Spanish Bioethics Comes Into Maturity: Personal Reflections

DIEGO GRACIA GUILLÉN

Soy cantor, soy embustero, me gusta el juego y el vino, Tengo alma de marinero . . . Qué le voy a hacer, si yo nací en el Mediterráneo.

I'm a singer, I'm a liar, I enjoy gambling and wine, I have a sailor's soul . . . What can I do about it, if I was born in the Mediterranean?

Joan Manuel Serrat, *Mediterráneo*

The Birth of Bioethics in Spain

Being Born in the Mediterranean: An Ethics of Virtue

The birth of bioethics in Spain—and the rest of Europe—has not necessarily been a replication of what happened in North America, despite the arguments made by a number of mainstream American authors. From a European perspective, this thesis looks incomplete at best, if not entirely erroneous. Let us see why.

Spain has long served as a crossroads, a place of concurring civilizations from either the shores of the Mediterranean or from Europe. Spain's most visible roots come from the language, law, and religion of Rome; the Arab legacy is also present, but in a more subtle way. After centuries of isolation marked by the chronic clash between the inquisitorial and liberal Spain, the last manifestation of which was the Civil War of 1936–39, Spain today is a European country that thinks within European categories. By common heritage, Spain is part of the Latin—or Mediterranean—Europe, together with Portugal, Italy, France, and Greece, with whom it shares a geography, history, cuisine, religion—and traditional ethics.

Ethics, as we understand it today, was born on the shores of the Mediterranean. The first book to carry a title containing the word ''ethics'' was in fact Aristotle's *Nichomachean Ethics*. Classic Greek ethics is not based on the idea of rights or duties. These traditions are modern and, in principle, alien to the Mediterranean culture of the past and present. *Virtue versus vice* instead are the central notions of the *Mare Nostrum* ethics, and along the 24 centuries that separate us from Aristotle,

Translated from the Spanish original by Pablo Rodríguez del Pozo and Joseph J. Fins.

Cambridge Quarterly of Healthcare Ethics (2009), **18**, 219–227. Printed in the USA.

doi:10.1017/S0963180109090367

the ethical tradition of the Mediterranean, in this sense, has not varied its innermost self. It continues to be exactly the same.

The place of virtue in Mediterranean ethics has distinct consequences for clinical practice. The doctrine of informed consent, the cornerstone of Anglo-Saxon bioethics, is based on the notion of patients' rights, such as the right to be informed and to accept or reject treatment. Latins cannot fully sympathize with this approach, which they often view with suspicion, most likely because informed consent can prosper only where medical relationships happen *between strangers*, as opposed to *between friends*.[1] Southern Europe sees the doctor–patient relationship as one of friendship. ''If I trust my doctor, why do I *want* to be informed? And if I don't, how can I *believe* what he tells me?'' For a Latin, if there is trust, informed consent is superfluous; if there is no trust, it is useless. Anglo-Saxons do not, in general, reason this way.

A North American Import?

Is European bioethics a homegrown product or just a mimicry of the North-American movement? Answers diverge. The *diffusionists*—whose doctrine is prevalent in the United States—maintain that all national or regional bioethics represent the *diffusion* of North-American bioethics. Albert R. Jonsen's *The Birth of Bioethics*[2] is the paradigmatic example of this position.

In the opposite corner, European authors think in *emergentist* terms. For them the birth and development of bioethics is related to indigenous factors, even if some of them are similar to those that helped launch American bioethics. Between these two opposing perspectives, some acknowledge the role of indigenous factors while appreciating the decisive influence of American bioethics on its latter-day European counterpart.

In my view, *diffusion* can only happen when adequate conditions are in place at the receptor. Otherwise, the message cannot be tuned in and is lost. The diffusionist thesis is, at best, incomplete, because it fails to look at the context in which it was received. When discussing the birth of Spanish bioethics, it is necessary to analyze the social and intellectual environment where it took root.

There are three intrinsic causes linked to the fast growth of bioethics in Spain. The first one is the spectacular advances of biomedical technology that started in the 1960s. In the last 40 years, medicine has developed more than in the previous 25 centuries. This comes as little surprise. After all, science progresses exponentially, to the point where there are more living scientists today than existed in all of history. This process was more compressed in Spanish history than in North America because of accelerated economic development in Spain during recent decades.

Science and technology have turned us from passive spectators into manipulators of the beginning of life and the evolution of the species. But this has posed multiple moral questions. Should any technique be used just because it is available? How? When? As noted, Spain's recent economic development has allowed us to incorporate increasingly refined medical technology, leaving the old deontological codes of the professions with few answers to the new questions that emerged. Medical deontology was manifested in the bureaucratic organization and administration of medical power, embodied in the professional guilds or organizations. These institutions made medical ethics a bureaucratic product,

which was rebranded as *medical deontology* and was, and still is, simply a written code of conduct elaborated and enforced by the Colleges of Physicians (*Colegios Médicos*). Those who allegedly break the code can be denounced by their colleagues—an infrequent occurrence—and punished—in a more formal than substantial way—by their own colleagues. The Hippocratic physicians legitimated their power and authority in a ''charismatic'' manner, to use Max Weber's language.[3] People saw them as possessed by, or invested with, a special charisma. After the 16th century, social power started to be legitimated and managed in a different way, which Weber characterizes as ''bureaucratic.'' Bureaucracy, which consists of the impersonal administration of social power, is the antithesis of charisma. Professional deontology has been and is today the bureaucratization of true charisma.

The bureaucratic formulas of this ancient deontology left us without an adequate response to the new ethical issues in medical practice. This necessitated the emergence of bioethics as a novel framework to deal with the new problems and to make proper decisions. Bioethics in Spain was an attempt to overcome the prevalent bureaucratic management of professional ethics in an effort to recover what never should have been lost: charisma.

The second intrinsic cause for the genesis of bioethics in Spain has to do with the emancipation of patients. The hectic 1960s brought a wave of movements to expand human rights to historically disenfranchised groups both in America and in Europe. Martin Luther King's advocacy for the civil rights of African-Americans and the authority-defying French revolts of May 1968 epitomized those times, along with the surge of the women's liberation movement and so-called liberation theology. These developments coincided with the progressive transformation of Spanish society from low economic development and political dictatorship to the rapid growth of a rich organized democracy.

The democratic transition began after General Francisco Franco's death in 1975 and was consummated in the passage of the Constitution of 1978 under the leadership of King Juan Carlos I. At that time, civil and political rights became as tangible as in Western Europe and the United States. During this evolution, medical culture reflected broader social changes and the relationship between doctors and patients changed, with a greater emphasis on patients' rights. Bioethics entered the healthcare scene just as the ancient professional deontology became ineffective in a democratic, modern Spain.

Socialized medicine is the third midwife of Spanish bioethics. When the state provides universal healthcare, the tension—always unstable—between justice and efficiency is the foremost ethical problem. Some questions are unique to a state-run, single-payer system. For example, patients and families have no financial constraints to pushing for treatment, even if that hurts other patients' interests. In Spain, bioethics was seen as a means to elucidate these kind of conflicts. Classic professional deontology, developed in an era when all medical practice was private, became unresponsive to the issues related to socialized practice.

Between Scylla and Charybdis

The growth of Spanish bioethics has also had to navigate between two other obstacles, both typical of the Mediterranean countries: the Catholic religion and Roman law tradition.

Spain is a traditionally Catholic country and, as such, has never made a clear distinction between religion and morality. The Catholic Church has historically regulated behavior, preventing moral rules from being determined by secular criteria. Throughout its history, this Spanish tendency has only tended to increase. For example, the First Vatican Council of 1870 recognized papal infallibility not only in matters of faith, which no one had disputed, but also regarding customs, which are in the sphere of morality.[4] The more the Catholic hierarchy has seen its hegemony threatened, the more thorough and aggressive has become its involvement in themes of morality.

This explains the difficult process of emancipation of Latin, and Spanish, bioethics from the ecclesiastical structures. More than half of the bioethics literature in the last two decades has been written under strict ecclesiastical criteria to defend the doctrine of the Church. A considerable fraction of Spanish society—generally the older generations—still consider the Church the most authoritative source on these issues.

Secularization is profound, nevertheless. Spain has kept pace with the secularization of Europe, which is perhaps more widespread and deeper than in America. This process will likely accelerate in the coming years due to the demographics of secularization and the aging of Europe—those who maintain religious practices tend to be older. The risk of mixing ethics and religion, although important, has diminished in recent years, and it will keep shrinking over time.

The other obstacle that bioethics has encountered in Spain is the equation of ethics and the law. This phenomenon is typical of nations that were part of the Roman Empire. Rome left two strong legacies: one is the solid centralization of political power and the government, and the other is the robust and meticulously developed legal system of the Roman law, which foresees all actual or potential minutiae. Such thoroughness induces people to frequently confuse ethics and the law.

Until recently actions were popularly deemed correct or incorrect by simply looking at the law. Once the act was deemed not to contradict some legal principle, the average Spaniard would ask if it was or was not discordant with Catholic morality. In both cases, ethics would disappear and be confused with law or religion. Today the situation is only partially different.

History in First Person

From Anthropology to Bioethics

I would like to speak of my own contributions to this movement. In part they are implicit in the previous sections. I studied philosophy in the first half of the 1960s and medicine during the other half, specializing in psychiatry. This is when I became interested in the history of medicine, completing my doctoral dissertation in 1973 on the history of Spanish psychiatry. After that, I did postdoctoral studies on medical anthropology in Germany, following the style and method of the School of Heidelberg. I returned to Spain in 1978 and accepted the History of Medicine chair at Madrid's Complutense University, just vacated by my mentor Pedro Laín Entralgo, upon his retirement.[5]

I first sighted bioethics in 1975. Following Laín's method, I had tried to approach medicine from two different and complementary angles: historical and philosophical. Medical anthropology was the intersection of these methods.

Nevertheless, after years of intense work in that field, I felt immensely frustrated because the analysis of all issues was invariably too theoretical and abstract, with no practical applications. This is what made it so meaningful to find the newly developed and growing field in the United States under the neologism of *bioethics.* What surprised me most was the profoundly practical character of the then new field, being always interested in the search for practical solutions to ethical problems. Its conceptual scaffolding was probably inferior to that of the Germans' medical anthropology, but its applicability, its utility, was much greater. This made me focus on bioethics, to which I have devoted myself practically full-time since the early 1980s.

Rediscovering the History of Ethics

My first research project was a revision of the history of medical ethics, following a rather unorthodox method. Instead of looking at who physicians *had been* or what they *had done*, my interest was to know the history of what physicians *had wanted to be* or believed they *had to be.* The sources of such study were the ethical texts themselves, which do not reveal the reality, but rather the *idealism* of the medical profession.

This work consumed an amount of time and effort that I could not have imagined when I started. In fact, I dedicated the first half of the 1980s to this work, and the product was the first part, ''History of Bioethics,'' of my 1989 book on the foundations of bioethics.[6]

When analyzing the texts of the medical ethics tradition, I realized that all of them adhered to the same logic and exposed the same ethical ideal: the Hippocratic *beau ideal*. My primary hypothesis was that medical ethics had evolved internally, and that it would be possible, therefore, to find those inflection points that would benchmark different phases, or even different ethics. But the sources rebelled against this idea, convincing me that there had been one medical ethics tradition throughout history, since Hippocrates. Changes had originated outside medicine and were invariably received as external threats by the medical establishment.

Another finding was that there were three lineages to medical ethics: the medical, from the Hippocratic tradition; the juridical, reflecting modernity; and the philosophical and political, drawn from antiquity and the Greek tradition. To my surprise, the first tradition revolved around the principle of beneficence, the second around the principle of autonomy, and the third around justice. These were, curiously, the same three principles identified by the Belmont Report. The confluence of those three traditions had happened very recently, in the second half of the 20th century, and had caused countless conflicts. Nonetheless, my conclusion was that this convergence and conflict had synthesized into bioethics as an independent discipline by the 1970s.

My American Experience and Return to Fundamentals

With those findings fresh in my mind, I felt the need to visit the main bioethics and medical humanities centers in the United States at that time. I visited them all[7] in the company of James F. Drane, who had just spent a year in Madrid writing a book, *Becoming a Good Doctor*,[8] strongly inspired by the works of Laín Entralgo.

Back in Spain, I believed that I had a clear picture of what was going on in America and what I should do in my country. I could not be satisfied with simply importing American bioethics. We belong to different cultures, with different philosophical traditions and values. It was necessary to do something more difficult, but also more fruitful: to rethink, redo, recreate everything from scratch, drawing on the American experience but also taking into account European traditions.

American bioethics had achieved something until then unimaginable, which was to have practical utility, solving conflicts and helping practitioners better handle the clinical relationship. This was a nonnegotiable outcome for any project in the clinical orbit. On the other hand, American bioethicists had been able to free clinical ethics from theology and from jurisprudence while staying on good terms with both disciplines. To my European mentality, however, American bioethics suffered from a deficient philosophical foundation; it gave disproportionate weight to conflict resolution at the expense of foundational considerations. This was understandable, given the empiricist and pragmatic American tradition, but difficult to understand and incorporate into European rationalism. To address these challenges, I devoted the second half of the 1980s to working on the foundations of bioethics.

The fruit of that effort was the second part of my *Fundamentos de bioética* (*Foundations of Bioethics*) of 1989.[9] There I analyzed the main doctrines that have given birth to medical ethics in Western history and proposed a model that tried to incorporate the wisdom of that historical process. I built that model upon the teachings of my mentor in philosophy, the late Xavier Zubiri, who was concerned with the inseparability of sensitivity and intellect in human reason, in what he called "sentient intelligence."[10] I also maintained there that it was not possible to construct a philosophical foundation for bioethics without proposing a method of decisionmaking. Corresponding methods were therefore included with each foundational theory.

This cycle, devoted to the history and foundations of bioethics, ended in 1990, with *Primum non nocere*, a discourse I gave upon my admission to the Spanish Royal Academy of Medicine.[11]

Clinical Ethics

My plan for the 1990s was to study the concrete problems faced by clinical ethics in order to publish *Clinical Bioethics* (*Bioética clínica*). This was a natural continuation of *Foundations of Bioethics*. The first step was to analyze the clinical decisionmaking methodologies, which resulted in the book *Clinical Ethics Decision-Making Procedures* (*Procedimientos de Decisión en Ética Clínica*),[12] published in 1991, where I discussed the then current methodologies and proposed another based on the four principles approach. (*Clinical Bioethics*, incidentally, was never published.)

During the 1990s I became incredibly busy publishing articles on clinical ethics issues. The production was so robust, and yet so specialized, that it was impossible to collect it in a systematic volume. Thanks to the insistence of friends and colleagues, most of those scatteredly published articles were collected in a four-volume collection, *Ethics and Life: Studies on Bioethics*, published in 1998.[13]

Starting Over: Ethics of Responsibility

After my deep immersion in clinical ethics and its specific problems in the 1990s, I became even more aware of how much bioethics, as it is understood in Europe—and in Latin America—demands sound philosophical foundations. Thus, with the new millennium, I felt the compelling need to go back to the beginning and rethink the foundations of bioethics. I believe that the most characteristic feature of the past century's ethical thinking has been its attempts to go beyond the classic dichotomy between deontology and teleology, toward what is properly called the "ethics of responsibility." This is the ethics that I consider most capable. Today I am working on a new book, *Ethics of Responsibility*, which I hope will be my final contribution to the foundations of bioethics.

An ethics of responsibility needs a decisionmaking method. Over the years I have become convinced that this method is based on *deliberation*. One of the most urgent tasks of bioethics is to understand the history and basis of deliberation, in such a way that it can be taught and applied. This will be another book, called *Moral Responsibility.*

Teaching Bioethics: Spain and Latin America

My work in bioethics has not been carried out by myself alone, nor has it been restricted to the confines of my office. It has been carried out in the classroom, working hundreds of hours with students and doctors in innumerable courses in the medical humanities both at the medical school and postgraduate levels.

European regulations require that each country define a number of core courses in the curricula of all medical schools. In Spain, bioethics was included in that core category, and my school at the Complutense University made it obligatory for all students to take two bioethics courses: Bioethics and Pain Management. This is the good news.

What it is not so good is that bioethics was included in the second year of the medical curriculum. In our 6-year program, that is too premature, because second-year students have had no clinical experience. It is a shame that in the clinical years the students do not have the chance to take a course on clinical ethics. I hope to fill this gap with a textbook of clinical ethics, which has a provisional title of *Facts, Values, Duties: Bioethics Textbook for Clinicians.*

In 1988 my department in the Complutense University organized a Master's program in Bioethics, which is still being offered. The first half of the 2-year curriculum is dedicated to the foundations of bioethics; the second year focuses on clinical ethics and decisionmaking methods. Inevitably, this curricular format traces my own personal voyage into bioethics. For more than a decade, the *Instituto Nacional de la Salud* (INSALUD)—the governmental agency that runs the Spanish national healthcare system—formed around our graduates Committees for Ethical Assistance (*Comités de ética asistencial*). The more than 300 Complutense graduates now hold key positions in public and private hospitals, government agencies, and IRBs, and constitute the next generation of my country's bioethics leadership. Graduates have created the very active *Asociación de Bioética Fundamental y Clínica*, which organizes a popular yearly congress and has published more than 11 books authored by its members.[14]

In 1996, in a joint effort with the Pan American Health Organization (PAHO), the Master's program was offered in Santiago, Chile, where PAHO had recently

opened a Regional Program of Bioethics for Latin America and the Caribbean. The curriculum has the same format and contents as that in Madrid, but the 600 hours of instruction are concentrated over two intensive 8-week annual retreats. Students and faculty live on campus during those weeks, which makes these courses a uniquely rich academic and vital experience, not least because of some puzzlingly different visions and sensitivities among students from different parts of Latin America, which—on another level—sometimes resemble the cultural gaps between American and European bioethics. Two groups of students graduated in the Latin American Master's program in Santiago between 1996 and 1999, another completed the course in the Dominican Republic in 2001, and yet another one graduated in Lima, Peru, in 2003.

Looking to the Future

I will perhaps never know if my contributions to Spanish bioethics were large or small. At any rate, I believe they have strengthened the independent identity of Spanish bioethics, which remains vulnerable to being overshadowed by religion and the law.

Religious organizations, particularly the most conservative ones, have embraced bioethics as one of their pastoral missions. The result is incessant activity, although the quality of these activities is academically rather uneven. Nonetheless, their campaigns strictly follow Vatican directives. We bioethicists have had to defend our identity and freedom of thought. At times this has been difficult, but this defense has proven fruitful.

The other singular duel has occurred between bioethicists and the law. It would be difficult to imagine that bioethics was safe in a country that has more lawyers than Germany and France combined. Jurists, naturally, do have a role in this field, but that is limited to health law. The problem is that—in a very Mediterranean way—jurists tend to identify ethics with the law and reduce morality to legality. The problem for Spanish bioethics is that many jurists call this approach *bioethics*.

Perhaps these tensions come from the fact that, although bioethics is a new arena, it enjoys a positive reputation and prestige in Spain. It thus attracts many people, some of whom are moved by their own agenda. But after so many years, bioethics still has to elbow its way forward. But if bioethics has so many suitors, it must mean that our efforts are worthwhile. I am generally satisfied with what I have done. But I also have to confess to my mistakes.

I was wrong when I insisted that bioethics had to be hosted by the departments of history of medicine in Spanish medical schools. And it took me too long to realize my mistake. My thesis was that bioethics had to stay together with its epistemologically closest disciplines. I believed that history of medicine had that closeness with bioethics, as both were social rather than natural sciences. Spanish philosopher José Ortega y Gasset considered that those sciences should be called ''humanities.'' And by following Ortega, I was wrong.

Social sciences deal with culture and values, but not with values in themselves, but rather with values as *facts*. This is why they are so specific and so limited. Ortega was wrong. Humanities cannot be identified with social sciences, simply because humanities are not sciences. They do not even want to be sciences. Ethics has always been part of philosophy, not part of any science.

I am convinced today that bioethics should be studied—and taught—in specific academic divisions of medical humanities, which should be equidistant from both the departments of social and biomedical sciences. It is necessary that the medical humanities, and bioethics as its main branch, have their own life and autonomy. And their own, dedicated, faculty. This way, society will judge bioethics and bioethicists by their works.

When that happens, we will know whether bioethics and bioethicists have truly provided a response to the real problems of Spanish medicine. And if we fail, we will have no one else to blame, for as Don Quixote said, ''Everyone is the son of his works.''[15]

Notes

1. MacIntyre A. Patients as agents. In: Spicker SF, Engelhardt HT Jr, eds. *Philosophical Medical Ethics: Its Nature and Significance*. Dordrecht: Reidel; 1977:197–212.
2. Jonsen AR. *The Birth of Bioethics*. New York: Oxford University Press; 1998.
3. Gracia D. *Fundamentos de Bioética*. Madrid: Eudema; 1989:72.
4. Denzinger H, Hünermann P. *El Magisterio de la Iglesia: Enchiridion Symbolorum Definitionum et Declarationum de Rebus Fidei et Morum*. Barcelona: Herder; 1999:3074.
5. The title of the academic positions have been translated into the most approximate American equivalents. *Profesor agregado* has been translated as Associate Professor, and *catedrático* as Chairman of the Department.
6. See note 3, Gracia 1989:21–311.
7. From Washington (Kennedy Institute: Edmund Pellegrino, Tom L. Beauchamp) and New York (Hastings Center: Daniel Callahan, Arthur Caplan) to San Francisco (Albert R. Jonsen), Houston (H. Tristram Engelhart), Texas A&M (John J. McDermott), Chicago (Mark Siegler, Stephen Toulmin, David Thomasma), Edinboro (James F. Drane), Hershey (K. Danner Clouser), Galveston (Chester R. Burns, Ronald A. Carson, William J. Winslade), and Memphis (Carson Strong, E. Haavi Morreim).
8. Drane JF. *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*. Kansas City, MO: Sheed & Ward; 1988.
9. See note 3, Gracia 1989:313–596.
10. See note 3, Gracia 1989:316–93.
11. Gracia D. *Primum non nocere: El principio de no-maleficencia como fundamento de la ética médica.* Madrid: Real Academia Nacional de Medicina; 1990.
12. Gracia D. *Procedimientos de Decisión en Ética Clínica.* Madrid: Eudema; 1991.
13. Gracia D. *Ética y Vida: Estudios de Bioética*. Santafé de Bogotá: El Buho; 1998. This edition was prepared by my friend Germán Marquínez Argote, who selected, ordered, and edited the content of all four volumes.
14. Graduates formed the very active *Asociación de Bioética Fundamental y Clínica*. Please visit www.asociacionbioetica.com.
15. Cervantes Saavedra M. *Don Quijote de la Mancha*. Madrid: Cátedra; 1990:119.