

Making a Difference to Patients: Perspectives of Health Care Ethics

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Abstract: The aim of this study is to highlight the importance of healthcare ethics in addressing the alleviation of the suffering of the poor and sick patients by healthcare givers. One's social, economic status, class, race, tribe, clan and gender become variables of branding or giving diminutive attributes to those different from 'us'. Those 'others' are the most disadvantaged to the level that they are regarded as 'things' or 'objects' instead of humans or 'subjects' with dignity. The study seeks to unveil the mindset that is behind the suffering of the 'others' who are basically the poor and the sick and suggest the way forward in re-establishing the dignity of a person irrespective of the social status, class, race or gender and health condition. Through modern advancement in medical technology, we have made an attempt to vanquish all diseases and postpone death indefinitely to the advantage of the rich who can afford it while the poor die in droves from preventable and curable diseases. Our assumptions and perceptions make the foundation upon which we act thereby laying bare our 'value systems'. The study focuses on healthcare ethics and will use a rational critical discourse to arrive at the conclusions. We use Martin Buber's concept of the 'I-Thou' relationship as our conceptual framework that assists to contextualize the healthcare ethics in the consideration of the healthcare giver as the 'I' and the patient as the 'Thou'. The Christian Scriptures form the basis upon which healthcare givers find the foundation of their values and actions. A human being irrespective of status is a subject 'I' and is the image of God who is the 'Thou'. This relationship ought to be contextualized in interpersonal healthcare network forming an 'I-Thou' link between healthcare giver and patient thereby delivering quality healthcare service without discrimination on the basis of 'status' or class.

Key words: Health care ethics, 'I-Thou relationship' holistic approach, option for the poor

INTRODUCTION

Healthcare provider's mission: In the 19th century, Florence Nightingale laid out the virtues required for those entering the nursing profession. Other healthcare providers include the Aides, technicians, radiologists, social workers, therapists, dieticians, counselors and chaplains who share the work of tending the sick and accompanying them along the path of their disease and/or recovery and in dying. In home based care, we cannot forget the parents, grandparents, family, clan and local community.

Care giving, places us in a special relationship with the sick. We have the duty to come to their aid, provide competent care, work diligently alleviate their pain and suffering, acknowledge their frailty and dignity, respect their privacy, trust and choices. We journey compassionately and lovingly with them in their moments of suffering, agony and death. Thus we need to be good healers, nurses and doctors, good caregivers practicing justice, fairness, righteousness, faithfulness and charity (McCormick and Russell, 2002; Farmer, 2005). A virtuous caregiver must exhibit the following traits; compassion, fidelity, justice, courage and prudence.

Compassion is a sense of solidarity with the sick, a willingness to pay attention to the uniqueness and dignity of each patient and a readiness to share in their suffering, to accompany them on the agonizing journey.

The details about the health of the patients are entrusted to caregivers, they must hence be trustworthy and faithful to the patients. In practicing justice, the caregivers must not discriminate the patients in respect to their financial status especially having a bias towards the rich against the poor and the vulnerable populations (Farmer, 2005). Further, they need to be courageous in the face of the challenging task of care-giving amidst the many illness. Prudence is critical in healthcare especially in determining what type of treatment, intervention measures, when to stop one type of treatment and start the other and so on. Caregivers must not forget to treat patients as partners who have rights to informed consent, and rights to avoid taking inordinate risks with their health or lives (Benatar, 2005).

THE CHRISTIAN SCRIPTURES AS BASIS OF CARE ETHICS AND 'I-THOU' RELATIONSHIP

Thought (word) precedes action: In the beginning was the Word, and the Word was with God, and the Word was

God. He was with God in the beginning. Through him all things came to be, no one thing had its being but through him (Jn 1:1-3)

'Word' is invisible, but it is the origin of the physical visible reality which includes woman and man. Thus the visible reality is a product of the invisible Word. That which is invisible (Word) is the more powerful than the visible. The invisible 'Word' is hence the 'father' and mother of the visible reality. The invisible reality is more powerful than the visible reality.

The visible physical reality of Woman and Man is a product of the invisible 'Word'. The invisible is the original or primary reality and the physical is the secondary reality. Both are integrated within a person, hence the term 'whole' or holistic.

God created man in the image of himself,
In the image of God he created him,
Male and female he created them (Gen. 1: 27)

The image of God in Woman and Man is the eternal invisible 'Word'. The eternal 'Word' takes abode in a finite, weak, physical reality that is limited in space and time (Jn 1:14, Col. 1:15ff). Woman and Man are hence finite 'gods'. The eternal becomes temporal in Woman and Man and experiences limitations in terms of sin, sickness and death. The image of God in us (Word) is however not vanquished in terms of the limitations in space and time.

Why the invisible eternal Word takes abode in the visible physical reality in Woman and Man (and in nature) is a matter of conjecture. The ambivalence (tension, war) between Word (Spirit) and Body in Woman and man is a 'fire' that was lit (through creation) and continues to burn so as to refine the gold (Word) in Woman and Man. The eternal Word in Woman and Man is constantly at pains, groaning towards the time-less and space-less rebirth back into the eternal Word.

From the beginning till now the entire creation, as we know has been groaning in one great act of giving birth; and not only creation but all of us who possess the first fruits of the Spirit, we too groan inwardly as we await for our bodies to be set free. (Rom. 8:22-23)

Thus the integral and antagonistic interrelationship between body and Spirit (Word) are established. Whenever there is a war (ambivalence, conflicts), casualties are end products. The integral human person is wholly or holistically affected; the healing or therapeutic process must hence be founded on the above fundamentals. The focus of one aspect of the integral whole of a person at the expense of the other is a fatal miscalculation. The health of the mind or spirit (Word) ought to be a priority, since it is the determinant of the state of the body.

The concept of a 'person' as a basis of 'I- Thou' relationships contextualized in healthcare: In the same way our origin is an end product (action) of the eternal Word, our thinking (Thought, Word, Idea) informs the way we act. It is hence important that we constantly re-examine our thinking processes if we desire good outcomes in respect to our actions (Kiruki, 2004).

In our African cultures, the name given for a human being (person) is always in reference to 'one of us' tribe, race, clan, or family. The one that is not 'one of us' is referred to as an 'enemy', 'thing' devoid of the 'Word' or 'Cultural identity or spirit'. Thus the 'other' is regarded not as a subject (person), but as an object in the diminutive sense. This way of categorizing the 'other' is a product of thought and is the basis of mistreatment of the 'other' without prick of conscience. Among the Agikuyu of central Kenya, the name of a person is 'Mundu', the 'other' who is not a Mugikuyu is diminutively referred to as 'Nyamu' – 'animal', hence the phrase, 'Nyamu cia Ruguru', literally the 'animals of the West'. Among the Pokot a Kalenjin sub-tribe of Kenya, a person is called 'Chito', the other is called 'Punyo' which literally means 'an enemy'. The 'other' in Kalenjin is also referred to as 'Lemin', referring to the 'Others' especially the Luhya and the Luo who are the neighbors of the Kalenjin (Katwa, 2011 Oral Interview; Kiruki, 2011). The various conflicts and wars within Africa and by interpolation elsewhere can trace its origin from the conception of a person and the extension of the concept. The other side of the argument is that, an African person's identity is based on the community, thus 'I am because we are' (Mbiti, 1969; Kunhiyop, 2008). However this aspect of the 'we' is normally confined into the clan or tribal cocoons; the 'other' outside the 'we' is usually regarded as an object instead of a subject. The way we relate to the patient who is the 'other' is determined about our conception of the 'other'. The ferocity of the Rwanda Genocide (1994) can partly be traced in the conception of the 'others' who were regarded not as persons but 'Cockroaches' destined to be crushed, hence the mutual annihilation process between the Hutus and the Tutsis.

Hitler's hatred and thought in respect to the Jews led him towards the Jewish holocaust during the second world war. The Nuremberg trials have brought to light the excesses committed in Nazi Germany on political prisoners, mentally retarded persons and alien groups 'others'; on whom various dehumanizing experimentations were carried out. The horrors of the so called 'experiments' in Nazi concentration camps should be a warning to all to respect the dignity of person in every kind of experimentation (Lobo, 1980; Frankl, 1984). Thus the consequences of 'demeaning' of a human person in whatever respect is horrifying to contemplate; however, human beings more often than not fall culprits

of the same folly because we are slow to learn from history or we simply do not learn at all.

A Person is not a means to an end: While things can be used as means to achieve specific objectives, a person is an end in himself/herself and cannot be used as a means to an end (Kant, 1993). Catholic teaching affirms that, from the time that the ovum is fertilized, a new life is begun, which is the new life of a new human being and that the human being must be respected as a person from the very first instant of his/her existence (McCormick and Russell, 2002). In scientific researches, it is immoral to produce human embryos designed to be exploited as disposable biological material and the freezing of embryos constitutes an offence against the respect due to a human being (CDF, 1982). The new Kenyan constitution acknowledges that, life begins at conception (Kenyan Constitution, 2010), hence the uniqueness and dignity of such a person must be upheld. The contraceptive pills like 'morning after' are supplied by the government in its health institutions, to be given out to women and girls by healthcare givers as a form of 'family planning'. Such pills have the function of expelling and destroying a person, a life with uniqueness and dignity, the same life that the constitution is said to protect.

During the 2007-8 post election violence in Kenya, patients were particularly concerned about the tribes of the healthcare givers who were to treat and nurse them, because, the prevailing thought that time was that, a particular person(s) was/were reduced to a tribe, a thing(s) and cockroach(es). Patients hence suffered double tragedy since the faith of healthcare givers took a backseat.

'The patient is not a case or a bed number, but a person with a unique character, a unique destiny and a unique problem...it is not so much a question of an organ malfunctioning or of hormonal imbalance or an abnormal rise in temperature, but of a person suffering. This insight calls for a method of treatment that is person centered' (Lobo, 1980)

Patients are critical priority partners in their medical treatment, they invite the healthcare givers to be loyal participants in the process of healing.

'I-Thou' relationship in the healing process: Since the Doctor and Nurse are persons, there is need for an interpersonal relationship between the healer 'I' and the patient 'Thou' whereby the healer assumes the subjectivity of the patient in a mutual exchange of the 'Thou'. In the perspective of Martin Buber, there ought to be an 'I-Thou' relationship between the Nurse and the patient but not an 'I-It' relationship (Buber, 1958).

A human being has his/her origin from the Word, and eventually returns back. It has been revealed to us that,

God is a Trinity or community of persons that are mutually united though distinct. Human beings made in God's image and though of distinct persons need to strive towards this unity in which the exchange of the 'Thou' is a reality in the healing process. May they all be one...as you are in me and I am in you... (Jn17: 21ff).

The biblical claims about community are intended to be claims not only about what is real, but about what is intended to become real through the power of human persons working with conjunction with God (Kirkpatrick, 1986) in the health care realm and the society.

In matters of interpersonal relationships, persons are contextualized as persons in respect to the consciousness of mutual relationships with other persons in the level of the I-Thou. Thus being conscious of the 'otherness' of the 'other' that is mutually merged with your own self consciousness (Kirkpatrick, 1986). The 'other' becomes the space and context in which the 'I' is mirrored, realized and transcended back into the original Word. By conquering the self (deflating one's balloon, or ego), space is created for the 'other' to occupy, and by so doing, one realizes the self in and through the other in real health care activity.

'And the Word became flesh' (Jn 1:14); the eternal word was incarnated into Jesus, who in turn is incarnated in the flesh of all human beings. Jesus proclaimed the Kingdom through the healing process; 'He went about ...preaching the gospel of the kingdom and healing every disease and every infirmity among the people...and they brought him all the sick, those afflicted with various diseases and pains, demoniacs, epileptics and paralytics, and he healed them (Mt. 4: 23-24; Mk 3: 10; Lk 6: 18). Sickness and consequent death was seen as a product of sin. Healing the sick and casting out evil spirits are two forms of the same victory over the dominion of sin. The same power of healing was transmitted to the disciples, hence the church becomes a community of a holistic healing process.

Looking down upon patients, not with loving care but simply as a duty done unwillingly is a grave injustice to the patient and the self in terms of Job satisfaction. Being a healthcare worker is a call, not merely a salaried job, but a serious selfless commitment to the service of humanity. The many cases of fistula in Kenyan health facilities affect mostly the poor women and this is a witness to negligence on the part of health workers who ignore pregnant women during delivery in respect to prolonged unattended labor. Those ignored are basically the 'other', thus the poor, a person of a different ethnic group or clan and so on. The words of pope Pius XII are to the point when he says that;

'Blessed is your devotion, which sees the living temple of the Holy Spirit in those bodies reduced by illness, disfigured by injury and paralyzed by infirmity' (Pius, 1945)

The Christian legacy in healthcare ethics: A Christian perspective of medicine, health, death and suffering and our obligations to take care of our own health and bodies will inform our attitude towards aiding our sick and suffering neighbors (McCormick and Russell, 2002). That which informs the Christian position is the Scripture, tradition, reason and experience.

Christian tradition views sickness as a result of sin and consequent fall from grace, as an invitation to share in the redemptive sufferings of Christ or as flowing from natural causes. Considering a human person as both integral of body and spirit, Christians have basically relied on medicine (body) and prayer (spirit) and have extended the same to those whom they serve. It has been a noble duty for a Christian to attend to the sick and the poor of the community. Christian hospitals and health care institutions became the spaces to accomplish the all important mission.

Tradition has it that, the sanctity of human life has been sacrosanct. Thus, every human life is sacred and that, we are stewards and not owners of our lives and lives of others. Christians have rejected abortion, infanticide, suicide and euthanasia. Christians are called to holiness and to wholeness. We humans en-fleshed souls, each of us a mysterious and sacred unity of mind, body and spirit fashioned in the 'image of God'. God has not only formed our embodied spirits, but taken up this sacred flesh and redeemed our whole humanity, body, mind and spirit, through Christ's suffering, death and resurrection (McCormick and Russell, 2002).

The distinctive moral tone 'voice' of men and women in healthcare ethics: The way we use language to communicate with the patients is a pointer as to whether we are quality healthcare workers or not. The tone or voices combine both emotion and content. Unlike theories, voices are not about right or wrong, true or false. How something is said is closely tied to what is said. Voices may be strong or weak, full bodied or hollow, tilting or deep, strident or sweet, excited or dull, trembling and hesitant, or clear and confident (Hinman, 1998).

Women tend to see moral life in terms of care rather than justice, in terms of responsibility rather than rights. Whereas men see problems as moral issues when they involve competing claims about rights, women see problems as moral issues when they involve the suffering of other people. Whereas men the primary moral imperative as centering on treating everyone fairly, women see that moral imperative as caring about others and about themselves. Men typically make moral decisions by applying rules fairly and impartially, whereas women are more likely to seek solutions that preserve emotional connectedness for everyone. Women are concerned about the preservation of relationship and not the obedience to the rules. In terms of responsibility men

are concerned about somebody being answerable for actions by following the rules. Women on their part, responsibility means primarily a matter of taking care of the 'other person as a specific individual' stressing a person's feelings and suffering. Responsibility is directed toward real individuals, not toward abstract code of conduct (Hinman, 1998).

The concept of the 'self' for men is seen in terms of autonomy, freedom, independence, separateness and hierarchy, rules become critical in respect to the negotiation of the positioning in the hierarchy. On the other hand, women see themselves in terms of relatedness, interdependence, emotional connectedness and responsiveness to the needs of others, the self becomes a network of relations following Martin Buber's perspective of the I-Thou relationship. Men see a hierarchical position as offering independence, or autonomy, while women see it as isolation, detachment and cutting off the connectedness which is strong at the lower level. These aspects of the definition of the self in relationship to the other has a bearing in respect to the outcome of the healthcare workers. When we know ourselves better, this helps us to give quality service, being ready to forego some of our perceived concept of the 'ego' self for the sake of the other.

A Healthcare worker is at the service of the sick; he/she must specialize in self mastery; a harsh gesture can bring new suffering to the patient, make a doctor ill at ease, inspire fear in the heart of the sick. The nurse must be unruffled in receiving unreasonable complaints and requests from the patients, and when faced with unforeseen emergencies, she/he must possess unassuming, sensitive and fine tact, which can understand the sufferings of the sick and forestall their needs, which can distinguish what must be said from that which is better left unspoken, tactful, too, in relations with the doctor and other colleagues in the profession and service (Lobo, 1980). His/her dedication must rise above the distinction of rich and poor, pleasant and unpleasant persons. Competence, integrity and professionalism are key to her service.

The disadvantaged poor as the 'other' and not the 'thou' in healthcare: Everyone has a right to a standard living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. At its best, medicine is a service rather than a science, it becomes pragmatic solidarity with the poor, when it is delivered with dignity to the destitute sick. Just as the poor are more likely to fall sick and then be denied access to care, so too are they more likely to be the victims of human rights abuses, no

matter how they are defined. A preferential option for the poor, and all perspectives rooted in it offers a way forward. Allowing 'market forces' to shape and determine who uses the modern medicine in terms of affordability, will mean that the poor will continue to be disadvantaged and this will constitute a human rights abuse (Farmer, 2005). It would be a contradiction for medicine and the healthcare givers to conspire to defeat objective of serving the most vulnerable in society.

The poor are byproducts of the system in which we live and for which you and me are responsible. They are marginalized by our social, tribal, class and cultural world. They are the oppressed, exploited workers robbed of the fruit of their labor and despoiled of their humanity (Kiruki, 2010). Hence the poverty of the poor is not a call to generous relief action, but a demand that we go and build a different social order which will take care of their needs including healthcare (Farmer, 2005). To the healthcare givers, the preferential option for the poor offers both a challenge and an insight. It challenges doctors and other health providers to make an option, a choice for the poor, to work on their behalf. In most cases diseases themselves make a preferential option for the poor, across boundaries of time and space, the poor are sicker than the rich. They are at increased risk of dying prematurely whether from increased exposure to pathogens or from decreased access to discriminatory services or both risk factors conspiring together to vanquish the victim.

The challenge in respect to the healthcare to the poor is simply intimidating! This is the outcome of social injustice, and unless policy makers make reforms necessary to deliver affordable healthcare to the destitute or wretched of the earth, then the law of the jungle will apply where the survival of the rich and death to the poor will be the rule rather than the exception (Farmer, 2005).

The International Pharmaceutical companies are profit driven wearing the angelic cloth of healthcare and using patents to protect their wealth for the sake of the wealthy. Meanwhile, the downtrodden poor are vanquished. The result is that, 'murder' by patent has been going on for a long time. This policy has been carried out by an international system of minority whose attribute include differential access to basic human rights, wealth and power structured by time and space, racism embedded in global economic processes, political institutions and cultural assumptions, and the international practice of double standards that assume inferior rights to be appropriate for certain 'others' defined by location, origin race or gender (Booker and Minter, 2006). Deep economic inequalities and social injustices continue to deny good health to many and persist as obstacles to

continued health gains world wide (WHO, 2004). There is a risk that, modern gains in genetic research will create 'genomic divide' thereby worsening global health inequalities. The designer drugs of the future will benefit only the wealthy. Healthcare workers, unless compromised, are expected to be the voice and hope of the poor and the downtrodden in a world full of injustice and inequality.

CONCLUSION

Our perceptions of the concept of a person is the foundation upon which we contextualize our relationship with the 'other' person. Negative dichotomies in our perceptions of a 'person' based on race, culture, sex, social-economic-political class, or religion lead to objectification of a person with its consequences especially in healthcare provision.

Healthcare ethics provides an avenue of offering quality therapeutic process for the patients. Such ethics are to be grounded on a relationship after the model of Martin Buber on the I'-Thou' perspective. The 'I' stands for the healthcare giver and the 'Thou' stands for the patient. Further, such a relationship is supported by Christian values based on the concept of the Trinity where Father, Son and Holy Spirit though distinct as persons sharing the I-Thou relationship are consummated into a UNITY of One God. Woman and Man are made in God's image, this image is to be seen in the service of the most vulnerable in the community in a mutual exchange of the 'Thou' in healthcare service.

Human beings may be the only creatures on the planet who know they are going to die, there is a fear of death and a desire to avoid dealing with death at all costs. The most serious problem facing us in health-care today is that we have failed to accept the fact that 'we are bounded and finite beings inevitably subject to aging, decline and death. We have tried to put that truth out of mind in designing a modern healthcare system, one that wants to conquer all diseases and postpone the hand of death indefinitely to the advantage of the reach and wealthy while the poor die in droves from preventable and curable diseases.

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End note:

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