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The medizinische Anthropologie of the Heidelberg School. Implications for bioethics

ABSTRACT

This paper presents some of the thought framework underlying the movement characterized as *anthropologische Medizin* and *medizinische Anthropologie*, developed by the Heidelberg School. Drawing particularly upon the work of Viktor von Weizsäcker and Paul Christian, an attempt is made to relate the basic concepts of solidarity and reciprocity to current American bioethical thinking. Attention is paid to the peculiar historical circumstances and consequences of Third Reich medicine and to the critical test of its major forms of theory and practice represented by the Nürenberg doctors' trial of 1947. A major conclusion need for a more complete reconstruction of the theoretical underpinnings of the Heidelberg School writings and a more thorough study of its relevance to contemporary medical humanities and bioethics.

Keywords: Heidelberg School, bioethics, reciprocity, solidarity, medical ethics, German medicine

"'Medizinische Anthropologie'" and "'anthropologische Medizin'"

The German terms '*medizinische Anthropologie*' and '*anthropologische Medizin*' belong to a family of cognate concepts developed by the writers of the so-called Heidelberg School, particularly Viktor von Weizsäcker, to designate an intense interaction between medicine and the human sciences. To translate them as 'medical

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anthropology' or 'anthropological medicine' is misleading, since the meaning of these expressions in English or American literature refers to the application of ethnographic and cultural anthropological methods to the study of medical concepts and practices or to the impact of medical conceptions upon societal uses.

During the final decades of the nineteenth century and the first ones of the twentieth a movement opposing the positivistic turn of medicine appears in some German medical writings. '*Naturwissenschaftliche*' or natural scientific medicine was based on the assumption that medical practice should be grounded on a systematic application of basic sciences like physics, chemistry, and biology to clinical work. German research could look back at a record of successes spanning from the field of basic research in physiology to important discoveries in microbiology, imaging techniques, genetics, and pathology. At the same time, it also recorded facts and observations which made the expectation of definitively conquering disease and death by means of medical science unrealistic. No lesser figure than Rudolf Virchow, the founder of '*Cellularpathologie*', impressed by the state of public health in Silesia around the middle of the nineteenth century, devoted himself to 'the social issue' and coined the phrase *'die Medizin isf eine Sozialwissenschaft*' (medicine is a social science). The contributions of Breuer, Freud and others, suggesting the influence of unconscious motives and drives on psychic functioning and eventually on bodily processes had not yet find their way to established opinion and were denied by some or ridiculed by others. The growth of social problems beyond the reach of medical practice made it imperative to address the organizational aspects of health care. Profound social and scientific changes characterized the period before and after World War I. Yet medicine was practiced as a 'natural science', dominated by mechanicism and positivism.

There were many manifestations of the reaction against a mechanistic and value-free view of medicine. Some took the form of theoretical elaborations of the principles which had informed Romantic Medicine in the 19th century, with its emphasis on 'ideas' and analogical thinking. A reappraisal of the works of Heinroth, Novalis, Carus and other writers of the Romantic period produced a flood of publications dealing with approaches to disease and illness different from those dictated by medical science. Many authors spoke of a 'crisis' in medicine, similar to the one being experienced by the natural sciences themselves [1]. The need for a reconceptualization of goals and practices was frequently repeated. The relationships of medicine to the humanities and the incipient social sciences were stressed.

The trend toward integration found a precursor in Goethe: *'Religion, Kunst und Wissenschaft eins sind von Anfang und am Ende, wenngleich in der Mitte getrennt*' (religion, art and science are one at the beginning und at the end, separated in the

middle) [2]. Eventually, these ideas also found expression in an epistemological and methodological synthesis known as 'theoretische Pathologie' (theoretical pathology) [3,4]. This expansion of the medical gaze gave rise to *anthropologische Medizin* and *medizinische Anthropologie*.

The Heidelberg School

at the beginning of the 20th century, extinguished the romantic influence on medicine, philosophical and anthropological questions were constrained within the limits of natural science and limited to the positivistic reformulation of Kantianism. Against this background should the teachings of the Heidelberg School be considered, designation proposed by the Spanish medical historian Pedro Laín Entralgo in the 50's summarizing the work and ideas of men such as Krehl, Siebeck, and von Weizsäcker. He considered them representatives of a definite trend in German medical thinking and its underlying philosophy [5].

Some developments leading to the establishment of the Heidelberg School had to do with the conception of the human person as the site where disease manifests itself and is presented as illness to the physician. Friedrich Kraus [6] had seen the unifying principle of the person in the biological constitution (*'das Vegetative')* and proposed a theory of context and relationships (*Zusammenhangslehre*). Others proposed different holistic concepts, including appropriate therapeutic means and objectives for practice. By the 50's, a consistent body of theory related to the person in medicine could be discerned [7].

Ludolf von Krehl (1861-1937) can be considered one of the first writers of the tradition termed Heidelberg School by Laín Entralgo. *Ordinarius* for internal medicine, he devoted part of his writings to the problem of the human person and its integration. He developed a form of medical personalism based on the spiritual-psychological unify and uniqueness of the human individual. One of his most highly quoted statements was, repeating Hippocrates, that "diseases do not exist, only diseased persons" [8], which can also be found in other authors [9]. Krehl was a prolific writer and his main work, which underwent more than a dozen editions and was published under the title *Entstehung, Erkennung und Behandlung innerer Krankheiten* in three volumes between 1930 and 1933, contains a valuable presentation of the core medical information of the period. Relevant here is his book *Krankheitsfonn und Persönlichkeit* (Disease form and personality), published in 1929 by Thieme in Leipzig. The importance of Krehl for German medicine and his presence as author of relevant treatises and textbooks since he went to Heidelberg in 1907 paved the way for a consideration of the humanistic and philosophical

dimension of medicine. Although a pioneer in considering psychogenic influences on medical disorders, Krehl would not have aligned himself with the "psychosomaticists" influenced by psychoanalytic thinking. The appropriation of this for medicine will occur in the work of Viktor von Weizsäcker.

Richard Siebeck (1883-1965) introduced the biographical anamnesis in an expanded form. Medical history was in his view a life history. Each person does not only have a disease but in some way this is produced by the person's actions. Medical history is not only a summary of medically relevant facts but reconstruction of a historical development, interpretable as a unit. Medical history is also a dialogue in which two persons exchange their views on the world and on life. One of the most influential works of Siebeck was *Medizin in Bewegung. Klinische Erkenntnisse und t1rztliche Aufgabe*, published by Thieme, Stuttgat, 1949. Of interest is also his paper on *Die prämorbide Persönlichkeit* included in the volume *Individualpathologie*, edited by C. Adams and F.Curtius, Fischer, Jena, 1939.

Viktor von Weizsäcker

Viktor von Weizsäcker (1886-1957) brought to a culmination the idea that a truly integrative psychosomatic medicine does not consist in juxtaposing natural-scientific and psychological theories and assertions [10]. It is not a matter of interaction between two substances, mind and body, but the comprehension of the fact that those aspects of the human being can be present to the observer in a complementary fashion. They re-present each other in a circular form, so that when a conflict arises the response can be a disease or a biographical turn, always endowed with a meaning which can be derived from the totality of human life. The principle underlying this cirularity of action and perception, of fate and disease, was called *Gestaltkreis*, and was grounded on physiological experiment and philosophical theory [11]. If physiological questions are asked about the totality of human life, then physiological answers appear; if, on the other hand, questions about the psychological aspects of life are posed, then psychological answers or answers expressed in psychological terms will show up. This methodological constraint was termed *Drehtürprinzip*. Both concepts show that complementariness is of the essence of a truly 'psychosomatic' theory of human disease and illness. In order to dissociate himself from a simplistic view of psycho-somatic theorization, von Weizsäcker started using the-expression *medizinische Anthropologie* as early as 1927, with the publication of three articles in the magazine *'Die Kreatur*', which he edited with Joseph Wittig and Martin Buber. According to his view, the psychosomatic medicine of his day should transform itself and develop a theory of man based on

medical thinking, the construction stages of which should be *anthropologische Medizin* and *medizinische Anthropologie*.

Throughout his career, von Weizsäcker consequently applied the notion of a formal, not a substantial, correspondence between those realities called mind and body. They constitute themselves in encounters between persons and one the most privileged is the one between the sick and the healthy, the needy and the helper, patient and doctor. His lectures and clinical demostrations would show the appearance of diseases at crucial points in life, when persons are confronted with biographical decisions and unsolvable conflicts. One of the basic questions he would ask was *Warum gerade jetzf*? *Warum gerade so*? (why precisely now? why precisely this way?). These were to constitute the crucial questions of psychosomatically and psychosocially oriented medicine, even in other traditions. For instance, Halliday condensed the diagnostic enterprise in three similar questions Why this person? Why this disease? Why at this time? [12].

The search for specificty was fundamental for psychosomatic theory, answered by different authors in different forms: *conflict* (Alexanderian), *disposition* or *attitude* (Grace and Grahamian), *personality* (Dunbarian), *developmental arrest* (Rueschian), *inability to emotional expression* (Nemiahian, Sifneosian), among others [13, 14]. Von Weizsäcker accorded a place to unconscious motives in his clinical studies and even presented his work *Körpergeschehen und Neurose* for revision to Sigmund Freud (whom he met personally only once, in 1926), who answered that, though interesting, the applications of psychoanalysis to organic diseases were not appropriate for psychoanalysts at that time. These should devote themselves to psychological suffering and resist the "temptation" of physiological theory.

In a biographical text of 1955, based on a talk delivered in 1947, von Weizsäker summarized his career indicating that it had been rather unsuccessful in the university environment [9]. He taught a complete course only one semester as deputy director of the Physiological Institute in Heidelberg in the winter of 1945. In 1941, during the war, he was appointed *Ordinarius* for neurology in Breslau and had to leave at the proximity of the Red Army in January 1945. He did not belong to any political party although in his writings he addresses political and social issues and took part in action as medical officer by the end of 1944. After 1946 he was appointed *Ordinarius* für Allgemeine Klinische Medizin, a position especially created for him with the aid of Richard Siebeck, then Director of the Heidelberg Clinic, in which he remained until September 1952. He died in 1957, after having produced a sizable written work and established a tradition which was continued by his assistant and succesor, Paul Christian (1910-1996).

The Heidelberg School after von Weizsacker

the legacy of Viktor von Weizsäcker found many expressions. Some developed aspects of his work outside institutionalized German university medicine. Parts of his work were expanded by disciples and students who would interpret them in radical ways.

The official follower of von Weizsäcker the Chair for General Clinical Medicine was Paul Christian (1910-1996). Born in Heidelberg, Christian was student when Krehl taught at the university and received training in neurology, both in Vienna and Heidelberg. He collaborated with von Weizsäcker from 1935 onwards and accompanied him to Breslau in 1941. He received his *venia legendi* in 1940 and did research on color vision, sensory and motor physiology, and theoretical pathology. His areas of clinical expertise were cardiovascular dysregulation syndromes and general medicine. When the Institute for General Clinical Medicine was reestablished in 1958, Christian was appointed Director and remained in that position until his retirement in 1980. He also established in 1958 an Institute for Social and Occupational Medicine with H.Schäfer and H. Jusatz.

Christian contributed to the development of the Heidelberg tradition both in empirical and theoretical ways. He developed the concept of "bipersonality' as the foundation of a medical sociology that could serve as an aid to practice [15] and studied extensively the neurovegetative syndromes. He became interested in stress medicine and was one of the summarizers of the main concepts of the Heidelberg School, beginning with his monograh *Das Personverständnis im modernen medizinischen Denken*, 1952, his work on the development of anthropological concepts, his theorization on Handlungstheorien (action theories) [16] and the impulse he gave to experimental analysis of dyadic and interpersonal behavior, particularly during psychotherapy.

After Christian's retirement, his succesor and follower was Peter Hahn, whose main contribution to the Heidelberg School tradition lies in his work Ärztliche Propädeutik, where he combines the efforts of reaching the patient's subjectivity with the idea that the doctor's subjectivity should also be considered during the formative years of training and practice [17]. This notion resembles some put forward by other writers such as Fritz Hartmann (18) and can be considered an extension of the demands placed upon doctors entering psychoanalytic training. Efforts to restore the particular combination of experimental work and powerful theoretical analysis characteristic of the brightest periods of the Heidelberg tradition did not produce noticeable effects on contemporary German medical thinking.

Some intellectuals who had accompanied the development of the Heidelberg School and taken part in some of its major accomplishments, undertook the task of preserving the legacy of von Weizsäcker, edited his collected works and founded a society which bears his name. Among the most important members of this society are Dieter Janz, former professor of neurology in Heidelberg, Cart Friedrich von Weizsäcker, renowned physicist and writer and nephew of Viktor, Mechthilde Kütemeyer, daughter of one of the disciples of Viktor von Weizsäcker, among many others. The objective of the society is to continue working towards the aims and in the spirit of Viktor von Weizsäcker, extending his intuitions and building extensive networks with people and ideas in different fields.

Some concepts developed by the Heidelberg School

a characterization of the basic tenets of the Heidelberg School, from the medical personalism of Krehl to the action theorization of Christian and Hahn's personalized medical propedeutics, through the diachronic biographic work of Siebeck and the seminal work of von Weizsäcker should include an appreciation of its profoundly conceptualized unity of the sciences of man. Medicine, as a science of the encounter between someone who needs help and someone who is willing to help, becomes a pivotal body of experience and ideas for the furtherance of a dialogic theory of human nature.

The fundamentals of medicine, von Weizsäcker wrote in 1944 in a document for medical students in the front, are knowledge of nature (*Naturerkenntnis*), knowledge of man (*Menschenerkenntnis*) and craftmanship (*Kunstfertigkeit*) [19]. The challenge was to widen and deepen the scope of medicine without losing what natural sciences had given it, that is, the possibility of turning subjective certitude into scientific truth. But this truth was a human one, based essentially on the reality and trascendence of the encounter between human beings. *Solidarity* and *reciprocity* were considered principles essential for the practice of human medicine. They were invoked to reject both the elimination of psychiatric and other patients and the human experiments performed by Nazi doctors [20]. Scientific medicine, powerful in action, considered human beings as objects and not as subjects, thus depriving them of the right to be responsible of their own health and destiny [21].

The main idea was repeated in different forms. Its best summary is probably the assertion that the task of von Weizsäcker, culminating the effort of the Heidelberg School, was the introduction (or re-introduction) of the subject into biology and medicine. This formula reflects the notion that beyond pure objectivity and without falling into the isolation of pure subjectivity there is a realm, sometimes called

interjective, which conceives of human individuals as part of larger units: dyad, work in common, successful dialogue or psychotherapy, group, family, profession, institution, nation. It also considers the whole of human life, as in one's own biography or the common history of groups and friends. Precisely where it might appear that the individual disappears the basis of the human person can be found. This is paradigmatically illustrated in Christian's concept of bipersonality and its applications in rehabilitation and treatment.

The Heidelberg School vs. American bioethics

no more discrepant scenarios could apparently be found than those of the Heidelberg School's *medizinische Anthropologie* and the bioethics movement of the United States. The latter Originated in an affluent society which suddenly realized that considerable harms to people could be done in the name of medicine and science and that instead of being a monolithic social body it was composed by a mosaic of diverging interests: minorities, special groups, professional groups, all striving for hegemony and far from the idea of a unified community with shared visions of the good and the just. It was kindled by the need to bridge the gap between conflicting visions of reality, that of the natural sciences and that of the sciences of man. Van Rensselaer Potter [22] who is usually credited with having introduced the term bioethics proposed a discipline that could bring together the knowledge of natural science with moral wisdom and did not want to see it confined to the medical field. Previously, moral theologians had examined the way medical practice was being conducted and rejected some of the forms it took in American society. In addition, by the sheer pressure of technological development, *de facto* some participation of lay people had been accepted. The first committee to decide on medical treatments on no-medical grounds was apparently convened in Seattle, Washington, with occasion of the development of artificial hemodyalisis. As a new treatment modality offering hopes to previously condemned people, the demand was beyond the possibilities of treating all the cases and some decision had to be taken. The lay people committee met with doctors and health care professionals and established what probably was the first ethics committee in a medical institution.

These developments, along with the realization that some practices within the field of medicine could not withstand a trial when considered from a humane point of view, led to the appointment of a Congress Commission and later of a President's Commission to set up a set of standards for human research in medicine and the behavioral sciences. The protection of the subjects was to be achieved by establishing several principles as aid to moral decision-making [23). The Belmont report,

summarizing some of the main conclusions derived from the proceedings of that commission, ended up with a more or less systematic approach to a field that rapidly grew and established itself as a discipline. It received press coverage and dealt with cases which attracted public attention, such as those related to death and dying and to reproductive health.

By contrast, *medizinische Anthropologie* remained confined to the medical sphere, its proposals were largely ignored and its humanly stance was contradicted by the very medical establishment which it set out to renew. Confronted with the physicians' trial in Nürenberg, Viktor von Weizsäcker wrote a valuable document in which he contends that not only were they personally responsible for what had happened but the spirit of natural-scientific medicine was guilty as well for not providing them deterrents to cruel and inhuman behavior [16]. The trial in Nürenberg became a milestone for a tradition which antedated it and for one which followed it.

No attempt is made here at characterizing the many strands and special varieties of bioethics. Only major features of the movement and the discipline as presented in standard reference works are considered for the analysis [24]. Selected topics dealt with by the Heidelberg School may be fruitfully integrated to a current bioethical thinking.

Both traditions seem to have in common an interdisciplinary character, expressed rhetorically in the trespassing of boundaries. The psychological and the human sciences had their place along with medical facts in the writings of the Heidelberg School. The social and moral considerations are considered *vis-a-vis* purely technical facts in bioethics literature.

A second major similarity is the *practical intention* of both attempts, The theoretical character of some works of the Heidelberg School notwithstanding, effort was directed towards anchoring the ideas on practice and bringing objective facts closer to human experience. American bioethics had from the beginning a tool-like character in the formulation and solution of moral dilemmas arising in the practice of basic biological research and medicine.

In both attempts a clear conflation between principles and cases is readily seen. It was perhaps the inability of traditional ethics to deal with the particulars what rendered it insufficient for tackling the problems posed by new advances in the biological and medical sciences. The practical emphasis came from an application of Simple principles to cases attempting not to remain abstract and detached. German scientific medicine appeared neutral and value-free when facing the demands of political power precisely because its-practitioners considered ethics an abstract set of norms. Von Weizsäcker found guilty a medical science which considers human

beings as objects only and does not address their need for explanation, comfort and human closeness.

Both attempts bear witness to the Goethean sentence that art, science, morals and religion are fused at the beginning and at the end, with transitory divergences in institutionalization in the middle. In this regard, both the bioethics movement and *medizinische Anthropologie* embody ambivalence regarding a value-free scientific enterprise.

The idea of total neutrality of science and the maxim of doing everything that is doable, irrespective of its legitimacy, is present from the nineteenth century onwards and as a literary motif can be found in Mary Shelley's Frankenstein [25]. In the novel, scientific production (in this case, an "artificial" human being), not being evil in itself, is corrupted by society and turns against its creator. Walton, who saves Frankenstein's life, is advised not to pursue a scientific career for the dangers it entails to society and to himself. Both in Germany and the United States, the predominant image of the scientist in the popular press has been that of a person devoted to scientific work, irrespective of its consequences. This may help explain the ambivalence with which the whole scientific enterprise is viewed by the lay public and the stance adopted by critical discourse. The pervasive feeling is that human life and welfare cannot be left to specialists without some form of social control.

The perusal of selected texts of German *medizinische Anthropologie* shows that some concepts may be incorporated to bioethical thinking. Essential motives and motivations are similar into both traditions, albeit differently expressed and with a different impact on society. For those aspects of American bioethics dealing with medicine, an examination of *Medizinische Anthropologie* might be appropriate.

Medical ethics in the work of Viktor von Weizsäcker

medical ethics appears frequently in the writings of Viktor von Weizsäcker. In a statement about the origins of the moral dimension, von Weizsäcker alludes to psychology, and calls psychoanalysis a "moral science" (7/372) [26]. He seems to favour situationism and a certain degree of relativism when he asserts that a general medical ethics does not exist (7/93) because the very idea of medicine is not unitary. Hippocrates is no longer a guide (7/121), as many other all-embracing and general rules of conduct." ... the moral norm manifests its real significance when it is expressed in the relation between two persons, without this it remains an unessential appearance"(5/87). We use to consider ethical norms "under the influence of

idealistic philosophy as something dissociable from the human persons"(5/71). The appropriate *locus* of moral certitude must be the encounter between patient and doctor. Both may be said to be constituted in it, sharing as partners tasks, burdens and responsibilities of life. Solidarity and reciprocity are to be construed as significant foundations of medicine.

When it comes to the foundation of those imperatives which could be called moral, by which people behave in civilized ways, von Weizsäcker refers in the first place to the *Vitalbindungen*, that is, those biological relationships which tie together the members of a family or a group. For the word to be a socially effective tool in the moral sense, *attachments* are a precondition. They do not possess in and by, themselves a moral character (5/84) but constitute the foundation for its development, provided they are adequately transformed during lifetime. To be effective moral norms have to be grounded on attraction but at the same time are related to hostility and repulsion. Other derived *Vitalbindungen*, like those represented by fear, shame or custom, may also help to establish obligations in a moral sense.

When von Weizsäcker traces back the origin of moral consciousness to the *Vitalbindungen* within the family first and then to the sentiments and feelings arising in social life, he is referring to sharing motives and expectations and the constitution of a community of moral friends [27]. The efficacy of the word as the locus of moral norm and action is not only dependent upon a common language but also common beliefs and the general acceptance that certain principles do exist and possess authority. Von Weizsäcker believes that Christian faith may be a powerful force shaping community *ethos* and thus providing the foundation for a consensually grounded medical science. Health is in some mysterious way related to truth and the real characterization of a person and does not reside in its being normal but in its being truthful (8/143). Science is, however, the only means to convert intuitive certainties into objective certitudes (8/143) but it is regretful that the foundational sciences of medicine lack moral and personal contents to command respect and prevent misuse or abuse of knowledge. Today, being more apart then ever.

Psychotherapy and psychoanalysis should be considered against this background. Von Weizsäcker saw them as means for guiding and accompanying persons in their search for truth and eternal life rather than as a therapy comparable to those employed by somatic medicine. However, for the word to be effective in psychotherapy either the *Vitalbindungen* have to be reconstructed (transference) or else feelings and sentiments (fear, shame. and habit) have to be employed. At about the same time, in 1929, Hans Prinzhorn wrote an interesting statement on the

efficacy of psychotherapy: "*Als unlösbares Problem aller Einwirkung von Mensch zu Mensch schwebt auch über dem Psychotherapeuten die Frage: im Namen welcher Instanz geschieht dies? Nur geschlossene kulturelle Gemeinschaften kirchlicher, staatlicher, parteipolitischer Art haben darauf eine feste Antwort. Die Entpersönlichung -Vorbedingung zur Lösung einer Übertragung- kann nur bei Berufung auf eine höhere Macht gelingen, in deren Namen der Therapeut handelt*"[1] [28]. The strength of shared convictions is missing in the practice of medicine and that difficults the effectiveness of the healing and comforting word.

The profession of medicine is determined by science, humanity and belief (*Wissenschaft, Humanität, Glaube*) (5/11) All these are, however, external definitions and determinations. Virtues like charity are imposed to medicine from the outside. Medicine does not have its own theory of the sick person and by consequence lacks a proper way to prevent its abuse or misuse. What happens in medical practice cannot be legitimized by abstractions and is not reducible to mere intuition. Medicine starts with the need of someone and continues with a question. As it is usually practiced the "I "(I am sick) is turned into an "if (es) : is it the lung? the heart, the stomach? Medicine tries to cope with the demands of sick people by means of fragmentation. The number of specialties grows not only because the epistemic base expands and more complicated methods of exploration appear. Although this is true, positivistic medicine multiplies the specialties because it finds no response to the challenge represented by the simple assertion: I am sick.

Von Weizsäcker observes that comprehending what is meant by "I am sick" without training to do so means that concrete experience precedes theory-building in medicine. He warns against psychologizing the medical encounter, for psychology like surgery or pharmacology is just a means and not an end. Nevertheless, psychological understanding (in a wide sense) is at the center of the relationship between the doctor, the patient and the disease, the famous Hipochratic triad. What constitutes the doctor-patient dyad is neither pure objective knowledge nor simple subjective impression. For describing it, a neologism is used: comprehension and understanding of Someone is transjektive knowledge (5/20).

Viktor von Weizsäcker falls short of proposing a procedural foundation for a moral in medicine. He rejects the neutrality accorded to objective facts by a critical science which sees the morality of actions not in themselves but in the way knowledge is

[1] Exposure from person to person also hovers the question above the psychotherapists: in the name of what authority does this happen? Only closed cultural communities of church, state, political party have a firm answer. The depersonalization - precondition for solving a transmission components can only succeed when relying on a higher power, in whose name the therapist acts

acquired. *How* would be more important than *what*, a position the author seems to reject (5/14). What is objective is not yet real (5/16).

Solidarity and reciprocity

viktor von Weizsäcker places a particular emphasis on the concepts of solidarity and reciprocity when giving a fundament to medical actions. It is obvious that he refers to an *association* between the *doctor* and the *patient*, although reciprocity is not equality and solidarity sometimes must be enforced. Both concepts are discussed within a theory of the person, comprising *Umgang*,

Gegenseitigkeit and Solidarität. Solidarity could be considered a modern form of sacrifice (7/102), which contains a powerful dialectical principle leading to the notion of solidarity in a secular context.

Reciprocity indicates a good *Umgang* and its origins can be traced to religions and to social situations where people come together. It is "*die Logik des Umgangs*" (7/364), a logic different from that of the objective sciences. Reciprocity should be considered "the" logical foundation of human medicine. The person needing help and the helper are on the same level, both are human beings in need of mutual support. If they agree, one of them may be accorded a restricted superiority in some aspects of the relationship.[2]

The idea of reciprocity should be related to the work of Christian on "bipersonality" (Bipersonalität). Christian starts off from the assumption that some realities do not find expression within the boundaries of individuals but in the relationship between persons, where they are constituted. Some diseases can be located in the three-dimensional space within the body, others in the multidimensional social space; its paradigmatic form is the bipersonal dyad, but can be "strategically" expanded when more actors organize themselves to attain a goal. Reciprocity does not always entail equal effort or contribution from the participants in an encounter. Experiments in which a handicapped works with a normal person show that they adapt themselves to each other; the contribution of each to the whole is not discernible. The new reality created is not the addition of individual contributions. It is not a distributive with, quantitative result but a new product, that of a bipersonal action.

This finding derives from the fact that each human being is not first an individual and then member of a group. He or she is simultaneously member of a group and a

[2] Much later the anthropologist Byron Good will analyse this relationship with the critical weberian stance that doctors poses the soteriological power. The question is do they know how to use it in a moral way?

conceived individual. One is always a father of a son, a student of a teacher, a brother or sister of-a sister or brother, a member of a certain group of people. The different identities do not exhaust the whole meaning of the person, which is in fact inexhaustible. But it can be asserted that each one is co-constituted by the others, co-determined by the relationships, be they biological, cultural, social or otherwise. This notion resembles Durkheim idea of *homo duplex* and has profound implications for the practice of helping professions. Fabrega [29] suggests an evolutionary basis for altruistic behaviors, particularly for those related to the care of the ill and the response to *infirmitas*, and disease that is the base of any appeal of helping others. Need, von Weizsäcker notes, is of the very essence of illness (5/13) and should build the foundation of any general theory of medicine. *ReCiprocity* is thus not a principle imposed from the outside but one developed from caring and curing within medicine. The institutionalization of this action-based description, its elevation to the rank of constituting an idea, is the starting point of a crucial disciplinary matrix for medicine. "*In the beginning was the Taf*", wrote Goethe. In the constituting actions of the encounter and of *Umgang* the "truth" of the human condition appears, and truth is also health.

The Heidelberg School transformed the epistemic demand for rigor and objectivity of the object sciences into an ethical imperative: solidarity and reciprocity are the basis of healing and helping. The objective is not, and cannot be, the real, because those sciences which appear as the foundations of medicine constitute a discourse about medicine but not medicine Itself. The divorce between formal knowledge of biological and physicochemical particulars and its application -human and social affairs- is in no other disciplineIn no other discipline is the divorce between formal knowledge of biological and physico-chemical particulars, as well as its application to human and social affairs as profound as in positivistic medicine. In extreme cases it may be said that that form of knowledge is partly irrelevant to the pursuits of the physician.

In one of his articles von Weizsäcker recounts the story of the peasant who goes to the "doctor"('Krankengeschichte", 5/48). The doctor is someone who knows. The peasant does not want to be cured when he first goes to see him. He wants to know. As we noted above, the scientifically trained/oriented doctor does not reflect upon the amazing fact that he can understand the other saying "I am sick". Who is sick? Certainly not the tissues, the cells or the organs. Someone beyond cells, tissues, and organs, somebody who owns them and can say "I". But the doctor is not a doctor, he is a physician. He converts that "I" into "i" he knows about". He knows about cells. tissues, and organs and little about persons. He turns to the familiar realm of his objective knowledge and converts the I into many "its": is it the lung, the heart,

the gut? What can we learn about metabolism? What about the lipids? All these questions are fine, but they do not answer the primary question of the peasant nor resolve his need. His need is first *to know* and then to eliminate those sensations he feels and the malaise which has made prey of him.[3]

Solidarity, reciprocity, bipersonality are means of constructing dyadic, triadic or multiple relationships appropriate to the actual circumstance and to the need without bypassing or ignoring it. The very first lesson professionals should leam is how to establish and mould the relationship appropriate to each situation. Everybody enters into relationships with others, everyone is made up of his o her relations. But only a well-trained helper or caregiver can have the tact, the *prudentia*, the *phronesis* to decide which type of dialogue, which kind of question, which mode of the relationship should be adopted. The superiority of his training and the value of his experience are tested in this praxis. He cannot resort to rules without letting the other decide whether or not they apply. Even less advisable is to moralize without charity or comprehension. People do not need compassion, they need professional help, and this is not always or solely provided through formal knowledge of biology and physiology. It is what really satisfies the need. To identify this need, to work through it, to respond to it are the real professional duties of a caregiver. The interests of the patient are best served if the medical encounter is shaped by solidarity and reciprocity and serves the transcendent goals of medicine.

Von Weizsäcker is aware that solidarity cannot be limited to the doctor-patient dyad; there is a social dimension to it. The larger society may demand sacrifices, as in war or adversity. The social context may impose some limitations on the practice of medicine. Recognizing these influences, von Weizsäcker comes close to recognizing at least two forms of solidarity: the horizontal, which binds individuals to each other, and the vertical, which ties them to a suprapersonal authority. This is evident in his essay on *euthanasia and human experiments* and in his other writings on social medicine. He might have accepted that the discretionary powers of the profession be reduced or be subjected to non-medical authority under certain conditions. He refers to this dilemma as an unsolvable one (7/131), making it necessary to elect the lesser of two evils.

Medicine is a science of actions; its quality does not reside in the objects with which it works or commodities it may produce, but in the way it brings about its constituting actions [30]. Reciprocity and solidarity are constituents of the bipersonal or multipersonal field in which good and bad medicines are practiced. *Handlungswissenschaften* or praxiologies do not produce goods or objects (*poiesis*),

[3] In the reality of interpretive medical anhtopology these dilemmas are analyzed bc, for instance good

they realize human actions in their qualities [31]. These are the reality-defining properties of acts: praxis can be instrumental or teleological; when attempting to produce an outcome; strategic, when involving concerned persons; dramaturgical, if it aims at representation, normative if it follows norms, and communicative if it occurs in the symbolic milieu of language and refers to a reciprocal interaction of two equivalent moral agents [32]. Von Weizsäcker may have subscribed the notion that medicine is based on a communicative praxis.

A historical test: the Nürenberg trial

one decisive event in the history of medicinde in the xxth century was the Nürenberg trial the Nazi doctors. The resulting code established principles for conducting scientific research with human subjects. Extensively studied and reelaborated in different contexts, it has affected the medical and legal professions. Its moral authority has influenced research and practice, especially regarding voluntary and informed consent. Although it may be argued that the principle of autonomy existed in medical European tradition before Nürenberg, it was certainly this trial which made it explicit and essential.

The doctors' trial and its outcome challenge the assumptions of *medizinische Anthropologie* and contemporary bioethics in several aspects.

The moral compromise of the medical profession with power during the Third Reich can be seen as a failure on the part of the humane medicine of the Heidelberg School to influence Germany's medical establishment. This was acknowledged by von Weizsäcker himself in his 1947 statement written as a reaction to the trial.

In this paper, Weizsäcker confronts himself with "so called euthanasia". He differentiates the Nazi practices from the accepted history of the term euthanasia as *ars bene moriendi* and divided into *euthanasia exterior* and *euthanasia interior* by Francis Bacon. He does not elaborate on the racial extermination but refers instead to the killing of incurable mental patients and to the experiments on human subjects, issues which he sees corelated.

After establishing that "a medical point of view" does not exist as such, he goes on to ask which might be the bases for proposing extermination of human life and he discusses three reasons: life unworthy of being lived, compassion, and sacrifice.

The notion of *unworthy life* was not a strange argument in pre-war Europe. Several countries enforced involuntary sterilization of incurable psychiatric patients. Binding and Hache, a lawyer and a psychiatrist, published a book in which they

pleaded for a humane elimination of those whose sufferings were unbereable or who were seen as leading an inhuman life [33]. A motif was the dignity of human life. Weizsäcker discusses the notion and observes that the whole of medicine is dedicated in fact to eliminating life that is unworthy, but not human persons as such. He adds that medical science, based exclusively on objective sciences cannot provide a control for not conceiving humans also as mere objects. He contends that unworthiness cannot be based soley on objective considerations but that human life should be viewed in relation to the trascendence it may achieve.

Compassion is not a medical argument for positivistic medicine and it is imposed from the outside. It does not serve to exculpate anyone.

Examining the notion of sacrifice, however, von Weizsäcker observes that this is a concept with such an appeal of dangerousness that it results in Nazi Germany may have derived from it. It combines the ideas of salvation and death and it is found frequently in the literature. Medicine sacrifices all the time: a limb that has to be amputated, a newborn with malformation who dies, a risk assumed because there is no choice, all these may be said to be sacrifices. The idea may find a place in an anthropological conception of medicine but not in the way the Nazis applied it. In order for sacrifice to be acceptable it has to be assumed personally and responsibly, that is to say, in solidarity and reciprocity. The locus of moral certitude is in the relationship between human beings.[4]

About the trial itself von Weizsäcker affirms that it is not only a trial of some people who may have gone beyond what is acceptable. It is also a trial of the whole foundation of medicine as a value-free scientific enteprise. It is, as Mitscherlich would put it, *Medizin ohne Menschlichkeit*, medicine without humanity. To legislate is correct, but isolated from the social context may lead to a legalism without equity or fairness and to a moralism without charity or concrete appeal. Natural-scientific medicine shows the clash between moral goodness (*honestas*) and advantage (*utilitas*), as presented by Cicero (*De Officiis*, book III, translated as *On Duties*).

With the principles of solidarity and reciprocity von Weizsäcker manifests that, essentially. What medicine is all about is not only scientific truth but ethical imperative. They become manifest in the encounter and in the relation and are essential for the establishment of a truly human medicine.

[4] Although, if anthropology is analyzed in the historical context of the Third Reich, it was physical anthropology (athropometry) that was the founding ground of much of medical evil. To this day (American) biology anthropologists remain uncosious of this fact.

Concluding remarks: a research agenda

sharing the ambivalence towards value-free science and placing the locus of moral certitude in concrete encounters and relations rather than in abstract principles, both *Medizinische Anthropologie* and the *bioethics* movement are characterized by a rhetoric of transgresion that crosses over the established boundaries of disciplines and professions and by basing their contributions on concrete proposals for the practice of medicine. The differ in context, content, and methods.

The historical context is different. One is Germany before, during and after World War II, the other the United States in the sixties and seventies. The medical enterprise ended with a few principles and some rules for conducting encounters, grounded in physiology and philosophy. The *bioethics* movement became institutionalized as a tool for ethical decision-making. Based on principialism it cannot, through the principles themselves, support their relevance, nor can it establish a hierarchy of principles. It may be said that an ethics of maxima is based on the principles of beneficence and autonomy, of the minima on non-maleficence and justice. The latter entails prohibitions, the former admonitions. A new casuitry has been developed in ethics committees and ethical review boards which might be expanded with the principles of solidarity and reciprocity, and the realization of the *Drehtürprinzip* and the *Gestaitkreis* as practical depictions of real life. Medicine is and remains a science of actions rather than objects and has to develop its ethics from within, abandoning the notion that value-free objectivity is an asset for helping professions. Its disciplinary matrix should be contextual, situational, action-based and action-directed from its very inception.

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NOTES AND REFERENCES

1 Lolas, F. *La perspectiva psicosom6tica en medicina*, 2nd edition. Ed. Universitaria, Santiago de Chile, 1995.

2 This incomplete quotation belongs to a text which the poet sent along with a letter to C.E. Schubarth on April 21't, 1819.

3 Christian, P. *Anthropologische Medizin*. Springer, Heidelberg, 1989 (Spanish translation *Medicina antropológica*, Universitaria, Santiago de Chile, 1997).

4 Lolas, F. Patología teórica y antropología médica. *Acta psiquiat. Psicol. Amer. Lat*. (Buenos Aires) 34:41-46.

5 Lain Entralgo, P. *Heilkunde in geschichtlicher Entscheidung*. Muller, Salzburg, 1950. See also Kutemeyer, M. Anthropologische Medizin oder die Entstehung einer neuen Wissenschaft. Zur Geschichte der Heidelberger Schule. Inauguraldisertation, MD Thesis, University at Heidelberg, 1973.

6 Kraus, F. *Die allgemeine und spezielle Pathologie der Person. Klinische Syzygiologie*. Thieme, Leipzig, 1926

7 Ct. Christian, P. *Das Personversttändnis im modernen medizinischen Denken*. Mohr, Tubingen, 1952.

8 'Krankheiten existieren nicht, wir kennen nur kranke Menschen', in von Krehl, l. *Pathologische Physiologie*, Vogel, Leipzig, 1923 (1 th edition, p. 2)

9 Particularly, Schweninger, E. & Groddeck, G. , 1898. This quotation is taken from volume 7 of the *Gesammelte Schriften* of Viktor von Weizsacker, edited by Peter Achilles et aI., Suhrkamp, Frankfurt/M. 1987, p. 405.

10 Cf. *Meines Lebens hauptsächliches Bemuhen* (1955) In *Gesammelte Schriften* (edited by Achilles, P., Janz, D., Schrenk, M. and von Weizsacker, C.F.I, vol 7., pp.372-392, p.374.

11 von Weizsäcker, V. *Der Gestaltkreis -Theorie der Einheit von Wahrnehmen und Bewegen*, 4th edition. Thieme, Stuttgart, 1950.

12 Halliday, J.L. *Psychosocial Medicine*. Norton, New York, 1948.

13 Lolas, F. *La perspectiva psicosomatica en medicina*. 2ª. ed. Editorial Universitaria, Santiago, 1995.

14 Bräutigam, W., and Christian, P. *Psychosomatische Medizin*. 4th ed., Thieme, Stuttgart, 1986

15 Christian, P., Haas, R. *Wesen und Formen der Bipersonalität*. Beitrage aus der Allgemeinen Medizin, Enke, Stuttgart, 1949.

16 Christian, P. *Moderne Handlungstheorien und der 'Gestaltkreis'*. Praxis Psychother. Psychosom. 31 :78-86, 1986.

17 Hahn, P. *Ärztliche Propädeutik*. Springer, Heidelberg, 1988.

18 Hartmann, F. *Ärztliche Anthropologie*. Schneider, Bremen, 1973

19 *Die Grundlagen der Medizin* (1944) In: *Gesammelte Schriften* vol 7, pp.7-28, p.7

20 Von Weizsacker, V. *"Euthanasie" und Menschenversuch*e (19471 In: *Gesammelte Schriften* vol. 7, pp.91-134.

21 The notion of responsibility, as employed by the Heidelberg School writers, should be studied on a comparative basis, acknowledging different notions of autonomy. The concept of solidarity, introduced through French language into English by 1848, means also "responsibleness" and is related to some form of obligation for people engaging in solidary action. A more careful study of the exact meaning of these terms would probably widen the scope of autonomy as it is usually considered.

22 Potter ,V. R., Bioethics: *Bridge to the Future* .Prentice-Hall, New Jersey, 1971.

23 Rothman, D.J. *Strangers at the Bedside: A History of how Law and Bioethics transformed medical Decision Making*. Basic Books, New York, 1991.

24 Beauchamp, T L and Childress J F *Principles of biomedical ethics* 4th edition, Oxford University Press, New York, 1994.

25 Ziolkowski, T. *Varieties of literary thematics*. Princeton University Press, N.J., 1983.

26 References to the works of Viktor von Weizsacker are made indicating the volume and the page of the *Gesammelte Schriften*, edited by Achilles, P., Janz, D., Schrenk, M. & von Weizsacker, C.F. and published by Suhrkamp, Frankfurt, 1987-1997.

27 Engelhardt, H.T. *Los fundamentos de la bioética*. Paidos, Barcelona, 1995.

28 Prinzhorn, H. *Psychotherapie. Voraussetzungen-Wesen-Grenzen. Ein Versuch zur Klarung der Grundlagen*. Thieme, Leipzig, 1929.

29 Fabrega, H. *Evolution of sickness and healing*. University of California Press, Berkeley and Los Angeles, 1997.

30 Lolas, F. Medical praxis: an interace between ethics, politics, and technology. *Social Science and Medicine* (Oxford) 39:1-5, 1994.

31 Lolas, F. Theoretical medicine: a proposal for reconceptualizing medicine as a science of actions. *The Journal of Medicine and Philosophy*. 21: 659-670, 1996

32 Habermas, J. *Theorie des kommunikativen Handelns*, 4th ed. Suhrkamp, Frankfurt/M., 1987 33 Binding, K. & Hoche, A. *Die Freigabe der Vernichtung lebensunwerten Lebens*. Meiner, Leipzig, 1920.

Fernando Lolas Stepke

Medicinska antropologija hajdelberške škole. Implikacije za bioetiku

SAŽETAK

Ovaj rad prikazuje dio misaonog okvira pokreta karakteriziranog kao antropološka medicina i medicinska antropologija koji je razvila hajdelberška škola. Temeljeći se uglavnom na radu Viktora von Weizsäckera i Paula Christiana pokušava se povezati osnovne pojmove solidarnosti i uzajamnosti s trenutnim američkim bioetičkim promišljanjem. Pozornost se posvećuje teškim povijesnim okolnostima medicine Trećeg Reicha i kritičkom ispitivanju njegovih značajnih oblika teorije i prakse prezentiranih na suđenju liječnicima u nirnberškom procesu 1947. Glavni zaključak je potreba za potpunijom rekonstrukcijom teorijske podloge spisa hajdelberške škole i temeljitije proučavanje njezine relevantnosti u suvremenoj humanističkoj znanosti medicine i bioetike.

Ključne riječi: hajdelberška škola, bioetika, reciprocitet, solidarnost, medicinska etika, njemačka medicina