was not an expert in the art of medicine, medical doctors were in charge of such teams. In the Muslim world, apart from the care offered by hospitals, where it would seem the most esteemed doctors worked, medical help was also provided at marketplaces.

In order to eradicate abuse, the office of *muhtasib* was established, in short *hisba* – a supervisor and inspector of marketplaces, buildings and public services. The *hisba* was responsible for supervising all artisans, including doctors and apothecaries, as well as ensuring the cleanliness of streets, inspecting the supply of water and the disposal

[19] *E. Savage-Smith*, Medycyna, p. 195 *et seq.*

of waste, as well as control over weights and measures etc. Doctors were obliged to swear the Oath of Hippocrates before a *muhtasib.* In addition, a *hisba* would examine doctors and – in the case of a positive application – produce permission for their practice.

The *muhtasib* was also responsible for supervising medical equipment. A doctor was obliged to possess instruments essential for the correct practice of medicine, such as those for cauterisation (Gr. *kautērion* – an iron for branding), tweezers for the removal of leeches and the extraction of teeth, a surgical saw for the amputation of limbs, a scalpel, a lancet, as well as needles for sewing wounds. All of these had a purpose – suggests the text of the preserved act of appointment of the *muhtasib* – namely the elimination of charlatans, or to be put simply 'crush like glass [so], these pieces of glass could no longer be put together'. Apart from the *hisba*, the regulation of doctors was also run by the *ra`is* – the Medical Doctor General – who, in the context of a defined "specialisation" (general medicine, optometry and surgery), assessed the competency of doctors in his charge, especially in respect to making diagnoses and the choice of healing methods.

5. In the late Middle Ages, when medical education in Europe took place in the con- **12**
text of universities, there was a noticeable decline in the rate of growth of medicine. This was largely due to the inadequate system of education and teaching methods in relation to existing needs. The fundamental method of teaching at universities was the study and commentary of treaties, often from the ancient world by Hippocrates, Galen, Avicenna, Rhazes and other recognised authorities. The main factor limiting medical education became, however, treating the above mentioned works as dogmatic texts, meaning that the arguments of recognised authorities from medical literature could not be subjected to empirical verification.

In addition, the practical aspect of medicine became considerably limited in the context of university education. Thus medical studies lasted between three and five years, depending on the university. Teaching methods that emphasised contact with the patient, which were developed in Salerno, in principle did not take place. According to *Brzeziński*, the only practical forms of teaching limited themselves to anatomical demonstrations on animals, and presenting therapeutic plants to students.[20] After two years of study, a student of medicine could apply for the Baccalaureate and afterwards the Licentiate. The latter entitled the graduate to undertake professional practice in a limited context. The right to practise independently to a full extent, as well as to teach, was given to graduates with a Doctorate, on the condition of having presented and defended a doctoral thesis.

4. The Modern and Contemporary Ages

1. In the modern age, models of carrying out medical professions and the form- **13**
ing of relations between the doctor and patient have not changed significantly. New

[20] *T. Brzeziński*, in: Historia medycyny (ed. *T. Brzeziński*), p. 54.

instruments and scientific tools, vivisections, bold hypotheses and research experiments, not limiting themselves only to proving but also disproving established paradigms, have contributed to a deepening of knowledge on the function of the human organism. Anatomical theatres began to appear at universities – first in Padua (1490), Montpellier (1551) and Basel (1588), although for a long time these were used more for the purposes – as would be said in the present day – of advertising rather than teaching.

Skeletons and anatomical atlases as scientific aids also began to be used. Doctors involved in research began to question the authority of scholars from the ancient world and to base their own knowledge and skills often on experience of a purely empirical kind. At the dawn of the modern age, there was a return to the responsibility of students finishing their medical education – to take the Hippocratic Oath, now adapted to the demands of the time. This responsibility applied to those sitting the doctoral exam. In the case of the University of Kraków, this had an enormously celebratory character. The future doctor in question would present himself before members of the faculty and solve a medical problem set by his research supervisor. After a successful *viva voce*, the newly ordained in doctoral garb would swear to the Hippocratic Oath. Subsequently, everyone would repair to the church, where the saviour was praised, singing "*Te deum laudamus*."

The text of the oath corresponded to the Christian view of the world. Instead of turning to the Greek gods, the newly promoted doctor would call upon "as witness the Father, Son and the Holy Ghost, swearing that he shall be faithful to the words of the oath in all his might and skills." Thus the doctor was obliged to pass on his knowledge of medicine to his students, to practise medicine in an honest and responsible way, provide medical help to patients until they recuperate, refrain from all manner of corruption and immorality, maintain medical confidentiality, as well as to treat women and men equally. Moreover, the oath forbade doctors from making available deadly poisons and abortive substances, so as to preserve life and the purity of medicine. In the context of the development of doctors' responsibilities, the instruction of responsible conduct should be emphasised. The essence of this responsibility was tied directly to the lack of any responsibility whatsoever, on the strength of the Magdeburg Rights in respect of a medical doctor committing a mistake in their practise of medicine.

In the event of a patient's death, even as a result of a mistake, the doctor could simply argue that the patient did not follow his advice and even – if without any other credible explanation – that he is not God and does not have power over life and death. A significant strengthening of the position of medical doctor, as well as an additional obligation to maintain professional standards, was the admission of doctors of medicine to the nobility, which took place in the Polish Republic on the strength of the privileges granted by *King Zygmunt I* in 1535.

14 **2.** Concern for and care of professional ethos was also noticeable among barber-surgeons. As emphasised the words of the original Hippocratic Oath, a doctor could not exceed his competencies, including "operating on a patient with a gallstone, leaving this to those who by profession carry out this operation." So-called blood-related operations were conducted by various artisans of the medical crafts. Particular groups of professions possessed various types of qualifications in these matters. The surgical

activity of barber-surgeons was, in principle, unlimited. Thus they – beyond their basic activity of barber – could practice bloodletting, set cups, extract teeth, set breaks and remedy sprains, as well as treating fresh wounds. Other medical artisans, like physickers or chirurgeons, were restricted to bloodletting, setting cups and setting breaks and remedying sprains.[21]

With the passing of time, barbers (also in present-day terminology as surgeons) took over the entire surgical practice. They, like other artisans in medicine, congregated in particular trade guilds, which the statute regulated in respect to all aspects related to the conduct and practise of their profession, such as education, structure of position, resolution of conflicts, as well as problems related to professional ethics. A person wishing to become a barber, as in the case of a physicker (doctor), had to possess an appropriately good background. Thus, such a person could not be born out of wedlock and nor could their father engage in work that was commonly disparaged (executioner, street sweeper, cattle merchant or gravedigger and in many cases also bath attendant [with some barber (non-surgical) duties]).

In addition, the skills of reading and writing were demanded from the candidate, which in principal was tied with possessing education at a basic level. In this context, studies lasted for three years, while every master had no more than four apprentices in a given teaching cycle. After completing his practicum, the candidate had to sit an exam, which also entailed problems in the field of professional ethics. This is one of the questions and its answer, which were found in the documents of the Gdańsk Guild of Surgeons: "What attributes should a surgeon possess? He should be conscientious, thorough, unblemished, sensible, dexterous and not unpleasant."[22] After passing the exam, the surgical student became a journeyman and was obliged to complete a half-year paid practicum by the master's side. Next, according to the model of doctors in the Ancient World, he would gain experience and complement his qualifications beyond his own guild, travelling across the country or Europe.

After complementing his qualifications, he could apply to gain the title of Master, to which an essential condition was passing an appropriate exam. It was only at this stage that the journeyman became a fully entitled member of the guild and could independently practise (also gaining the citizenship of a given town). The position of barber-surgeons, especially in relation to students of medicine studying at university, was often dependent on the attitude of the former. It was not rare to find a medical doctor and surgeon by the side of the patient in bed conferring like a professional with a professional. Moreover, bearing in mind that there were, on average, five times as many medical surgeons in the Polish Republic as there were doctors, it is possible to conclude that models of ethical behaviour were created mainly within the circle of surgeons.

3. More serious changes in the system of education of doctors were brought about by the French Revolution. Tied to the turmoil of war, the growth in the need for surgeons forced the introduction of teaching programmes in ever broader fields of anatomy **15**

[21] *T. Brzeziński*, in: Historia medycyny (ed. *T. Brzeziński*), p. 151.
[22] *Ibidem*, p. 191.

and surgery. A similar situation took place in Prussia. The needs of the army first forced a broadening of the range of knowledge passed onto surgeons as a typical university education of a medical doctor, such as the basics of internal medicine, and then joined these two competencies. In 1825, a reform was introduced in medical practice, thanks to which both university doctors and surgeons of the first and second degree were given rights to practise. In the case of the former, who in surgery passed only an exam in theory, there appeared the possibility of sitting an exam in the techniques of operations, after which – in the case of receiving top marks – they would receive the title of "Operator", and in the case of receiving a lower grade, that of Medical Doctor and Surgeon.

With the passing of time, other specialities began to be distinguished in the context of teaching programmes, such as psychiatry, neurology, dermatology, paediatrics, then laryngology, orthopaedics, syphilidology, dentistry and others. In the 19th century, this type of education framework dominated across Europe. As an example, in 1895 at the Jagiellonian University, *Collegium Medicum*, there were the following departments: Pathological Anatomy, General Pathology, Forensic Medicine, Physiology and Pharmacology. Two years later, the Clinic of Gynaecology and Midwifery was founded, as well as the Ophthalmological Clinic. The foundations of medical ethics also underwent change. This framework continued to be based on the Hippocratic ethos, though it became clearly secularised. To a significant degree it lost its philosophical worldview foundation.

The suspension of the ethical framework in a particular ontological and epistemological vacuum, notwithstanding elements that certainly were deeply humanistic, meant that it lost its highly important point of reference, which had hitherto made possible the interpretation of particular examples of medical ethics, especially in extreme situations. The place of great ethical frameworks that constituted a natural part of the outside world, where the education of doctors had begun, were beginning to be replaced by newly established systems of deontology in the professions, together with codes of medical ethics that established their normative expression.

Codes of ethics were to fulfil a series of functions. The first was the construction of a professional ethos and status of being a doctor, to which representatives of various social groups obtained access, as well as delineating various world views. Another role of the code was the internal consolidation of the medical fraternity through the acceptance of a strictly defined system of norms and values. The collection of ethical principles were to represent a clear response to progress occurring in the context of natural sciences, and equally – on account of their similarity to commonly binding normative acts – the guarantee for both the patient and medical doctor of an appropriate form of conduct of the latter. As *Henryk Nusbaum* noted, a physiologist, neurologist and philosopher of medicine at the turn of the 20th century, "… the responsibilities of the medical doctor demand certain forms of definition and leaving this matter purely to the independent philosophy and boundless freedom of every individual, is in conflict with the principle of socialisation and civilisation."[23]

[23] As cited in: *J. Borówka*, Polska etyka lekarska, p. 366.

4. Polish codes of medical ethics, initially formulated by medical associations and subsequently by medical chambers, completed the functions described above. Proclaimed in 1876, "Resolutions of the Association of Medical doctors in Galicia on the subject of responsibilities of medical professionals in respect to their colleagues and the medical profession in general," recognised as the first proclaimed Polish code of medical ethics, was divided into three principal parts. Part one obliged the doctor to upkeep the responsibility of maintaining the respect and honour of the medical profession, as well as keeping a watch over its welfare. Part two entailed proscriptions relating to acts that would lower the honour of the medical profession. Accordingly, a doctor could not be a gambler, could not advertise his practice in a "dishonest and boastful" manner, and in particular could not in the wording of advertisements: 1^0 advance his professional experience, 2^0 offer promises of radical treatment, 3^0 offer treatment by post or send medicines, 4^0 offer treatment free of charge and 5^0 announce the possession of a mysterious form of treatment hitherto unknown to other doctors. **16**

In addition, actions considered dishonourable on the part of a doctor remained: disseminating fraudulent brochures describing symptoms and means of treating particular diseases, attempts to gain forms of praise for medical practice in journals other than medical ones, as well as forms of public gratitude for treatment free of charge. Also forbidden was the application of untried medicines, especially those that were meant to possess universal application, treating a patient without making sure they are being treated by another doctor, making arrangements with those who could direct potential patients to a doctor, imposing oneself on a patient, as well as making comments to patients or their family on the matter of the qualifications and decisions undertaken by other doctors etc. Part two was closed by an outline of dishonourable actions on the part of the doctor that could take place during medical consultations, such as for example, showing jealousy, antipathy or undermining the authority of another doctor in respect to the patient or his family.

The third part of the resolution concerned actions that could form an abuse of the medical profession. Contrary to the good of the medical profession were all actions that could harm the material interests or those that weaken the influence of the medical fraternity in respect of legislation relating to the profession of doctor or matters relating to public health. In particular, resolutions decried actions aimed at "the support or establishment of the commonplace custom of exploiting doctors." The condemnation of indifference and tardiness of doctors with respect to bringing to justice persons attempting to carry out treatment without the appropriate qualifications (midwives, village wise women, homoeopaths etc.) for those making use of undeserved medical titles. Doctors should undertake actions aimed at the abolition of restrictions imposed on their freedom of earnings and that of professional dictate, the reform of remuneration principles in respect to the issuing of court opinions, as well as the development of medical associations and the introduction of medical chambers.

5. Another document proclaimed in Poland, which fulfilled the function of a medical code of ethics, was the "Principles of the Responsibilities and Rights of Medical doctors" accepted by the Warsaw Medical Association on 29 April 1884. An elaborate preamble opened the document in which the authority of the principles of rights and **17**

customs was recognised. It was emphasised that the particular issues tied to the work of a doctor, including his responsibilities and rights, are the subject of various controversies, even in medical circles. Consequently, they must be clearly formulated. The "Principles of Responsibilities and Rights of Medical doctors" contained four sections. From a formal point of view it is a complete work that contains a preamble and sections relating to particular categories of ethical problems related to medical practice. Many parts of the document (sections or points distinguished within them) were begun by a general principle that can constitute an interpretative rule of the regulations contained therein. Moreover, the principles make possible a reconstruction of values that were introduced in the preamble and which constitute the basis of medical practice: responsibility, conscientiousness, honesty and care of the health and welfare of the patient, personal culture and professionalism.

On the other hand, however, because of the resignation from a clear indication of the above-mentioned values in the text of the Principles, there arises uncertainty in respect to the direction of resolving the conflict between some of these and other principles directly arising from the contents of the Principles, such as solidarity in the profession, care for the good of the medical profession and that of personal profits etc. This uncertainty becomes all the greater given that the Principles – despite a general reference to "incontestable principles recognised widely and respected commonly for a long time" – in essence do not identify the axiological basis on which they were established.

18 **6.** The ideal, turning back to medical literature, became the welfare of the patient. In accordance with the above-mentioned *Code of Medical Deontology*, passed in 1907 at the Congress of Medical Doctors and Natural Historians in Lwów, it was resolved that: "Every doctor should conscientiously carried out the responsibilities of their profession, having above all in mind the welfare of the patient and should maintain the dignity and honour therefore of the common moral and material interests of the medical profession."[24] The decided change with regard to the paradigms on which the native codes of medical ethics were established occurred during the second Polish Republic. In the "Deontological Principles of Medicine", passed by the Wilno-Nowogród Medical Chamber in 1929, the following gained the status of basic values – the welfare of the patient, public health and calling for humanitarian work. According to the Principles, "every medical doctor should conscientiously carry out the responsibilities of their profession, having first and foremost in mind the welfare of the patient and public health, as well as remembering their calling for humanitarian work…"

The crowning of a normative development of ethical thought in medicine before World War II in the second Polish Republic was the "Collection of Deontological Principles of Medicine" accepted by the Executive Chamber of Medicine on 16 June 1935. This document was made up of two sections, where the first – called the general section – was in part a preamble, outlining the values and rules in a perspective through which particular principles contained in the collection ought to be read. The deontological principles of medicine were meant to be based not only on written sources of medical

[24] *A. Sikora*, Pojęcie, rozwój i struktura polskich kodeksów etyki lekarskiej, p. 104.