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PHILOSOPHICAL ANALYSIS OF THE CONCEPT OF THE POLITIC PHYSICIAN

IN FRIEDRICH HOFFMANN'S *MEDICUS POLITICUS*

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PHILOSOPHICAL ANALYSIS OF

THE CONCEPT OF THE POLITIC PHYSICIAN IN FRIEDRICH HOFFMANN'S *MEDICUS POLITICUS*

by

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idea developed from previous research in the History of Medical Ethics and I am so very grateful that he shared his professional instincts about this project with me. He has also been my best professional support throughout the dissertation process and is responsible for the committee's teamwork in helping me complete the dissertation. Finally, he provided me some clinical experience by letting me accompany him on his "rounds" in Houston and sit in on some lectures at the medical school there. These first-hand experiences were very motivational. If Whitburn planted the seed, then McCullough nurtured the plant.

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Tasha deserve special mention. I also want to thank the multitude of family, friends, and well-wishers who prayed for me or encouraged me in their own way throughout the past few years. They are too legion to list.

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PREFACE

There has been little English-language research on the *Medicus Politicus* (The Politic Physician) (1738) of Friedrich Hoffmann (1660-1742). This is probably due to the fact that it has never been translated from Latin into English. Latin was the language of the intellectual community at the time of Hoffmann's tenure as head of the medical school at Halle. However, it was translated almost immediately into French, *La Politique du Médecin* (1751), and it was one of several important medical texts by Hoffmann for physicians in the eighteenth century.

The English-speaking *philosophy* community would not have been motivated to translate the work because the *Medicus Politicus* would have been seen as a medical and not a philosophical text. The English-speaking *medical* community, on the other hand, may not have seen a need to translate this work either. When the work was originally written, most of those in the medical profession would have been well versed in Latin. Later generations of the medical community, aware that much of the medicine of Hoffmann was subsequently better developed by others, might no longer see the work as relevant.

However, the current emergence of biomedical ethics as both an intellectual activity and a practical pursuit has caused a renewed interest in

searching for our *roots* in the history of medical ethics. Additionally, there is an interest to see if the past has any advice to inform contemporary medical ethical issues.

The recent work of McCullough (McCullough 1998) resulted in a strong case that Dr. John Gregory (1724-1773), who taught at the medical school at the University of Edinburgh in Scotland, is the father of modern medical ethics in the English-speaking world. However, McCullough, during his research in Scotland, found interesting references to Hoffmann and determined that this German[1] first professor of medicine at Halle may have had a greater influence on the development of medical ethics than has previously been determined by scholars.

Dr. McCullough initially brought this project to my attention and has encouraged me to research Hoffmann's contributions to medical ethics. This contextual analysis of the *Medicus Politicus* is the result of that encouragement.

The analysis is based on my own translation. I do not make any strong claim to a philologically-complete work. I used both the Latin (*Medicus Politicus*) and the French (*La Politique du Médecin*) versions in the translation process. My French was vetted in part by Dr. Michelle Broussard, McNeese State University, and Mrs. Veronick Desmarais. The portions of Part I of the original Latin used in

[1] At the time of Hoffmann's tenure at the University at Halle, Germany had not yet been formed as a nation and Halle was a territory of Brandenburg-Prussia.

the contextual analysis were vetted by Dr. Scott Goins, McNeese State University. The portions of Part III of the original Latin used in the contextual analysis were vetted in part by Dr. Leslie Dean-Jones, University of Texas, and Fr. Theophilus Herlong. The translations from the Latin of the *Commentarius de vita Friderici Hoffmanni* and the *Dissertatio Theologico-Medica de Officio Boni Theologi ex Idea Boni Medici* as found in the *Opera Omnia Physico-Medica* (1740 Edition) were graciously completed by Monsignor Vincent Fecher. Dr. Robert Forrest, Professor of History, McNeese State University, graciously reviewed the history of Brandenburg-Prussia and directed me towards excellent resources. Margaret B. Clark, D. Min., Teaching Chaplain, Spiritual Care and Cultural Services, University of Alberta and Stollery Children's Hospitals, whom I count both as a dear family friend and a professional advisor, provided keen insights on my research and gave great advice as I prepared for my oral defense.

Before any translating could be initiated, copies of both the Latin and French versions had to be obtained. This turned out to be a difficult process that lasted nearly two and one-half years. Getting copies of rare books is not research-friendly. However, along the way, I received good support from the following library professionals: Serita Oertling (The Truman G. Blocker, Jr. History of Medicine Collections, Moody Medical Library, The University of Texas Medical Branch at Galveston) and Elizabeth Borst White (McGovern Historical Collections and Research Center, Houston Academy of Medicine-Texas Medical Center Library). My daughter, Mireille Baril, is to be credited with breaking a long

stalemate with the National Library of Medicine in obtaining a copy of the French version. She found a sympathetic and devoted librarian there, Mrs. Crystal Smith, who cut through over two years of bureaucratic delays.

Although initially there was only a general hope that this research would provide a significant insight to the medical ethics of the period, I have become enthusiastic about the wealth of medical ethics that is actually contained in the *Medicus Politicus*. And, while much more research on the Hoffmann corpus is needed before any substantial claims can be made, initial indications are that Hoffmann's contributions are philosophically and clinically significant for the history of medical ethics and that much of his work may be applicable to contemporary medical ethics issues. There may be historical value of the *Medicus Politicus* for the general field of the history of medicine; especially, in the development of laws regulating the practice of medicine and in the development of medicine as a profession. Most significantly, the *Medicus Politicus* will require that historians will have to reevaluate claims that there was no significant medical ethics in Germany until late in the eighteenth century or even the early nineteenth century.

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A philosophical and scientific eclectic, Dr. Friedrich Hoffmann (1660-1742) brought together the wisdom of ancient writers with the new science and philosophy of his day. In the *Medicus Politicus* (The Politic Physician) (1738) he applied his concepts to medicine and medical ethics.

The *Medicus Politicus* contains the lecture notes of Hoffmann as first professor of medicine at the University of Halle. The work is divided into three parts: the personal characteristics required by the new politic physician; the physician's relationship with other members of the medical community (often competitors); and the patient-physician relationship.

This dissertation provides the first comprehensive English-language philosophical analysis and commentary on this work. It addresses two issues

found in the *Medicus Politicus*: Hoffmann's model for the new physician and the medical ethics required in the patient-physician relationship.

The political, intellectual and religious upheavals of the Long Eighteenth Century inform the work of Hoffmann. Physicians were not yet considered professionals and competed with the untrained. The new Hoffmannian physician would change that and would develop the personal qualities that were found in the professions of theology and law. Specifically, the Hoffmannian physician would be moral, rational and clinically competent.

Hoffmann provided two independent but harmonious foundations to justify these requirements: one theological and one rational. Specifically, Hoffmann was an enthusiastic Pietist, a Natural Law theorist and an evidence-based scientist.

His applied ethics is one of the most complete systems ever found in the medical clinical setting as it addresses each stage of the healing process. The focus of the patient-physician relationship is trust and trustworthiness. The physician is trustworthy when he is compassionate and competent. Patient and physician work together towards a mutual goal of the patient's healing. The judgments of both patient and physician are directed by prudence—seeking that which preserves society and individuals. This very mature concept of the ethics of the patient-physician relationship founded on trust and trustworthiness is the basis of modern concepts of *patient, fiduciary trust, medical ethics* and *medicine as a profession*.

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INTRODUCTION

By all accounts Dr. Friedrich Hoffmann was a popular professor of medicine both at the University of Jena and at the University at Halle. One way in which students showed respect for their favorite professors in Europe was to publish their lecture notes. In 1738, Hoffmann's students did just that. The work, the *Medicus Politicus*, enjoyed immediate success. It was not only widely distributed throughout Europe but was translated from its original Latin into French. However, unlike a number of his medical treatises, the *Medicus Politicus* has never been translated into English. As a result, subsequent generations of English-reading thinkers were not familiar with this important work. This dissertation is intended to fill part of this shortfall by introducing English-speaking readers to the portions of the *Medicus Politicus* (*MP*) that express the medical ethics contained in Hoffmann's lecture notes.

The *Medicus Politicus* shows that Hoffmann conducted a highly systematic and very comprehensive medical course which addressed the personal development of the physician, medicine *per se* (i.e., medical science and its clinical application), as well as the appropriate relations between the physician and his contemporaries and his patient. My dissertation will not address those items that are specifically medical in nature as these are beyond the scope of his medical ethics. Nor will it significantly address the practical and ethical relationship between the physician and his contemporaries. The foci of

the dissertation are the ethical character of the physician and the patient-physician relationship.

In putting forth his philosophical and clinical conception of the ethical physician, Hoffmann was responding to widespread and significant societal changes that were taking place during his lifetime. In fact, it would not be an overstatement to claim that nearly every aspect of society was undergoing drastic change or challenge: politics, religion, science, philosophy and university curricula. It is therefore necessary to begin this philosophical investigation of Hoffmann's medical ethics by setting it in its historical context.

In Chapter One, I identify and discuss the key elements of the historical context of the Long Eighteenth Century[1] in which Hoffmann developed his concept of the new physician. In politics, this period would be highlighted by the struggles between the loosely independent German territories and the Princes (eventually, Kings) in Prussia who ambitiously (and often violently) consolidated these territories under one rule.

[1] The concept of *the Long Eighteenth Century* is explained in more detail in Section 1.4 below. It is sometimes used interchangeably with the term *Enlightenment* or a significant portion thereof. For the purposes of this dissertation, the claim will be made that in Prussia, the concept of *the Long Eighteenth Century* can be associated with the period from the founding of the University of Halle (1694) until its decline with the founding of the University of Berlin (1810). A further refinement to this date might be argued in that the denouement occurred in the 1770's when all the universities were placed under the ministry of education. By the 1790's reforms were mandated to the course curricula. For the first time since the reforms instituted by Melanchthon in the sixteenth century, the universities had lost much of their academic freedom (Hochstrasser 2000, 190-1), thus hastening the end of the independent thinking and teaching aspects of the Enlightenment era.

However, to accomplish their goal, the Brandenburg Electors/Prussian Kings had to overpower the entrenched nobility and they also had to escape the power of the clergy. In the territory of Brandenburg-Prussia most of the universities were under the control of the orthodox Lutheran Church. The Brandenburg-Prussian Electors/Kings found an unusual but effective ally in the religious group known as Pietists.

In religion, much of this period is characterized not only by the conflict between orthodox religion and the state but also the struggle of religious authorities to retain control of the curricula of the university. Historically, the theology faculty was considered most important and they maintained control over the other faculties. However, various thinkers of the time were challenging this tradition. The eventual separation from religious control that took place at the university—for example, in the law faculty at Halle—followed into the community.

One appeal of the Pietists was its focus on the poorest members of society. The life of the people was difficult as most of them lived at the subsistence level—a result of the devastation of the Thirty Years War. The new physician envisaged by Hoffmann—himself a Pietist—was required to meet the needs of not only the state but also these poorest members of the civilian community.

It was not so much that the life of the physician was much better than that of the average citizen. In fact, the physician's position in the community was still economically, socially, and politically precarious: physicians had to compete with

non-physicians in the community—apothecaries, surgeons and barbers, midwives, other “irregular” practitioners, and, especially, self-care by the sick themselves. Physicians did not enjoy the social, economic and political advantages that they do now, so failure to compete successfully in this crowded, unregulated medical marketplace could well mean economic ruin. Additionally, the abuses committed by unregulated physicians and other medical care providers had led to a lack of trust on the part of the public. Hoffmann intended to re-build—create might be more accurate—that trust; in fact, much of Hoffmann’s concept of the patient-physician relationship in the *Medicus Politicus* centers on the concept of patient trust and physician trustworthiness.

There were also strong currents of intellectual change during this period: the concept of *enlightenment* was distinct in many respects in Prussia. While it felt the impact of the new Baconian, experienced-based science and new philosophies that challenged the traditionally and previously-unchallenged beliefs of the wise ancients, much of the intellectual debate was centered at the universities—the primary exception being the influence of the great thinker Gottfried Leibniz (1646-1716). The German territories were looking for a uniquely German solution to their problems.

The impact of the religious wars was especially felt in the German territories and the thinkers of the time were striving for a *universal* legal and philosophical approach. The philosophical system that was used extensively throughout this period is Natural Law. The impetus for the flourishing of Natural

Law is often attributed to Hugo Grotius (1583-1645), the Dutch jurist who founded a concept of international law based on Natural Law. In Germany, Samuel Pufendorf (1632-94) furthered the work of Grotius. His influence can be traced to the University at Halle where his strongest advocate, Christian Thomasius (1655-1728), taught.

One response to this ferment of change by the Brandenburg Prince was to establish a new, non-traditional university at Halle. By "non-traditional" I mean that the professors initially chosen for Halle were primarily Pietist activists who opposed the traditionally-organized Lutheran universities, such as those at Jena and Leyden. In the end, Halle became a microcosm of all the changes taking place in the German territories and ended up playing a significant role in the development of German thought and politics.

My second chapter is directed towards developing an understanding of Hoffmann and the *Medicus Politicus*. Having provided an analysis of the general historical context of Hoffmann's writings in Chapter One, in Chapter Two I will provide the reader with an insight into the author and his text. This includes a biography of the life of Hoffmann as both a physician and a professor of medicine. The *Medicus Politicus* was not the first Hoffmann work. On the contrary, he was a prolific writer and was a noted medical authority throughout Europe.

Chapter Two also examines his application of Natural Law to the clinical practice of medicine. This is important because one of Hoffmann's central rules

for a rational physician is that he must be a philosopher—specifically, a Natural Law philosopher.

Finally, this chapter takes a historical look at the *Medicus Politicus* and an outline of its major divisions. Because the *Medicus Politicus* was published by his students, we need to authenticate the basic concepts as being truly Hoffmannian. I do this by examining other Hoffmannian works for confirmation.

The third and fourth chapters are intended to be the philosophical focal point of the dissertation. These provide my philosophical account and analysis of the medical ethics of Dr. Hoffmann. One difficulty I encountered in analyzing the *Medicus Politicus* is that the ethics is sometimes intermingled with instructions to the students on medicine *per se*. Fortunately, there are also sections that are primarily ethical in nature and help us in understanding his other statements.

Chapter Three addresses the concept and development of a Hoffmannian physician. Hoffmann clearly is preparing his new physician for the new world that was emerging in the German territories. He shows considerable foresight in their preparation for the new and emerging reality of clinical practice.

A Hoffmannian physician would be prepared to have three primary characteristics: he would have to be morally strong, rationally skilled and clinically competent. In Chapter Three, I examine each of these characteristics separately.

Chapter Four focuses on the deployment of the concept of the politic physician in the clinical setting (*Medicus Politicus,* Part III). Hoffmann had a

thorough-going understanding of the patient-physician relationship and anticipates many modern concepts of the professional physician.

Two unique aspects of Hoffmann's system of medical ethics are emphasized. First, Hoffmann addresses every stage of development of the patient-physician relationship. And, second, Hoffmann addresses rules for both the physician *and* the patient, the latter becoming a distinctive feature of his medical ethics and crucial for understanding it, for example in his controversial account of deception (See Section 5.3). Hoffmann also has prudential rules to guide the physician when dealing with unusual patients/circumstances.

The fifth chapter deals with the significance of Hoffmann's contributions. It also draws the reader's attention to some underlying key themes developed in this work: the balanced power relationship between patient and physician and the concept of physician deception. I then apply the concepts of social contract theory to Hoffmann's approach. Social contract theory as a political philosophy had already been developing for some time and Hoffmann undoubtedly would have been familiar with social contract theory. I make no claim that Hoffmann was consciously writing a social contract theory for medicine; however, as I will argue, the social contract theory seems to fit well with Hoffmann's primary explanation of the patient-physician relationship. The Hoffmannian physician is the politic physician, a philosophically sophisticated and clinically nuanced concept that Hoffmann contributed to the history of medical ethics in his *Medicus Politicus*.

CHAPTER 1: THE HISTORICAL CONTEXT OF HOFFMANN'S *POLITIC PHYSICIAN*

In this chapter, the historical context of the *Medicus Politicus* will be developed to provide the reader with an understanding of the world that influenced Hoffmann. This understanding is important to the extent that it helps us to decipher both his written and unstated motivations and concerns when teaching medical students. While trying to remain true to the written word of the *Medicus Politicus*, understanding *why* he said what he said is both important in itself and because it helps us determine if there are any parallels with our contemporary situation. I will identify whenever I draw possible conclusions that extend past the material provided us by Hoffmann himself. For example, in the final chapter of this dissertation I draw the conclusion that Hoffmann may have had some form of social contract in mind when he was developing the ethical standards of the patient-physician relationship. While Hoffmann never uses this terminology directly in the *Medicus Politicus*, it was a concept well-known at the time of its writing.

There are five sections in this chapter describing five significant historical aspects of the period: the historic and political landscape (Section 1.1), the religious landscape (Section 1.2), the philosophical landscape (Section 1.3), the intellectual landscape (Section 1.4) and the university landscape (Section 1.5).

1.1 The Historic and Political Landscape in the Long Eighteenth Century in Brandenburg-Prussia

The greatest problem for the German territories in general and Brandenburg-Prussia in particular during its development in the seventeenth and eighteenth centuries was its lack of unity—territorially, politically and religiously. This problem, with roots going back through their separate histories, played a major role in the development of Enlightenment ideas and practices to include that of medicine.

Brandenburg itself had been established in 1356 as a Principality of the Holy Roman Empire. The house of Hohenzollern established their dynasty in 1417 with the acquisition of Brandenburg. The acquisition included the title of Elector of the Holy Roman Empire, which allowed them to vote for the Holy Roman Emperor. Further acquisitions were minimal until two centuries later when Hohenzollern inherited the Duchy of Prussia (East Prussia) in 1618 upon the death of Albert Frederick, a member of the Ansbach branch of the Hohenzollern family.

The Duchy of Prussia lay outside the Holy Roman Empire and had originally been established as a fief of the King of Poland in 1525. The Duchy was established as the first Protestant (Lutheran) state and had its capital in Königsberg (present day Kaliningrad, Russia). It remained under control of Poland (although ruled by a Hohenzollern prince) until the Treaty (Peace) of Oliva in 1660 when the Hohenzollerns of Brandenburg were given sovereignty

over the Duchy of Prussia. Many of the residents of Prussia opposed their new (Calvinist) rulers from Brandenburg and unsuccessfully appealed to the King of Poland to incorporate them into the Kingdom of Poland to which many felt a greater loyalty.

The sovereign of Brandenburg-Prussia had two primary titles. He was the Prince-Elector of Brandenburg and (actually, his highest title) was King in/of Prussia. However, the political center remained in Brandenburg and its capital of Berlin—a distance of over three hundred miles.

During the Thirty Years War (1618-48), Brandenburg-Prussia was a passive spectator and its territories were invaded by all sides; eventually, it was forced to allow Swedish forces to occupy its Prussian territories. (Carsten 1954) The French supported Brandenburg-Prussia in the territorial settlement at the end of the War and in 1648 Brandenburg-Prussia became the largest north-German principality, "second in size and rank within the Empire only to the Habsburg territories." (Carsten 1954, 177) However, the territory was so geographically separated that the prince had no real power and each territory was ruled by Electors and/or territorial noblemen.

Brandenburg-Prussia suffered terribly during the War. Its resources were depleted and it lacked any centralized power or sense of unity. Yet, the settlement that gave it more territories offered it some hope for the future. Brandenburg-Prussia started its road to recovery and centralization under Frederick William (1620-88) – often referred to as the Great Elector – who had

succeeded to his position as Elector in 1640 at the age of twenty and remained in power until his death in 1688.

It was the ambition of Elector Frederick William to unify the territories. He was not the only one vying for power. Within each territory there were struggles between electors and nobility, between town and country, and between nobility and burghers, creating an atmosphere of upheaval. Yet, struggle as they might among themselves, the combatants also wanted to retain their independent territories.

In 1688, Frederick III (1657-1713) became Elector of Brandenburg. He ruled from 1688-1713. He is said to not have exercised strong monarchical control. His goal was to consolidate the gains made by his predecessor through the establishment of administrative institutions to centralize power. (Dorwart 1953) The political confusion resulting from his weaknesses caused instability in power relationships and gave rise to the strength of the bureaucrats. (Rosenberg 1968) His successors would prove to be much stronger leaders.

This is not to say that Frederick III was totally unsuccessful in furthering the Hohenzollern aim of consolidating power under a monarch. Frederick used the financial woes of the remnants of the Holy Roman Empire in Europe to buy the limited title of “King in Prussia” in 1701. He took the title of King Frederick I. This was a major step toward political unity.

He also set in motion an act that would help the (Calvinist) Hohenzollerns separate themselves from the power of the Lutheran church. In 1694 he

established a University at Halle and appointed professors who were religious activists and who supported the concept of the head of state having power over the ecclesiastical elements of the church (see Section 1.2 below).

It would take two other Hohenzollern monarchs to complete the ambitious drive for unity: King Frederick William I (1688-1740) (ruled 1713-40) and King Frederick II (1712-88) (ruled 1740-88), who is better known as Frederick the Great. The drive initiated by Elector Frederick William and continued by his successors to create a monarchial autocracy would be successful under Frederick the Great when in 1772 the Duchy of Prussia was raised to a Kingdom. However, it would be almost a hundred years (1871) before the German Empire was declared. But in striving for this political and territorial unity the internal struggles would set back the development of a business or middle class and would drain the country of its assets to the point of poverty. (Carsten 1954)

The Hohenzollerns achieved their success by using an expensive and expansive standing military – the second largest on the Continent – to enforce their taxes and consolidations. Uprisings were common and the punishment for participants was quick and severe. Not even academia was spared the wrath of the Princes. Christian von Wolff (1679-1754), a professor at Halle with Hoffmann, was given 24 hours to leave the King's territory or be hanged. (See Section 1.4 below) No one, including Physicians, escaped the need to be political in this environment.

One of the developmental issues from which Brandenburg-Prussia suffered as a result of their power struggles was the lack of a significant middle class. In this way, it strongly differed from its European neighbors. In England the middle (business) class had wrested significant power from the aristocracy by the end of the seventeenth century and had become well integrated into the social and political fabric of the nation (Anchor 1967, ix). And while the middle class was growing in both France and Brandenburg-Prussia, the lack of a unified nation kept the middle class of Brandenburg-Prussia from attaining any power.

The poor were everywhere in Brandenburg-Prussia. The Thirty Years War had devastated the land. Invading troops often lived off the land and roving bands of mercenaries roamed the land long after the war was over. Even when agriculture resumed, the lower classes were often used as pawns in the political struggles. Additionally, East Prussia was devastated by a plague in 1709.

It should not be surprising that physicians experienced difficulty earning a living under such austere conditions. They had to compete for patients with surgeons (often barbers), apothecaries, midwives and an assortment of charlatans. They also competed with the sick, who engaged in self-diagnosis and self-treatment with home remedies, in an era before government regulation of pharmaceuticals. Just as there was no unified Prussia during this period, there was no unified medical association or guild, which should, in any case, not be equated to a profession.

Of all the Hohenzollern kings, it would take the drive and talents of Frederick William I to change the medical landscape in Prussia. He passed royal edicts that established minimum standards for everyone practicing medicine and he established the required bureaucracy needed to effectively administer these edicts. He was only able to do so with the help of University of Halle medical school and its leadership (see in Section 1.5 below).

1.2 The Historical Influence of the Role of *Religion* and the Concept of *God* in the Ethics of Medicine

One of the two appeals used by Hoffmann to justify his concept of the ideal physician is based on religion. In fact, the first rule of the *Medicus Politicus* [Part I, Chapter One, Rule One (PIC1R1)] and the first character requirement of the Hoffmannian physician is a religious requirement: The physician should be a Christian and live a Christian life.

The first aspect of that requirement is that a physician should be a Christian. It is interesting that the requirement to be a Christian is not more definitive (i.e, the physician should be a *Pietist*, a *Lutheran* or a *Protestant*.) However, given the recent history of religious conflicts in the German territories, it should not be surprising that a more generic appeal should be put forward. Hoffmann's contemporary, Leibniz, had gone so far as to attempt to reconcile the divisions in Christianity. The second aspect of the requirement is that a physician should live a Christian life. A Christian life means a life of Christian

virtues—specifically, compassion and humility. The life of the doctor was to be modeled after the life of Christ and would be something shared by all Christians.

The historic context of the relationship between medical ethics and religion is thus important to the philosophical interpretation of *Medicus Politicus.* I examine this relationship in three historical respects: first, the role played by religion or God in the ancient medical tradition; second, the role religion or God played in medical ethics in the Christian tradition; and, finally, the specific interpretation of medical ethics from the Pietist viewpoint.

1.2.1 The Role of *Religion* and the Concept of *God* in the History of the Ethics of Medicine—the *Ancient Tradition*

There are three historically significant factors in the role of religion and God in the Ancient tradition of medicine: first, the traditional role of God (the gods); second, the traditional role of the physician; and third, the physician's dilemma and its solution.

The first historically significant factor is the traditional role of God or the gods in the ancient world. A reading of the history of medical ethics clearly shows that virtually every ancient ethical system in history has a religious role model and is connected with a religious principle.

Early Greek mythological literature contains a strong medical element that included a religiously significant medical personage and a belief that the medical art was a gift from the gods. "… almost every god in the Greek pantheon, as well

as many demigods and heroes, seems to have had some association with illness and health." (Lyons and Petrucelli 1987, 165)

Apollo was the chief god associated with controlling disease. In legend, Asclepios was thought to be the son of Apollo. In the *Iliad* Asclepios is a warrior-king who had two sons, Machaon and Podalirios, who were knowledgeable in the healing arts. However, within two centuries Hesiod reports that Asclepios had become the principal god of healing. Many of his family members were also associated with medicine: his wife, Epione, soothed pain; his daughter Hygeia was a medical deity who eventually became identified with preventive medicine; Panacea, another daughter, was associated with treatment; and Telesphoros, his son who normally was seen with Asclepios, represented convalescence. (Lyons and Petrucelli 1987, 170)

Hippocrates, himself, was said to belong to a group of medical men who were followers of Asclepios. The medical code known as the Hippocratic Oath specifically identifies these gods as the models under which the doctor should place himself: "I swear by Apollo, Physician, and Asclepios and Hygeia and Panacea and all the gods and goddesses…."

In Egypt all deities were involved in some aspect of either health or illness. Ra, the sun-god, and Isis, a healing goddess, were the most powerful. Temples dedicated to the healing powers of Isis were prevalent throughout Egypt. Imohtep became the most important healing god in Egypt until the arrival of the

followers of Asclepios. In time the Egyptians combined these gods into Asclepios-Imhoutes. (Lyons and Petrucelli 1987, 82)

The second historically significant factor was that the physician or healer of ancient times had a dual role—both healer and holy man. This corresponded to the perceived dual nature of illness itself. Diseases were seen primarily as a result of the anger or punishment of the gods. Therefore, diagnosis centered on understanding what the person had done to upset the gods. And the treatment and cure included religious incantations. So as not to misrepresent the past, it should be added that the application of natural remedies was also important. Therefore, the natural remedy was normally administered by the holy healer as part of a ritual directed at appeasing the gods.

> In pre-Christian times the office of healer was most generally identified with that of priest. In Egypt and Mesopotamia, in India and in most of the Eastern cultures, and among the Germans and Celts, the task of physical healing was practiced by holy-men, who used a combination of empirico-rational and magico-supernatural methods. (Kelly 1979, 47)

In primitive cultures healers had different names: the medicine man (North American Indians) or shaman (Eskimos) or witch doctor (Congo). (Lyons and Petrucelli 1987, 31)

Egypt furnishes a common example of ancient religious-based treatment:

> In treatment itself, religio-magical gestures played a vital role. Accompanying the administration of drugs and mechanical procedures were incantations to drive out demons and supplications to the gods for protection from evil spirits. Amulets could ward off illnesses of most kinds, but serious mental disease required the exorcism of demons, often calling for the use of excrement. For snakebite, rituals were virtually the only therapy – in marked contrast to the management of snakebite in India,

> where sound, rational medical principles were combined with the supernatural. Nevertheless, in most other healing activities the Egyptians combined their religious rituals with an exceptional and varied array of vegetable, mineral, and animal drugs. (Lyons and Petrucelli 1987, 97)

In all of these cases there are several compatible themes. For instance, the art of medicine began with the gods. Initially, they are seen to heal each other. Eventually, the art is given to man as a gift. Finally, those associated with the knowledge of medicine are perceived to share in this divine knowledge; consequently, they become god-like themselves.

A third (and later) historically significant factor was the development of a dilemma for the healer. This dilemma in medicine during this early period was the result of the influence of rational pre-Socratic thinkers on medicine. Specifically, they viewed the world as rational and, thus, everything in nature was discoverable by a rational human. This led to a conflict with mythology and other misinterpretations of religion in that the gods were thought to be the direct source of illness and, thus, treatments. The primary medical ethics issue faced by the ancient physician-religious man was about the decision on diagnosing and treating the sick. What role, in fact, did the gods play as the source (and cure) of diseases? The ultimate ethical principle developed as a result of this moral dilemma was to make a distinction: the gods had given to man the rational capabilities to diagnose and treat the sick and disease was caused by and cured by natural remedies.

This solution to the dilemma is found in the Hippocratic texts. Hippocrates is generally regarded as the first physician in the Western tradition to distinguish between the role of the healer and the role of the priest. He also distinguishes between religious and natural causes of diseases. In this regard it may be said that he corrected errors in both theology and medicine by identifying the proper role of each. (Kelly 1979, 47-8)

His approach to medicine is rational and follows from original pre-Socratic thinkers who had separated themselves from mythology in much the same way. Pure imagination is replaced by observation and a new belief that there is a sufficient reason for each effect that is encountered in nature. For the Hippocratic physician medicine was a *technē*, an art or skill, and not an extension of imaginative theology.

> It was Hippocrates who first developed for Western man a rational approach to medical methodology, establishing medicine as a "technē," an art or skill based on the rational investigation of cause and effect, diagnosis and prescription. (Kelly 1979, 47)

The Greek physicians had separated their gods from the natural diseases. This might be interpreted that the gods no longer played any role in medicine; but that can't be true. As can be seen in the Hippocratic texts, the Hippocratic physician remained a religious believer as well as a healer. The Hippocratic Oath specifically requires the physician to swear by the gods of healing.

Also, throughout Greece there were many temples dedicated to Asclepios. Many had a special building for the ill, an *abaton*, where actual cures were

administered. These temples were popular healing places because they were open to all regardless of financial status. After all, the art of medicine was believed to have been a gift from the gods.

The ancient physicians had resolved the medical dilemma between the gods and nature in a harmonious manner. The effects (disease) were natural and so were the causes. The source of the 'gift" of medicine was the gods and it was a gift to be shared with all mankind. In medicine, there would be an appropriate distinction in the role played by the gods and nature but there would also be a harmony between them. The distinction was accomplished as an intra-religious reform. (Kelly 1979) For the Hippocratic physician, if there was a conflict between nature and God, then God prevailed: "according to a passage in the Hippocratic corpus, medicine because of its limited powers treats the gods "in most cases" with reverence." (Schleiner 2007)

1.2.2 The Role of *Religion* and the Concept of *God* in the History of the Ethics of Medicine—the *Christian Tradition*

The ethical crisis in medicine during the period of the Christian tradition was initiated by the transition from religious physicians (*medica clericalis*) to lay physicians. As a response to this crisis, literature on ethics in medicine during this transition focused on the appropriate behavior and duty of the lay physician as regards the sick.

Before the seventh century there was no unique ethics for medicine in the Christian tradition. The Roman model of physician was dominant. The uniquely Christian aspect was that the Christian physician of the time saw himself as imitating Christ and rendering service to his “neighbor”. Following the parable of the Good Samaritan, physicians saw all men as their neighbors and treated the poor for free. Near the end of this period some monasteries began caring for the sick and hospices were built to include some medical care. (Kelly 1979)

Within the Christian tradition, there has always been a history of associating Christ as healer of the body and soul with the physician. In this sense, Christian medical ethics is strongly linked to its moral theology. The history of this tradition is usually divided into three periods: the pre-Scholastic Period (seventh to twelfth century), the Scholastic Period (through the Council of Trent; ending 1563) and the Modern Period (up to the present time). (Kelly 1979, 14)

All intellectual activities of the pre-Scholastic period were theocentric—including medicine. By the seventh century there was a strong movement of priests and religious taking over the primary duties of the physician in society. Lay physicians became the exception. As a result, theology and medicine became intertwined—similar to that of the pre-Hippocratic era of the ancient period. This was a natural outcome of educational institutions being dominated by religious teachers. The religious community also required medical knowledge to carry on its missionary activities. (Kelly 1979, 50)

One significant change that occurred as a result of the transfer of medicine to the religious community was in the role of the physician. "Rather than an art, "technē", medical practice became an office, "officium", where the monk or priest practiced medicine as part of his religious duties." (Kelly 1979, 50)

Writings on ethics in medicine were religious in nature. One of the most significant events of the pre-Scholastic period (in terms of the history of medical ethics) may be the development of the *libri penitentiales*. While these were not strictly speaking "systems" of moral issues, they did provide the clergy with guides to helping the penitent. However, it was historically too early for this to develop into a systematized grouping of these issues under the concept of medical ethics *per se*. Most importantly, at this time there was no specific listing of sins peculiar to the office of the physician himself. (Kelly 1979, 19-20)

In the twelfth century, Alan of Lille (c. 1128 – 1202) wrote a treatise entitled *De virtutibus et de vitiis et de donis Spiritus Sancti* (c. 1160) in which he divides theology into two sub-disciplines: one rational and one moral. This may have been the first time the term *moral theology* was used [Vereecke 1967 (in Kelly 1979)]. After this time moral theology is seen as a separate discipline. Alan of Lille organized his treatise along the lines of the three theological virtues and the four cardinal moral virtues.

The scholastic period continued the theocentric approach to intellectual activities. Religious educators still taught at many universities and most universities required the study of moral theology.

The most significant change during this period was in the role of the physician. There was a gradual transition from religious to lay physicians. This transition, begun in the twelfth century, led to the end of the *medica clericalis*. The change was the result of several factors. First, the Church passed a number of decrees forbidding religious to practice medicine. Also, a medical school was open at Salerno which graduated lay physicians; eventually, other universities established a Faculty of Medicine. Lay physicians initially saw themselves as having a *vocation* to help the needy.

Medicine itself had become more scientific and rational. The scholastics had integrated Aristotelian philosophy into Christian theology. This led to the reintroduction of "technique" in medicine. "Now medical practice could shift back from an "office" (part of the duties of the clerical state) to an "art" (a scientific and rational endeavor which develops its own skills." (Kelly 1979, 52) Experiments in medicine were initiated during this period.

Literature on the ethics of medicine changed during this period to match the change in the role of the physician. On a practical level, the informal *libri penitentiales* are replaced by the more systematized *summae* as a guide for confessors. Two approaches were taken. The first was to organize the moral topics based on the moral virtues (as Alan of Lille had done) and the second was to organize them under the Decalogue. Both started to make reference to specific obligations for various vocations or states of life—although the physician

is not singled out until near the end of this period. Thus, the history of medical ethics in Christian texts will follow one of these two organizational patterns.

De-clericalization, however, is not the same as secularization. The lay medical model of the Roman period had already set a precedent for lay physicians. And the separation of the medical profession from the influence of the Church was a gradual one. However, as these changes occurred, the roles, duties and ethics of the physician and the physician-patient relationship needed to be redefined. Medicine was changing from a *vocation* to a *livelihood*.

This challenge was answered by Antoninus of Florence (1427 – 1459). As physicians relied less on moral guidance from the Church and the practice of medicine became a livelihood, physicians were left with common business morality as their primary alternatives. And it was to this moral gap that Antoninus was responding.

His work, *summa moralis* (1477) is the first significant work which places the physician in a separate category with unique responsibilities. Book Three specifically identifies the honors and the vices of physicians. The book starts with a short history of medicine, recalling Apollo, Asclepius, Hippocrates, Galen, Avicenna as well as the evangelist, Luke. "Antoninus compares the doctor's vocation to Christ's. His ethical guidance to physicians include:

> The doctor is urged to be knowledgeable in his field, to apply the best therapies, and to prefer commending the patient to God rather than harming him with doubtful remedies. He must visit the patient in person. The doctor sins gravely if he advises his patient to do anything against God's law, such as having sex with a woman outside of marriage, getting

> drunk, or ignoring the fast laws. He must not procure an abortion or advise the patient to do so in order to hide a woman's sin…. He must charge a just fee, must not drag out an illness in order to increase his fee, and must serve the poor for free…. He must not boast about his own achievements or scorn those of his colleagues. (Kelly 1979, 26)

His approach can be characterized as an attempt to re-link the ethics of practical medicine with the higher religious standard.

The modern era starts in the mid-sixteenth century. The *Summae* are replaced by the *institutiones morales* in the Jesuit education system. However, the one which has the most interest to this discussion is that written by the German theologian Hermann Busenbaum, S.J (1600 – 1668). The work entitled *Medulla theologiae moralis* (1648) was an instant success and had more than 50 printings (Kelly 1979). The organization of this work was followed by moral theologians through the middle of the twentieth century.

Most of the medico-moral questions in Busenbaum's work are spread throughout the work following the Decalogue organizational pattern. Most of these are aimed at individual members of society. However, under the heading of "Obligations of various states of life", he lists the duties of doctors, surgeons and pharmacists. (Kelly 1979, 36)

Two pre-Enlightenment works are important to the Christian Tradition. The first, *Quaestiones medico-legales*, was written by Paulo Zacchia. Zacchia is considered the forefather of pastoral medicine. (Kelly 1979) The work, started in

1621, has three volumes: medical-theological, medical-canonical, and medical-ethical. Its topics include many issues studied by modern medical ethics.

The second work of this period is by Michael Boudewyns. Boudewyns is considered the forefather of medical ethics in the Christian tradition. (Kelly 1979) His *Ventilabrum medico-theologicum* (1666) focused on the practice of medicine. He addresses "all cases concerning doctors and patients and others" applying the understanding of the Church fathers, scholastic principles and a safe conscience. The book was written for theologians, confessors and (especially) doctors. (Kelly 1979, 57-8) This is the first such attempt to unify and harmonize ethics in medicine from each standpoint.

Hoffman justifies his medical ethics on two grounds: theology and philosophy. In the former, his writings include much of the above from the history of the Christian tradition. For instance, as a general requirement, the physician is to use Christ as his model. In organizational approach he chose to base his ethics on Christian virtues – specifically compassion and humility. Many of the ethical issues addressed by his contempory, Boudewyns, can also be found in Hoffmann. But, whereas Boudewyns harmonized his ethical positions with theology, Hoffmann will add a second (harmonious) justification from philosophy.

1.2.3 The Role of *Religion* and the Concept of *God* in the History of the Ethics of Medicine—*Enthusiastic Religion*

The Pietist movement, generally referred to as *enthusiastic religion*, had three important theologians: Johann Arndt (1555-1621), Philip Jacob Spener (1653-1705) and August Hermann Francke (1663-1727).

Arndt is general accredited with being the initiator of the Lutheran Pietist movement. His work, *True Christianity*, focused on the Gospel requirement that we are to become new creatures. Arndt wrote that it is possible for humans to achieve this in our lifetime and we were to be guided by the Bible as to how to live our lives as Christians to become that new creation.

> As every seed produces fruit of a like nature, so the word of God must daily produce in us new spiritual fruits. If we are to become new creatures by faith, we must live in accordance with the new birth. In a word, Adam must die, and Christ must live, in us. It is not enough to know God's word; one must also practice it in a living, active manner. (Arndt 1979, 21)

Spener organized small group Bible studies in homes which he called *collegia pietatis*. The emphasis, as with Arndt, was on the faithful encouraging each other to actively live the Christian life. His primary work on religion was *Pious Wishes* (1675). It contained three parts, the first of which was a critique of clergy, state and laity. The complaint was that all emphasized the rituals but had not put Christ into their daily lives. The third part was a series of proposals to correct the problems that resulted from this shortcoming.

Two of these proposals capture two major themes of Pietism that are eventually found in the Pietism of Halle. Proposal 3 argues that Christian life should become a matter of the heart and of practice, rather than only a matter of knowledge.

Proposal 5 calls for a reform of schools and universities. Theological training should include training in piety as well as in biblical studies and formal theology. Professors were to expect their students to display a genuine practice of Christian faith as well as knowledge of theology.

The third key figure was Francke who developed Pietism and implemented Spener's proposals within a university setting. Francke was a Pietist activist at the University of Leipzig for which activism he was expelled in 1687. He was a friend of Spener and when the latter helped the Brandenburg Elector start a new university at Halle, Francke was given an assignment there. Eventually, Francke took over the most prestigious post, as head of the theology department. Francke was also responsible for getting positions at the university for other Pietists – such as Hoffmann.

The Pietist movement is clearer when compared to its Orthodox counterpoint:

> Lutheran Pietism, the movement with which Francke, as one of its central figures, was identified, should be briefly described. It was not sectarian; that is it never separated from the Lutheran church, as did more 'enthusiastic' groups. There was no dissension on central matters of belief. And yet there was a clear-cut antagonism, for the orthodox did not care for the revivalist activism. Pietism differed from Lutheran orthodoxy in that a fervent Christianity came first and other details of life – money, clothes, careers – came second. These beliefs made for an 'equality' before God, and aristocrats could be reminded of the fact. Pietism also represented a revival of Lutheran thought on the nature of man, a non-materialist emphasis (counter to solely empiricist mechanics), and it therefore influenced medical teaching at Halle. (Geyer-Kordesch 1985, 189)

In fact, much of the criticism of the Pietist movement was that it seemed to be a form of monasticism and re-introduced a Catholic element into Protestantism. (Gäbler 2004 4) The Pietists, in turn, accused the orthodox Lutherans of imitating the hierarchical structure and rituals of their Catholic predecessors.

Pietism in the northern German territories played a significant role in developing the Enlightenment of those regions and balancing its secularism. (See Section 1.3 below) Among the Enlightenment leaders of the eighteenth century, such notables as Hoffmann, Georg Ernst Stahl (1660-1734), Leibniz, and Kant (1724-1804) were all Pietists.

1.2.4 Hoffmann's Concept of the *Virtue of Compassion* in its Historical Context

The virtues that Hoffmann had in mind for the physician were derived more from the Christian tradition than from Aristotle directly. The virtue of *compassion* is the primary example of this difference.

In the *Rhetoric*, Aristotle defines *pity* as follows:[1]

> Pity may be defined as a feeling of pain caused by the sight of some evil, destructive or painful, which befalls one who does not deserve it, and which we might expect to befall ourselves or some friend of ours, and moreover to befall us soon. [*Rhetoric*, Book 11, Chapter 8; R.1385b12-16; trans. by W.D. Ross (quoted in Carr 1999, 414)]

To place this definition in its proper context, it is at the beginning of Aristotle's discussion of *emotions* in this work. He is observing how particular

[1] Many contemporary writers use the term *compassion* interchangeably with Aristotle's *pity*. [Nussbaum (1996), Carr (1999), Deigh (2004), Keaty (2005)].

emotions are aroused through rhetoric. There are three necessary elements needed by the rhetorician to arouse an emotion: first, the disposition of the mind of the person in whom you are trying to evoke the emotion; second, the kind of person toward whom someone will likely feel this emotion; and third, the occasion(s) that gives rise to the emotion.

In the case of the emotion of pity, the disposition of the mind is "a feeling of pain." Carr calls this the *affective* element of Aristotle (Carr 1999, 411). The type of person who might evoke such an emotion is someone who does not deserve "some evil, destructive or painful." The occasion is seeing such an evil befall such a person and identifying this as something that could befall us or our friends soon.

Noticeably missing in Aristotle's definition is any call for a response by the person affected by pity to relieve the suffering of the one in pain. Carr critiques Aristotle's definition on this point because it is purely self-centered.[2]

> The overall impression given by these passages is of an emotion which if fundamentally focused on the self. Again I do not mean that Aristotle is speaking of self-pity… in fact, he does not mention self-pity in this chapter

[2] Carr's critique is useful but has some limitations in that Aristotle's purpose was clearly limited to a discussion of evoking emotions. Emotions for Aristotle were a natural part of the irrational soul but were not harmful to man *per* se. It was what a rational man did with the emotions that made him virtuous or otherwise. For example, fear was an emotion and courage the appropriate response of the virtuous man. The problem undoubtedly stems from trying to equate Aristotelian *pity* with contemporary *compassion.* That Aristotle meant for *pity* to be purely an emotion and not a virtue is confirmed in the list of emotions found in the Nicomachean Ethics. However, a detailed response to Carr is beyond the limit of this paper.

> of the *Rhetoric*. In a sense, though, pity is still self-centered in that it is only felt towards those who are close to us (but not too close) and those who we see as very much like ourselves. We do not, on this account, feel pity for example for the Asians in Idi Amin's Uganda, and we do not feel pity for the street beggar who [sic] we do not personally know." (Carr 1999, 415)

In comparing Hoffmann's concept of *compassion* to Aristotle's concept of *pity*, we can start by examining the similarities. First, the initial state of mind of the moral agent for both is one of pain. Also, there is a sense in Hoffman that the victims of pain are undeserving in that they are victims of the misery of the general human condition which is constant in the state of nature. The body is weak and life is short. Hoffmann does not address issues of self-inflicted wounds or carelessness. We might have to assume that given his Christian and Natural Law perspectives of love that blameworthiness was not at issue for the physician. In fact, part of the physician's therapy was to bring to the attention of patients any condition brought about by their living out of harmony with the Natural Law (PIC1R5). Finally, the occasions that prompt pity or compassion are the same for both Aristotle and Hoffmann in a general sense. We find ourselves identifying with victims who suffer harms that we might anticipate ourselves.

However, the similarities exist only on the surface. In its depths, Hoffmann's *compassion* is a different account of the basis of the moral agent's response to the plight of others and the obligation to respond to that plight.

The appropriate *initial* emotional response for both Aristotle and Hoffmann is the same. The agent feels some sense of pain. However, Hoffmann goes

further than Aristotle by describing the appropriate (virtuous) response to such an emotion. That response is to act from a position of love for all human persons. This is both a Christian response and a Natural Law response (see my Chapter 3). The appropriate form of love, when dealing with such human misery, is compassion. Hoffmann shares Aristotle's teleological goal of human decision-making and action as *happiness*. For Hoffmann, though, there can be no happiness without recognizing our obligation to others. (PIC1R5)

The victims that evoked the emotion of *pity* for Aristotle were those who did not deserve such harms. This required the (moral) agent[3] to evaluate the situation each time. For Hoffmann, only a single evaluation was necessary. All men are mutually bound by the state of misery and by their social obligations. As such, compassion was to be the moral virtue of choice when dealing with any and every human victim of harm. Hoffmann emphasizes this to make sure the new physician will not forget to take care of the poorest and weakest members of society.

Finally, the occasions that aroused pity for an Aristotelian agent were those in which the agent could identify with the victim's harm. That is, the harm that the agent was observing was one that had a high degree of likelihood to befall the agent himself or his friends. Again, this required an individual

[3] I bracket "moral" agent for the sake of our discussion of Aristotle's concept of pity. If Aristotle is only describing an emotional state, then he never intended pity to be the prescriptive action of a moral agent but more appropriately a descriptive reaction of all humans under similar circumstances.

evaluation of each situation. For Hoffmann, the mutual state of human misery was sufficient to arrive at this decision for all humans; no particular identification of the physician with the particular circumstances or desert of the patient was required. The appropriate occasions were simply any in which a patient approached the physician for help. The appropriate response for the physician was to be available at all hours.

The most important distinction, however, was the issue of self-interest versus the interest of others. In Section 5.1, I consider Hoffmann's focus on a concept of shared interest in greater detail. What seems to mark Hoffmannian compassion as significantly different from Aristotle's views is the former's commitment to self-sacrifice over self-interest. What is important for this discussion is that the Hoffmannian physician was to share the health interest of the patient. That is, the health interest of the patient was not only prior to the physician's self-interest but actually became the physician's self-interest through an altruistic adoption of the patient's end as his own.

In Section 1.2.2 we saw that the Christian tradition going back to the earliest times had two themes which made them distinct from the Greco-Roman traditions. First, the Christian physician was to see all men as his "neighbor." Unlike Aristotle's limitation on having pity for those who don't deserve the harm and only when the harm can be seen as a threat to oneself or a friend, no such particular identification was required for Hoffmann. As a consequence, the Christian physician must view no one as a stranger but all as a neighbor.

Hoffmann would have embraced Terence's (c. 190 -158 BC) statement: *Homo sum; nihil humanum a me alienum puto* (I am a man; I think nothing human alien from me). Second, he was to use the model of Christ as the perfect healer. Hoffmann's *Medicus Politicus* captures both of these elements (see my Chapter 3 for a more detailed discussion).

Just as many contemporary writers[4] try to build a contemporary concept of *compassion* on the foundation of Aristotle's *pity*, Thomas Aquinas, in the *Summa Theologiae*, modifies his beloved Aristotle's concept of *pity* so that it corresponds to the theologically more appropriate response of the virtue of *mercy*. (Aquinas, ST, II-II.30) Hoffmann took a similar course in his time: Aristotle's concepts were important to understanding the emotion of encountering human misery but insufficient to ground an ethical theory of the appropriate (virtuous) human response of the physician to the plight of patients.

1.3 The Philosophical Landscape in the Long Eighteenth Century in Brandenburg-Prussia

The dominant philosophy that influenced the intellectual community in the German territories during this period was Natural Law Theory. The primary

[4] Much of the current discussion is a response to Martha Nussbaum's writings on comparison (cf "Compassion: the basic social emotion", *Social Philosophy and* Policy, vol. 13(1), 1996 and *Upheavals of Thought: The Intelligence of Emotions* Cambridge: Cambridge University Press, 2001). Among the many respondents, see Brian Carr, "Pity and Compassion as Social Virtues", Philosophy: Vol. 74, No. 289, 1999, 411-429; John Deigh, "Nussbaum's Account of Compassion", *Philosophy and Phenomenological Research*, Vol. LXVIII, No. 2, March 2004, 465-372; and Anthony Keaty, "The Christian Virtue of Mercy: Aquinas' Transformation of Aristotelian Pity", *HeyJ* XLVI (2005) 181-198.

(Continental) thinkers of Natural Law who influenced the course of philosophy in the German territories included Grotius, Pufendorf, Sturm, Thomasius, Leibniz and Wolff. However, another personage of importance during this period who had a lower profile was Erhard Weigel (1625-99). Weigel received his PhD in Philosophy at the University of Leipzig (1650) and taught at the University of Jenna (1653-1699). He was Professor of Mathematics but his philosophical roots were never abandoned; for instance, in 1673 he published an influential work which included the use of mathematics as a paradigm for philosophy. Of importance is that among Weigel 's most famous students were Samuel Pufendorf, Gottfried Leibniz and Johann Sturm. Additionally, both Hoffmann and Stahl attended the University of Jenna during Weigel's professorship and, although my research cannot confirm this, it would not be unreasonable to conclude that both attended his classes.

The "current situation"—i.e., the one faced by intellectual thinkers of the Long Eighteenth Century—was established by Phillipp Melanchthon (1497-1560). Melanchthon was a sixteenth-century professor and theologian who taught at the University of Tübingen. His work on moral philosophy, *Philosophia moralis Epitomes* (1542) was highly influential well into the long eighteenth century. He attempted to save Aristotle's ethics and his own work is a synthesis of Aristotle and Lutheran thinking (Hochstrasser 2000, 32). Melanchthon was a friend and associate of Martin Luther. He was also an education reformer and it was his concepts of Natural Law ethics which dominated Protestant universities.

Much of the dispute in Prussia during the long eighteenth century is a reaction to overturn Melanchthon and replace his concept of Natural Law and the exclusiveness/dominance of theology in philosophical thinking.

Another pre-Enlightenment Natural Law thinker who influenced the philosophical discussion of this time was Hugo Grotius. His influential work, *On the Law of War and Peace* (1625), was begun while he was in prison and published while he lived in exile in Paris. It was intended to be an international legal system justified by Natural Law; to be binding on all people regardless of nationality or custom. Its focus was on a concept of just war and natural justice.

Grotius lived through two wars—the *Eighty Years War* (1568-1648) between Spain and Holland and the *Thirty Years War* (1618-1648) between European religious groups. He concluded that law should be independent of specific religions or national customs. His concept of Natural Law is based on an understanding that an act is good or bad as it is in harmony with human rationality. He believed that God had given human reason the ability to be a guide for human actions.

These early pre-Enlightenment writers were influential in opening a broader discussion on Natural Law. This was taken up in the Long Eighteenth Century by Pufendorf, Leibniz, Thomasius and Christian Wolff .

Pufendorf abandoned the study of theology at the University of Leipzig and relocated to Jena, where he studied under the renowned mathematician,

Erhard Weigel, and read Grotius, Hobbes and Descartes. Later, while in prison, he reflected on these works and started to develop a system of universal law; he published the mature concept under the title of *Elementa jurisprudentiae universalis libri duo* (Elements of a universal jurisprudence) (1661). He was rewarded with a newly-created chair (in the Philosophy Department) at Heidelberg—Professor of International Law and Philology—but Pufendorf always called himself Professor of Natural Law (Hochstrasser 2000, 42). He published a work (1667), under a pseudonym, attacking the Holy Roman Empire, the house of Austria and the politics of ecclesiastical princes. Shortly thereafter, he left for Sweden.

In 1670 he published *De jure naturae et gentium libri octo* and in 1675 a shorter version under the title of *De officio hominis et civis* (On the duty of man and citizen). In these works Pufendorf advanced the theories of Grotius and Hobbes. Natural Law, he claims, does not extend beyond the limits of this life and regulates only external acts. He disputed Hobbes on the state of nature and claimed it was a state of peace—albeit an insecure one. Following Grotius, he believed that Natural Law was international in scope and not just applicable to Christians.

Of great interest to Prussian princes and the Halle intellectual community, Pufendorf drew a distinction between the authority of the church and of the state without attacking either. The authority of the state transcends the authority of the various churches under its jurisdiction while each church maintained a

subordinate ecclesiastical power. Pufendorf accepted a position as privy councilor to Frederick III in 1688 and his concept was pursued and adopted by the Prussian princes during the Long Eighteenth Century. Pufendorf's primary adversary during this period was Germany's most brilliant philosopher, Leibniz.

Gottfried Wilhelm Leibniz declined opportunities to teach at universities and opted for a life as advisor and counselor to a series of influential patrons. Leibniz was a prolific writer—but most of that was accomplished through personal letters. His accomplishments were extensive and covered mathematics, philosophy, law, politics, and other areas of intellectual and practical endeavor.

Leibniz was influenced early by his patron, Baron von Boyneburg, who was interested in international law. Leibniz wrote several works on the organization of the Holy Roman Empire and other such matters. His work was recognized and Leibniz was appointed privy councilor to Elector Frederick in 1700. Shortly thereafter, he traveled to Berlin to oversee the founding of the Brandenburg Society of Science which he had encouraged. He was a frequent and most influential visitor to Berlin in the years that followed.

Leibniz might easily bear the title "'The Great Reconciler." He made extensive efforts to reconcile the Catholic and Protestant churches believing there was fundamentally greater unity than difference. In philosophy, he opposed the Cartesian method of doubt. The starting position should rather be to find how close to the truth each previous philosopher had come:

> Descartes was convinced, or at least assumed the conviction, that all the philosophers who went before him were in error, because they appeared to be involved in inextricable contradictions. Leibniz was equally well convinced that all the great systems agree fundamentally, and that their unanimity on essential is a fair indication that they are in the right. Leibniz therefore resolved not to isolate himself from the philosophical, scientific, and literary efforts of his predecessors and contemporaries, but, on the contrary, to utilize everything that the human mind had up to his time achieved, to discover agreement where discord and contradiction seemed to reign, and thus to establish a permanent peace among contending schools. (Catholic Encyclopedia, http://www.newadvent.org)

Similar drives toward unity can be found in his study of language where he attempted to identify a 'universal' language.

One of the most popular and controversial contributors to German philosophy in the eighteenth century was Christian von Wolff. Wolff taught mathematics at the University of Halle in 1706. He was regarded as a Leibnizian and had, in fact, been encouraged by Leibniz. Soon he taught throughout the philosophy department.

Wolff argued that philosophy should be elevated to a full departmental ranking: "The highest degree conferred by the philosophical faculty was the "Magister, whereas study in the other three faculties could lead to the doctorate…." (Saine 1987, 102) Most importantly, theology and philosophy should be considered as separate and philosophy should not be subject to justifications from revelation. He also argued from a mechanistic view of causality and was accused of a strict determinism which violated Christian principles. Throughout, Wolff insisted that he was the greatest defender of the

Christian faith. Yet his views were often at odds with those of the theology department and other faculty members.

In 1721 Wolff gave a presentation in which he praised the Chinese Confucius thinkers as advocating an ideal human existence. This met with an outcry from the Orthodox Lutheran faculty as it was viewed as much too generous to a group which they considered pagan. By 1723 Wolff's continued antagonism with other faculty members led to complaints being made to the King in Berlin. The following is one version of how Wolff found himself with 24 hours to get out of Halle or be hung.

> It was not Wolff's praise of Chinese philosophers, however provoking that may have been, but rather the suspicion that he taught a thoroughgoing determinism that led to the famous cabinet order of Frederick William I expelling him from Halle on pain of death. Wolff had the most difficulties with the doctrine of the preestablished harmony between body and soul that he had explicated in the "German Metaphysics" as Leibniz's solution to the problem of the relationship between body and soul…. The doctrine of preestablished harmony presented the best point of attack by the theologians, for there was the clear proof of Wolff's dangerous determinism…. His flight from Halle as a result of the cabinet order of November 8, 1723, no longer had anything to do with a philosophical controversy, but rather with the passion of King Frederick William I for his so-called "lange Kerls," his oversize guard regiments recruited by hook or by crook from all over Europe. Wolff's opponents had whispered in the King's ear that according to Wolff's teaching he had no right to punish a soldier who deserted, because in deserting the soldier would have acted not by choice, but by necessity. That was about the worst thing anyone could have told the King about Wolff, and Wolff's whole consciousness of his modernity, his knowledge, his certainty about the correctness of his philosophical positions – nothing was of any use against the royal threat of the noose. (Saine 1987, 118-9, 124-5)

A new methodology in Natural Law emerged in the German territories during the Long Eighteenth Century. Rejecting the authority of any single previous theory to explain German thinking, Natural Law theorists developed and advocated a conscious acceptance of *Eclecticism*. One of its most strident advocates was Johann Christoph Sturm. Sturm was a professor of mathematics and physics at Altdorf and eventually the successor to his teacher, the renowned Erhard Weigel, as the most renowned mathematician of the time. His work *Philosophia eclectia* (Eclectic Philosophy) (1686) was a defense of experimental philosophy and influenced the concept and advancement of *eclecticism*. Natural Law thinkers, such as Thomasius, were strongly influenced by Sturm.

An example from Hoffmann's writings reflects this influence. In the *Fundamenta Medicinae* he emphasizes that the moderns should be followed in methodology but that the ancients should be followed in application. Further support for the influence of *eclecticism* on Hoffmann can be found in the *Medicus Politicus* where Hoffmann recommends Sturm to his medical students.[5]

1.4 The Intellectual Landscape in Brandenburg-Prussia—the Long Eighteenth Century and the Enlightenment

If we accept the starting date of the Enlightenment in Germany[6] as "about 1740" (Beck 1969, 244)[7] then the publication of the *Medicus Politicus* may well be considered among the earliest Enlightenment works. Originally published in

1738, further editions and translations soon followed and ensured a widespread distribution throughout the German territories and beyond.

However, any such strong claim for the *Medicus Politicus* would require considerable support to meet the satisfaction of most scholars—and justifiably so. First, there is the problem that the very term "German" is misleading; then, relying on a start date of 1740 is tenuous as there are good arguments for an earlier date; next, there is no agreement on the characteristics that define German Enlightenment; and finally the *Medicus Politicus* is actually a set of lecture notes developed over the 40 years prior to its publication.

The first problem that needs to be addressed is using the term "German" as if it were the single nation it is today. Asserting a single start date would assume that it would apply equally throughout the German territories. In fact, there was no such centralized Germany (see Section 1.1). The territories were not only partitioned by political differences but also by cultural and religious differences as well.

[5] Throughout the *Medicus Politicus* Hoffmann periodically provides a recommended reading list to his students; sometimes he only mentions a person's name, other times he identifies a specific writing by that author.
[6] It is difficult enough to assert and justify the dates and characteristics of the "German" Age of Enlightenment so that the more general issue of the European Enlightenment is well beyond the scope of this dissertation.
[7] Lewis White Beck, *Early German Philosophy*, is actually stating that this is the common start date given by many researchers. In the next few paragraphs we will see that he argues for earlier dates.

> … if we enquire into the special character of the German Enlightenment, the answer can leave out of account the difference in time and content between Protestant and Catholic Germany. (Vierhaus in Raabe and Schmidt-Biggemann 1979, 32-3)

> The focal point of German intellectual and cultural life moved gradually eastward from the Rhineland, where it was up to the fifteenth century, into Saxony in the sixteenth and seventeenth and, finally, into Prussia and Brandenburg in the eighteenth. After the Reformation, and until the nineteenth century, the towns in South Germany, with the exception of Nürnberg and Stuttgart with their satellite universities in Altdorf, Erlangen, and Tübingen, played no great role in German intellectual life; even the universities in the Rhineland, such as Cologne, Heidelberg, and Freiburg, gradually lost in importance. (Beck 1969, 306)

There is also a problem in establishing 1740 as the starting date of the Enlightenment in Germany. Indeed, the problem of trying to establish a start date for *any* such historical period is well-recognized in the research literature about the Enlightenment. The follow excerpts are typical of such analysis:

> So long as historians divide the past into specific periods and give names to them, there will be debate about when each specific period begins and when it ends; and this will lead to debate about whether periodization has any justification at all. (Beck 1969, 243)

> Enlightenment as a socio-cultural movement cannot be restricted to the "age of Enlightenment". To try to date its origins certainly leads to hopeless difficulties. (Raabe and Schmidt-Biggemann 1979, 26)

There is mild agreement by those who venture to establish such dates that the Enlightenment does not begin in Germany until the middle of the eighteenth century (Raabe and Schmidt-Biggemann 1979, 26)[8] (Kors and Korship 1987, viii).

[8] It is noteworthy that Raabe and Schmidt-Biggemann edited a book entitled *Enlightenment in Germany* (originally published in German) but never try to establish a specific start date for the Enlightenment.

However, because the *Medicus Politicus* was developed by Hoffmann over a period of more than 40 years (i.e., since his arrival at Halle in 1694), then the "content" of the *Medicus Politicus* most likely would have easily predated a start date of 1740. This would make this work pre-Enlightenment. If we are trying to establish the *Medicus Politicus* as an authentic Enlightenment work, we need to be able to justify moving the start date of German Enlightenment to a much earlier date. In fact, Lewis Beck, a noted scholar on early German philosophy, does just that.

While Beck notes that some historians of German philosophy begin the Enlightenment at about 1740 (see above), he believes the beginning of the German Enlightenment is much earlier and does not differ significantly from that of the other European nations.

> Faced with the problem of defining and defending two cut-off points for the purpose of choosing writers whom I consider representative of the Enlightenment, I elsewhere suggested the following dates: 1687-1688, the publication of Newton's *Principia* and the Glorious Revolution, and 1790-1793, the publication of Kant's last *Critique* and the Reign of Terror….
>
> … it is easier to defend the name *Aufklärung* and such a pair of dates in Germany than it is in other countries. In fact, if there is any error it is likely to be that a date about 1690 is too early; there is a far greater preservation of "typical" seventeenth-century modes of thought and feeling into the eighteenth century than anticipations of "typical" eighteenth-century *Weltanschauungen* in the seventeenth. (Beck 1969, 243-4)

Determining the starting date of an era depends on how one defines the significant characteristics of that era—and there are definitely differences in how the Enlightenment in Germany is defined. In fact, this debate had already

occurred during the latter part of the eighteenth century among the *Aufklärer* themselves. In 1784 Kant penned his response: *An Answer to the Question: What is Enlightenment*? By this date it had become clear to Kant that the Enlightenment was the "emergence of man from his self-imposed minority." (Kant in Raabe and Schmidt-Biggemann 1979, 9) Kant separated those men who had courage to make use of their own reason from those who lack such resolve or who even remain comfortable in being placed under the guidance of others. Kant optimistically believed that the Enlightenment could spread from the few who have shown the way to an enlightened public. What was required to make this happen was *freedom*… freedom to express oneself in public.

Contemporary researchers have looked at the perspectives of Kant and a number of other Enlightenment thinkers as well as analyzing earlier writings that were considered influential in the development of Enlightenment. For those who establish the middle of the eighteenth century, or more specifically 1740, as the start date of the *German* Enlightenment, the justification is based on several key events at or around that time—possibly the most important event in Brandenburg-Prussia was the enthronement (1740) of Frederick II (the Great) who is often referred to as the Enlightenment King:

> … some historians of German thought prefer to see the Enlightenment as beginning about 1740, at about the time of the establishment of the University of Göttingen (1737) and the re-establishment of the Berlin Academy (1744). Certainly Germany in, say, 1720 had very few resemblances, intellectually, to England and France…. Brandenburg and Hanover about 1750, however, do seem to be synchronous with Paris, London, and Edinburgh of that date, so we might well conclude that

> Germany joined the European Age of Reason only in the middle of the century." (Beck 1969, 244)
>
> After 1740 the most important home of Enlightenment thought in Germany was Berlin, the capital of Brandenburg and the home of Frederick II, King of Prussia. Brandenburg-Prussia was rapidly becoming the leading German state, after Austria. (Beck 1969, 244)
>
> … Kant thought highly of Frederick and called his period not only "the age of Enlightenment" but also "the century of Frederick." (Kuehn 2001, 54)

As we saw earlier, some modern writers, such as Beck, attempt to establish an earlier start date based on significant events such as the English Revolution or Newton's *Principia*. Beck goes further in validating his start date of "about 1690" (which, as we saw, he admits might be a little on the early side) by analyzing the unique characteristics of the "German" Enlightenment.

> The German Enlightenment was unique in several respects. First, it did not spring from an upsurge of the new science coming out of England. Second, it arose at a time of religious revival, whereas in England the Methodist revival was to occur later against the Age of Reason and in France the Jansenist movement was already dying. Third, it did not have a political base; the social classes that could carry the ideology of Enlightenment were weak and ineffective. (Beck 1969, 245)
>
> … the German Enlightenment, a philosophical movement against Protestant scholasticism, was pervaded with religious concern and sought to maintain religious attitudes and values. (Beck 1969, 245)

In addition to these characteristics which show the differences between the German and other European Enlightenments, Beck offers some similarities as well:

> Yet the Enlightenment in Germany was a part of a general change in the intellectual climate which extended from England to Russia…. As a Europe-wide movement it had some common features in each country. Everywhere it was marked by optimism, intellectualism, and a concern

> with human affairs and a weakening of speculation, orthodoxy, and respect for authoritarian institutions. Dilthey's classical statement is: "The main features of the Enlightenment were everywhere the same: the autonomy of reason, the solidarity of intellectual culture, confidence in its inevitable progress, and the aristocracy of spirit." (Dilthey 1923-36, 131; quoted in Beck 1969, 245)

Beck concludes that the German Enlightenment is best understood by its two early mentors, Christian Thomasius and Christian Wolff. Beck excludes the influence of Gottfried Leibniz:

> Yet Leibniz seems to me to be much more characteristic of the age that was dying than of the one that was coming to birth. He was a good European writing in Latin and French for a European audience; he was fearful of what he saw coming out of the teachings of those from whom the eighteenth century was to learn most…. His direct influence on German philosophical thought from 1720 to 1765 was small…. The mentors of the German Enlightenment were two professors in the University of Halle, not… Leibniz, the great mathematician and philosopher and man of affairs. (Beck 1969, 244-5)

One characteristic which Beck does not address is *German eclecticism* (See Section 1.3 above). German thinkers everywhere were united in one way that transcended territorial, social and religious divisions—they wanted a uniquely German solution to a uniquely German state of affairs. As eclectic thinkers they rejected any wholly systematized approached—especially, from outsiders. Thus, it should not be surprising that it is difficult to establish firm characteristics of the early German Enlightenment that cover all or most of the writers.

I would add one additional support in favor of Beck's earlier date—i.e., the establishment of the University of Halle in 1694. In the next section (Section 1.5), I will show that all these historically significant factors played out in only two locations: Berlin and Halle. And Halle was the intellectual center that supplied the graduates that changed the political, social, religious and intellectual character of all of Brandenburg-Prussia. Hoffmann was a key figure in the Halle-Berlin Axis and his graduates took his philosophical principles and ethical applications throughout the German territories and beyond.

However, not every work written during the pre-Enlightenment or Enlightenment periods actually contributed to Enlightenment thinking. Thus, the most critical justification must show that the "content" of Hoffmann's *Medicus Politicus* is "characteristically" Enlightenment.

Using Beck's three criteria of a *unique* German Enlightenment we see that Hoffmann's work compares favorably. First, he exceeds Beck's scientific requirement in that Hoffmann was an internationally-renowned medical scientist (see Section 2.1.4 "Hoffmann's Writings"). The *Medicus Politicus* shows that the Hoffmannian curriculum emphasized the necessity for the future physician to be a life-long scientist—adherents of an evidence-based medicine.

Second, Hoffmann's work definitely reflects the religious revival of his period. Hoffmann was an active Pietist (see Section 1.2.3 "Enthusiast Religion" above). The extent of the influence of his religious convictions on his concept of

a moral physician is further explained in my Chapter 3 “The Character of the Hoffmannian Physician”.

Hoffmann once again exceeds Beck’s third characteristic. Specifically, Hoffmann had a very quiet—but powerful—political source to implement his philosophically-supported changes to the practice of medicine and especially medical ethics. That source was the Prince himself. In Section 1.5.4 below, I document how Hoffmann was supplying his politic physicians directly to Berlin to fill important bureaucratic positions there and throughout the territories.

Further support for the Enlightenment direction of Hoffmann’s work is found in the *rational* character of his medical training. In Section 3.2.3 “Development of the Rational Character of the Physician,” I develop one of Hoffmann’s major emphases in developing the new physician as a rational agent. This was the element that we addressed earlier that Kant had emphasized as the basis of the true German Enlightenment spirit. By nearly every criterion, Hoffmann was an *Aufklärer*.

The one remaining question is whether the enlightened Hoffmann can date back as far as the 1690’s. That is, does the *Medicus Politicus* reflect Hoffmann’s mature work or does it form part of a continuum going back to his arrival at Halle? In fact, in the area of science we can confirm a continuum. Hoffmann’s earliest work, the *Fundamentals of Medicine* (1695), shows that Hoffmann’s scientific commitment traces back to the earliest years of the Enlightenment. However, confirming other aspects of the *Medicus Politicus*—

especially, his medical ethics—as having been part of his medical school curriculum dating back to the early years of his teaching will not be possible until more of the Hoffmann corpus has been translated.

Meanwhile, there is an alternative title for the era covering Hoffmann's arrival at Halle up to the publication of his *Medicus Politicus*—i.e, the *Long Eighteenth Century*. This title seems both more contemporary, less controversial, and maps more easily onto the issue of medicine and medical ethics.

Mary Lindemann (Lindemann unpublished, 1) establishes the dates of the Long Eighteenth Century as 1650 through 1815. Unfortunately, she does not argue for these dates and nowhere in her fine essay do these dates appear to give us a clue on what she intended. However, in the development of medicine as a science, profession and ethics in Germany, a slight adjustment of the dates works very well—specifically, 1694 to 1810.

In her excellent essay "German Medical Education in the Eighteenth Century: the Prussian context and its influence", Johanna Geyer-Kordesch addresses the founding dates of three major universities as the key to understand the development of medical education in Prussia during this period: Halle (1694), Göttingen (1744) and Berlin (1810). Her extensive research in this area shows that the establishment and progress of the three is interrelated and reflects an on-going development in medicine. By the time of the founding of the

University of Berlin, the medical courses and clinical instruction were already in place (Geyer-Kordesch 1985, 180).

The Halle-Berlin axis was a major reason for this. Leading the charge were the two medical professors from Halle. First Hoffmann, then Stahl, went to Berlin to pave the way for their graduates and to implement changes in medicine. In 1716 Frederick I, supported by Stahl, convinced a reluctant Prussian Academy (originally founded by Leibniz in 1700) to establish a *theatrum anatomicum* which eventually became the center of medical teaching in Berlin (Geyer-Kordesch 1985, 184) Halle graduates such as Drs. Heinrich Henrici and August Buddeus exemplify the importance of the Halle-Berlin axis. Both were appointed as primary medical teachers at the *theatrum anatomicum* in Berlin as early as 1723. By the time a university was founded in Berlin, Halle-trained physicians were well entrenched.

In summary, the development of enlightened medicine was just as scientific, just as rational and just as critical to the German culture as in other national Enlightenments, e.g., Scotland. Geyer-Kordesch's account shows that the advance of the scientific approach to medicine, the implementation of medical laws, the founding of charity hospitals for the poor as a state obligation and the professionalization of medicine advanced steadily throughout the Long German Eighteenth Century. Hoffmann's commitment to scientific medicine resulted in an anti-speculative, evidence-based approach to medicine, which becomes defining features of Enlightenment medicine. A distinctive feature of

the German Enlightenment culture was its eclecticism, to which Hoffmann also contributed. Thus, while we await further translations of Hoffmann's other works to fill in all of the details about how he fit into the Enlightenment picture, we can safely situate the *Medicus Politicus* within the Long Eighteenth Century.

1.5 The History and Politics of the University at Halle

> At Halle… Enlightenment and enthusiastic religion, two trends formed and articulated by the turn of the (eighteenth) century, vied for allegiance. (Geyer-Kordesch 1985, 180)[10]

The history of the development of institutionalized medicine and medical ethics in eighteenth-century Prussia is closely tied to the founding and development of the Universities at Halle (founded 1694) and Berlin (founded 1810). In turn the development of the university system (especially the medical university) is just as closely tied to the political developments of an expanding Prussia. The university became a microcosm for all the changes that were taking place throughout Brandenburg-Prussia and all the German territories.

1.5.1 The Founding of the University at Halle[10]

In 1680 Magdeburg was added to the Brandenburg-Prussian territory and on its outskirts was the city of Halle. Magdeburg had suffered some of the greatest devastation within the German territories during the Thirty Years War

and was nearly totally destroyed.[11] One of the first efforts at re-development of the area was the establishment of a Lutheran academy at Halle.

The University at Halle was founded in 1694 by Elector Frederick III of Brandenburg (later Frederick I, King in Prussia). The founding of this university followed a tradition started by Frederick II of Saxony, also known as Frederick the Wise, who founded the University of Wittenberg in 1502. There was significant disagreement within the power circles of Berlin, but the Brandenburg Elector prevailed. Although the rulers of Brandenburg were nominally Calvinist, they wanted to offer a prominent university to their Lutheran subjects.

1.5.2 The Organization of the University at Halle

Halle had the three typical major departments of a European university: theology, law and medicine. It also had a smaller department of philosophy. Theology was still considered the *first department* and its students often came

[10] The primary source of information for this history is from Johanna Geyer-Kordesch (1985, 177-205) (1993, 181-202). The difficulty for the English-reading researcher is well supported by a review of the footnotes in the first article. Geyer-Kordesch's well-researched and documented article contains over one hundred references in the footnotes. Nearly all of them are references to German-language works.

[11] The University of Halle was originally called the *Fridericiana* and that name often appears in literature when referring to the university.

[12] The quick and sometimes violent history of developments of Prussia and Germany has resulted in the loss of much of that history to the world: "The universities of the German-speaking world were more subject to the vicissitudes of religious, cultural and political pressures than, say, the insular, elite and strangely traditional medieval foundations of Oxford and Cambridge. Whereas the traditions of monasticism in these two towns still strike the eye today, much of what was formerly the extensive, amoebalike contour of the Holy Roman Empire *Deutscher Nation* has disappeared or changed beyond recognition." (Geyer-Kordesch 1985, 177)

from families connected with the church. The legal program attracted students from aristocratic and middle-class urban families. These were the largest departments in terms of the number of students who attended.

Of the four programs, only those who graduated from medicine had to compete with non-educated practitioners: "only practical medicine in the eighteenth century was suffused with empirics of various persuasions and with practitioners in fields outside university training (surgeons, midwives, apothecaries). A medical doctorate was not essential for practice." (Geyer-Kordesch 1985, 181)

The medical program at Halle was very successful and grew steadily throughout the early eighteenth century: "Halle from 1710 onward consistently ranged over 300 (medical students), making that university's medical faculty with its two to three full professors one of the largest next to (the University of) Leiden." (Geyer-Kordesch 1985, 183)

1.5.3 The Staffing of the University at Halle

Geyer-Kordesch has done extensive research on German medical education during the eighteenth century. It is her conclusion that the acquisition of the teaching faculty at Halle had two significant factors. First, the faculties of the three major departments were distinguished. Second, the appointments to the faculty marked a victory for dissidents. These were dissidents of two types – actually, two seemingly disparate types – of intellectual movements. The Department of Law, especially influenced by Thomasius, represented the ideals

of German Enlightenment. Thomasius, by some accounts, eventually abandoned his Pietist leanings in favor of a purely secularized system of jurisprudence. The Department of Theology, especially influenced by Francke represented the ideals of a Pietist activism. (Geyer-Kordesch 1985)

Francke had been actively involved in the Pietist movement at the University of Leipzig and later at Erfurt. The Orthodox Lutherans responded by firing him. However, he had a protector, Phillipp Jacob Spener who left a lucrative court position on moral grounds and moved to Berlin. Spener's call for religious renewal and activism earned him the derogatory title of "pietist". He was defended by one of Brandenburg-Prussia's leading administrators, Veit Ludwig von Seckendorff whose organizational abilities were so well recognized that he was appointed as the first pro-rector of the University of Halle. Spener also played a key role in supporting the Elector in founding the university and in affecting its first appointments. Francke received one of the first positions at the university and arrived at Halle in 1691 several years before its opening. Thomasius was appointed shortly thereafter.

These original thinkers were not always in agreement on the direction that the university should take in its development and intellectually opposed each other at various points. The reports seem to indicate that there was exceptional academic freedom and expression of beliefs; both sides had a strong sense of respect for intellectual freedom. The two most significant conflicting values were the *secular* interpretation of the Enlightenment versus the *religious* interpretation

of the Enlightenment. The latter may be characterized as an emergence of an *enthusiastic* personal interpretation of religion.

Both Francke and Thomasius were products of the Enlightenment's opposition to authoritarianism and closed systems. As a result, a stimulating intellectual environment developed. However, power politics was also important and both sides vied for advantage. And because the two departments were considered equals in deciding key administrative and policy issues, the influence of the Faculty of Medicine became the key to the balance of power within the university.

At this point our story focuses on the Faculty of Medicine. The initial medical faculty at Halle consisted of Friedrich Hoffmann and George Stahl. Both had received their doctorates from the University of Jena, which had a strong medical program and one which emphasized the chemical interpretation of physiology and therapeutics. Both Hoffmann and Stahl were fine chemists who had studied under Georg Wolfgang Wedel (1645 – 1721) while at Jena.

1.5.4 The Importance of the University at Halle

The influence of the University at Halle is only now being explored in English language research. Halle was the center of most of the contextual elements we've discussed in this chapter. It was co-influential on the others. Its influence seems to have been recognized elsewhere at a much earlier date: "*Voltaire had said that to see the crown of German scholarship, one must go to*

Halle." (Cassier, Ernst, *Kant's Life and Thought*, Trans. James Harden 1981, 119)

The story of Halle is largely the story of the emerging influences of Pietism and the Enlightenment during the development of Brandenburg-Prussia. It provided an academic outlet for enthusiastic religion and most of the key staff were Pietists who had the opportunity to develop curricula and train students in accordance with their high ideals. It also was an academic forum for Enlightenment thinkers who challenged the conventional boundaries of authority. The university became a microcosm of the tension between these two powerful intellectual forces on the Continent.

The story of medicine in Brandenburg-Prussia is largely the story of the influences of the University at Halle on Berlin during the development of state institutionalized medicine and medical ethics. The medical faculty at Halle was a strong advocate of change in medicine—an examination and licensing requirement to ensure that competent medicine was practiced and a code of ethics to ensure that all citizens had access to medical care. First Hoffmann, then Stahl went to Berlin as personal physician to the King in/of Prussia—and also to advocate for change. Stahl would prove to be the more effective advocate.

In Berlin, the seat of power in Brandenburg-Prussia, an administrative program (the *collegium medicum*) would eventually turn into instrument of those changes: it would found the University of Berlin, it would institutionalize higher

medical standards and it would expand medical care for the poor. A significant number of faculty and graduates from Halle – including many trained by Hoffmann – would eventual fill the positions which made these changes. The Berlin – Halle connection became the center of a progressive program of medical change in Prussia.

> The Pietist university (of Halle) exported talent to the centre of administrative power, Berlin. Practical matters, there in particular, were at issue: (1) bureaucratic control of medical qualifications; (2) better surgical and medical care for the expansion of the Prussian army; and (3) expanded hospital facilities for the sick poor. In Berlin these three areas of medical expansion and institutionalization progressed on the basis of personal influence and recruitment managed along a Berlin – Halle axis. (Geyer-Kordesch 1985, 180)

The ethical and practical concepts taught by Hoffmann and Stahl to the medical students at Halle were foundational to the eventual changes that would occur in Prussia. The ethical and practical ideals reflected in the lecture notes of Hoffmann captured in the *Medicus Politicus* became the statutes and practices of the Prussian territories—and much further.

The role of Halle graduates in effecting all these changes cannot be overstated. A degree in medicine didn't ensure that a graduate could make a living as a local physician, but degreed physicians did have some advantages as they were most frequently appointed to the higher administrative positions: court physicians, city physicians and university professors. These public and visible positions also required that the physicians needed to be trained in the *politic* dimension of medicine; i.e., how to respond to power over them. This process of

placing degreed and politic physicians in key public positions would prove important—actually, this is arguably the single most important factor—in the eventual implementation of changes in medicine and medical ethics.

Of all the contextual factors addressed in this chapter, there were only two locations in the German territories where they all occurred and converged: Berlin and Halle. The political consolidation of territory and power took place in Berlin—its bureaucracy was fed by faculty and graduates from Halle. The intellectual changes of pietism, Enlightenment and Natural Law were uniquely combined at the University of Halle—thanks to the political support in Berlin. Together, they formed the Halle-Berlin corridor—and it took the two working in harmony to navigate the shaky, political and intellectual waters of the Long Eighteenth Century.

1.6 Application of the Historical Context to Hoffmann and the *Medicus Politicus*

I believe it would be very difficult for a contemporary reader of the *Medicus Politicus* to understand and appreciate it without some general sense of the context in which Hoffmann taught. As the reader proceeds through this dissertation and the text of the *Medicus Politicus*, he or she will see the influence of these historic events on Hoffmann.

Hoffmann himself never played a direct role in government—yet his influence was significant and accomplished through his students. In Section 1.5.4 “The Importance of the University of Halle”, I establish the importance of

the Halle-Berlin Axis. Some of Hoffmann's physicians took up powerful positions within the State. Many of the public health safeguards and care for the poor advocated by Hoffmann in the *Medicus Politicus* were enacted into law. Meanwhile, other Hoffmannian physicians were taking positions in universities throughout Europe as well as local town physicians. Unprotected and also unregulated by state law, Hoffmannian physicians were prepared to practice the highest standards of clinical care through the scientific and ethical self-regulation for which he argues.

The poor were everywhere. In Section 1.1 we establish the history and contemporary status of the German states in general and Brandenburg-Prussia in particular. Devastated by a history of wars, the German territories were disunited and lacking a strong middle class. The economy was in distress and the economic life of the populace (including physicians) was harsh. One response to this was the rise of an enthusiastic religious group, the Pietists. (See Section 1.2.3). The Pietists were committed to living a Christian life instead of preaching one. The poor were to be helped—for Pietist physicians this meant without pay. But, the poor were not the only ones in society needing the help of physicians, everyone in society lived in a state of constant misery as regards their health. While all members of society had a Natural Law obligation to help their neighbor (Sections 1.3 and 2.2), Hoffmann saw the special role played by physicians in fulfilling this obligation. To respond appropriately, the physician needed to respond on the basis of the virtue of compassion. This was a

traditional Christian virtue (Sections 1.2.2 and 1.2.4). Any physician who imitated the life of Christ would necessarily have such a virtue. Thus, the Hoffmannian physician was properly motivated by his religious and philosophical commitments.

For Hoffmann, there should be no conflict between moral philosophy and natural philosophy or between his religion and his commitment to an evidence-based science. Hoffmann's *Medicus Politicus* shows the politic physician deftly balancing all of these interests. Like the ancient physicians (Section 1.2.1) who resolved the medical dilemma of the properly balance for a physician as a priest and as a healer, Hoffmann resolves the seeming conflict of his time by clarifying the role of each.

The historical context (Section 1.1) shows that the long history of religious and political conflict was often generated by foreign nations. These nations tried to impose their beliefs and methods on the "Germans". As a result, it is not surprising that the intellectual community was looking for uniquely German solutions to what they perceived were uniquely German problems. The result, was a balance between a drive for harmony (a universal principle) and an eclectic approach. Hoffmann was himself eclectic and neither rejected nor accepted any "system" entirely. (See Sections 1.4 and 2.2) Hoffmann advised his students and his European readers to respect much that the ancients had taught us but to recognize the power of modern science, with both put in service

for the health and life of the sick. His eclecticism thus cohered around the goal or end of the patient-physician relationship.

Hoffmann was able to play such a significant role because of his position at the University of Halle (Section 1.5). Halle became a microcosm for all that was occurring throughout Brandenburg-Prussia and the German territories. The Prince had found an ally in the Pietists—and vice-versa. Hoffmann would take advantage of his position to train physicians for the changing world they were entering. They would be strongly moral, rationally skilled and clinically competent. The Hoffmannian physician was the result of the historical factors in which they found themselves but not confined by these factors. Hoffmann provided them an optimistically ideal education for the world he believed was possible.

CHAPTER 2: FRIEDRICH HOFFMANN AND THE *MEDICUS POLITICUS*

This chapter will examine both Friedrich Hoffmann and the *Medicus Politicus*. The chapter starts (Section 2.1) with a biography of the life and works of Hoffmann. There is not much known about his personal life but the reader will gain a knowledge of many of the influences that formed Hoffmann. The concentration of this biography is on his academic and professional development. This will be followed (Section 2.2) by placing Hoffmann in the contextual Natural Law issue that I developed in Chapter One. In many ways, Hoffmann and his works reflected the changes that were taking place in the Long Eighteenth Century. Hoffmann may have been the first to apply these changes to the medical arena. Section 2.3 introduces the reader to the *Medicus Politicus per se*. This discussion will cover its publication, organization and a technical analysis of its contents to include its relationship to other medical writings.

2.1 Biography of Friedrich Hoffmann[1]

Friedrich Hoffmann flourished in the first half of the Long Eighteenth Century. He was much more than a bystander of the period and his contributions are worthy of research and discussion. Hoffmann was exceptionally successful

[1] This biography of Hoffmann is based on a translation by Msgr. Vincent Fecher of Johann Schultze's (1687-1744) biography of Hoffmann which appears in the *Opera Omnia* of Friedrich Hoffmann (1740 Edition). Schultze is identified there as a student of Hoffmann.

in his own lifetime. He was a beloved professor of medicine; an esteemed medical advisor to kings; a prolific and highly influential writer of medicine, theology and science; and a key historical figure in late-seventeenth and eighteenth century medicine and ethics in medicine.[2]

The purpose of this biographical sketch is to inform the reader on the personage who played such a significant role in the development of the practice of medicine in the Brandenburg-Prussia territories – and much further beyond.

2.1.1 Hoffmann – The Early Years

Friedrich Hoffmann was born in Halle on February 19, 1660 and died there on November 12, 1742. He lived in his beloved home town for all but 15 years. Yet, those 15 years of education, teaching and traveling, did much to form his character and ideas.

Hoffmann showed a strong early interest in anatomy, physics, chemistry, and mathematics during his four years at the gymnasium (1675-8). Hoffmann, himself, attributes much of his later success to his interest and skill in mathematics. He also records that these early years convinced him to

[2] The term *medical ethics* was not yet in use. However, there was a long tradition of medical writers addressing various aspects of physician behavior (see Section 1.2 above).

emphasize only what was ”clear and distinct,” overtly Cartesian language. Although it isn’t clear when Hoffmann was first introduced to Descartes, we do know that Hoffmann referred to Descartes regularly in his writings.

Hoffmann entered medical school at Jena at the age of 18. This career choice would not be unexpected because he came from a family of several generations of physicians and apothecaries. In fact, a member of his family had been connected with medicine for 200 years before him. In choosing the medical school at Jena, he was also following in the steps of his father, Andrew Hoffmann.

The little that is known about Hoffmann’s family comes from the biography of Schulze. Andrew Hoffmann was a court physician to the Duke of Saxony and the administrator of the Magdeburg archdiocese. It is reported that he also wrote several celebrated pieces although these seem to have not been preserved. His father married the daughter of a very prestigious senatorial family.

Before graduating from medical school, Hoffmann extended his education at Erford. There he attended seminars under Kasper Cramer, noted for his expertise in chemistry. During this educational period Hoffmann concluded that future physicians would need to study a wide range of disciplines including mathematics. He returned to Jena the following year and, at the age of 21, he received his medical degree from the medical school at Jena.

2.1.2 Hoffmann – Physician and Professor at the University of Jena

Following his graduation and the publication of a thesis, Hoffmann remained at Jena where he became a popular medical educator. However, according to at least one account, his popularity generated jealousy from his fellow faculty members. Hoffmann was also dealing with health problems during this time, believed to have been caused by his commitment to a life of studying and consequent self-neglect. In the end, the combination of the two drove Hoffmann to leave Jena.

Hoffmann decided to take up residence with some relatives at Minden. This gave him a chance to practice medicine while taking some additional courses. He also made some observations on health maintenance and concluded that living a sedentary life is not healthy. There he initiated a personal program of walking while meditating and dictating instead of sitting down. The benefits of this program were recorded in his later writings on health maintenance. In fact, Hoffmann taught his medical students to consider the lifestyle of the patient when attending him or her for the purpose of evaluating the disease and determining the appropriate course of treatment.

He remained at Minden for two years and then decided to further his education by traveling and seeking out the more prominent personages of his time. Among these travels is a visit to Oxford, England where he became well acquainted with the British physicist, Robert Boyle (1627-91). Boyle's influence on Hoffmann is seen in Hoffmann's writings and correspondence. From

England, Hoffmann traveled to Lyons, France and to Holland. At each location, he used the time to contact celebrated and distinguished scholars about physics, astronomy and chemistry.

Hoffmann returned to Minden where he established a medical practice and married the daughter of an apothecary. A year later, Hoffmann accepted the position of "Physician to the Military" at Minden and shortly thereafter he was appointed "Official Physician" to the whole province and was also appointed a court physician. In 1688, Hoffmann was invited to serve at Halberstadt and he practiced medicine there for five years with the title of "physician to the principality of Halberstadt."

2.1.3 Hoffmann at the University at Halle

Hoffmann was appointed to the first chair of the new medical school in 1693. However, this was not his only assignment. He was also given the job of organizing the medical school and drawing up its procedures and standards. Finally, he also filled the chair of natural philosophy at the University. He excelled at all of these undertakings. It did not take long for Hoffmann to gain a reputation as an outstanding and motivational teacher at Halle.

Friedrich Hoffmann, George Stahl and Hermann Boerhaave (1668-1738) are often considered the three most influential and important medical personages of the period. Thus, when Stahl joined Hoffmann at Halle, it brought great prestige to the medical school.

Both Hoffmann and Francke had prior acquaintance with Stahl. Hoffmann had known Stahl at medical school. Stahl, while court physician to Duke Johann Ernst von Sachsen-Weimar, had approached Francke with an offer for him to become court chaplain. Francke was already on his way to Berlin (1691) and turned down the commission. However, another committed Pietist and long-time correspondent of Francke was given the position. Francke also wrote some correspondence in which he talked about an inspiring sermon he heard from Dr. Stahl while traveling.

Hoffmann also had pre-appointment contacts with Francke. In 1692 he wrote a letter congratulating Francke on his appointment and discussed some Pietist matters that he thought would interest Francke.

Both Hoffmann and Stahl accepted positions despite poor financial arrangements… *Berlin was notoriously stingy*. (Geyer-Kordesch 1985, 191) Their Pietist motivation was not directed towards wealth.

2.1.4 Hoffmann's Writings

Hoffmann became one of the most celebrated writers of medicine in the Long Eighteenth Century. Hoffmann's first significant effort, the *Fundamenta Medicinae* (The Fundamentals of Medicine) (1695), was written shortly after he assumed the professorship at the medical school at Halle. It became an immediate success. Although it was originally designed primarily for students it

became widely accepted and distributed as a medical textbook for practicing physicians.

It was written in a classical style known as the *Institutes*. Hoffmann's work falls both chronologically and conceptually between the two other major institutes of the period. Lazar Riverius (1589-1655) published his *Institutes* in 1655. However, Hermann Boerhaave's (1668-1738) *Institutiones Medicinae* (1708) may be the best known of the medical "institutes." Each has strongly unique features which reflect the different approaches to seventeenth- and early eighteenth-century medicine.

The institutes were organized in accordance with the five categories of the medical art: *physiology, pathology, semiotics, hygiene and therapeutics*. The parts of the work on semiotics, hygiene and therapeutics comprise the *art* of medicine. It teaches the young physician some clinical applications of the previous chapters. There are instructions on the diagnosis and treatment of sick patients as well as prevention of disease.

Here we see the different emphasis by each writer. While Boerhaave's work was nearly totally devoted to physiology, Riverius was more concerned with the clinical aspects of medicine and devoted a full third of his work to the study of semiotics or what we might call diagnosis. Hoffmann tried to achieve a balance between these two emphases.

The physiology of Riverius' institutes was essentially Galenist, emphasizing anatomy. Riverius' institutes represent those fighting to retain the

traditional concepts of medicine. Boerhaave, on the other hand, emphasized physiology over anatomy; especially, the mechanical aspects of physiology.

Hoffmann's physiology was much more inclusive than the other two writers. He strongly embraced the new mechanical science and experimental philosophy but he also integrated the new chemistry into his theories. He advocated that both physics and chemistry were essential areas of knowledge for the modern physician. Physicians must study nature and nature is mechanical.

All three writings are approximately the same length. Hoffmann, like Riverius, placed a greater emphasis on the clinical aspects of medicine—semiotics and therapeutics—than Boerhaave. However, Hoffmann put his greatest effort into a discussion of pathology. The physiology of Hoffmann was well integrated into his pathology. The physiology covered the principles of physics and chemistry as well as the bodily structure and function of the healthy body. The pathology complemented this understanding by developing an understanding of the unhealthy body and its dysfunctions.

Hoffmann's second important work was the *Medicina Rationalis Systematica* (1729-39). This is a major work meant to include all of the elements of medicine that Hoffmann had learned and taught. Although it is primarily a work on medicine *per se*, it reflects Hoffmann's rational approach to medicine (See Sect 1.4) as a physician and scientist as well as giving us a further insight into how he taught medicine at Halle.

The work is exceptionally well organized and equally usable by a clinical or teaching physician. It is organized primarily by categories of diseases. For example, Part III is entitled *Of Spasmodic and Convulsive Diseases*. In the first section of that chapter he addresses *Epilepsy* or *the Falling-Sickness*. Each such section is then divided into four sub-sections: (1) General History (of the disease); (2) Method of Cure; (3) Practical Cautions and Observations; and (4) Histories of Cases.

This highly influential work was widely distributed in its original Latin. However, it was also translated almost immediately into French (*La Médecine Raissonnée de Mr. Fr. Hoffmann*) (1739). In France, Hoffmann's rational medicine also became popular through the medical and philosophical writings of Julien La Mettrie (1709-51). The English translation was not issued until 1783 (*A System of the Practice of Medicine from the Latin of Dr. Hoffman*). The work was begun by William Lewis who died before the translation was completed. Lewis was a well-known Pharmacist of his time and published a work called the *Edinburgh New Dispensatory*. Although the date of the original work is not given, a later edition refers to the numerous editions printed during the author's lifetime. (Rotheram 1801) It was credited as being at the forefront of Chemical Pharmacy. (Duncan 1806) The translation apparently lay incomplete for an extended period before it was completed by Dr. Andrew Duncan (1744-1828) a Fellow of the Royal College of Physicians in Edinburgh.

The Hoffmann connection with the medical college at Edinburgh has been documented by McCullough (McCullough 1998). There is now further evidence of the influence of Hoffmann on that academic center. The famous physician William Cullen (1710-90) had been a professor at the universities at Glasgow and Edinburgh and he had adopted Hoffmann's system with only a few modifications (Lyons & Petrucelli 1987, 467). Dr. John Gregory (1724-73), who "wrote the first philosophical, secular, clinical medical ethics in the English language" (McCullough 1998, 1), replaced the aging Cullen in 1789. Duncan succeeded Gregory when the latter replaced Cullen. Duncan, who had translated Hoffmann's work, now taught Gregory's course on "The Theory of Medicine". (Kay 1838, 54) Upon the death of Gregory in 1821, Duncan was appointed "First Physician to his Majesty for Scotland."

2.2 Hoffmann's Philosophical Application of Natural Law to Medicine

Although Hoffmann is not considered one of the important eighteenth-century German philosophers, his philosophy (especially as expressed in Part I of the *Medicus Politicus*) played a significant part of the justification he provided for his medical ethical principles.

Hoffmann himself was philosophically *eclectic*. He practiced, taught and wrote during a time when there was a contemporary debate as to the role of the ancients. His approach was to reject neither but to find what each had to offer to

the best understanding of the facts as determined by a rational mind. On the one hand, he was a strong advocate of certain aspects of the ancient philosophers at a time when the ancients were under increasing attack. On the other, he recommended the mathematical logic of Descartes and the new experimental philosophy of Leibniz to his students.

Hoffmann believed the proper method in scientific investigation of medicine requires both observation and reasoning. He referenced and used the empiricism of Bacon and Boyle. From Bacon we see an emphasis on scientific observation and demonstration as well as his emphasis on taking “histories of diseases.” As a committed Baconian scientist of medicine, science required logical inference and a rejection of any speculation or ”hypothesis” not founded in observation. The true medical scientist must observe nature to determine the healthy and unhealthy states of being and then work with nature to implement a restoration and maintenance of health. In this sense, Hoffmann was an empiric.

However, Hoffmann derided the “mere empiric.” For physicians, this was a leading argument against apothecaries and other competitors in medicine. These competitors tried to practice medicine based on their limited experiences or mimicking the medicines prescribed by physicians in relation to specific cases of diseases. Competitors lacked a rational theoretical foundation which could be used to make prudential decisions in specific cases because while diseases may be general, the patients and their circumstances are unique. We have already seen that Hoffmann was influenced by mathematics early in his life and attributed

much of his success to the study and application of mathematics. Thus, reasoning should be a process conforming to mathematics. Just as theorems are deducted from axioms, Hoffmann tried to reduce the principles of medicine to a small number of basic (clear and distinct) propositions arranged in logical and systematic fashion. These propositions could then be applied to particular cases or further principles could be derived from them.

Previously, we noted that Hoffmann was influenced by the seventeenth century Aristotelian, Wiegel, who joined in the project to reconcile Aristotle with mechanistic explanations. Hoffmann not only writes of the need to retain the best from the ancients but his concept of prudence, as we shall soon see, often reflects an Aristotelian mean. Hoffmann may have expressed it best himself when he says that the use of such a variety of ideas can be justified in general by making the distinction that the ancients and the moderns each have something to share with the modern physician and philosopher:

> Just as science is best provided by the Moderns and the present-day philosophy, so judgment and wisdom are best learned from the Ancients, from their various observations and from adjusting oneself to events. (*Fundamenta Medicinae*: To The Reader: 2)

It would be difficult to list the number of times that Hoffmann appeals to natural philosophy and the need to acquire our knowledge from nature. The following selections are illustrative.

> HIPPOCRATES, the ancient father of medicine, writes reverently and wisely, *Try to acquire a knowledge of nature*. It is unfortunate and disgraceful that up to the present time the warning of the divine elder is

> neglected by those who practice the rites of medicine. (*Fundamenta Medicinae* 1695, 2) (My emphasis)

> Without natural philosophy the whole science of healing is maimed and weak, and is not suitable to explain any disease or wisely direct any cure. The natural philosopher peers into the recesses of nature, examines the hidden structures, proportions and mixtures, and from these he draws conclusions most fruitful for medicine. (*Fundamenta Medicinae* 1695, 2)

Hoffmann also is consistent in putting an emphasis on experience in acquiring true knowledge. This is equally true for the physician:

> We do not here understand by science what arises from mere speculation and lacks solid *experience - the first parent of truth*. Rather do we consider as science what is concerned with demonstrating and establishing its conclusions by a simple clear mathematical method…. (N)o physician is rational unless he is accomplished in natural philosophy and has a precise knowledge of natural principles. (*Fundamenta Medicinae* 1695, 2) (My emphasis)

The physician, however, must also have practical judgment or prudence to deal with a variety of situations:

> However great is the science of medicine, no less great is the practical judgment and wisdom of a physician. Science is the eye of medicine, judgment and wisdom its hand. Without judgment the physician cannot discern the proper occasion for what is to be done, nor seize the fleeting opportunities, nor conduct himself cautiously in prognosis and strive for reputation. (*Fundamenta Medicinae* 1695, 2)

In the *Medicus Politicus*, one of the two pillars of justification for Hoffmann's prudential rules comes from *Natural Law* (PIC1R5). The emergence of Natural Law is reported by contemporary researchers as a trend in European

philosophy: "Whereas for the seventeenth century *Truth* seemed to be the key-word, this time (the eighteenth century) it is *Nature*." (Willey 1969, v)

But, above all, Hoffmann calls upon the philosophical tenets of natural law to support his ethics. Natural Law theory played a significant role in the German intellectual community. Although there has been much written about its application to the field of law—especially, in the personage of the Halle professor of law, Christian Thomasius—and politics, there has been nothing written about its application to medicine.

Hoffmann is not so much separating his theology from his philosophy as trying to unify the two through reason. Even many writers who were serious about their religion were referring to Natural Law instead of Revelation. It provided an appeal to reason which fit into the period. There is often a misconception that the scientific movement and the Enlightenment were anti-religious which is not true as most of the key figures of this period were strongly religious:

> Most of the great scientists… conceived that they had rendered the highest service to religion as well as to science, and Descartes, Boyle and Newton, as is well known, were notable theists. As Bacon had said… science was the study of the *works* of God…. But now the more fortunate Francis Bacon could announce with conviction and authority that science was not the forbidden knowledge; that God had provided two channels of revelation, not one merely: the Scriptures, of course, but Nature also. (4) For what had science revealed? Everywhere design, order and law, where hitherto there had been chaos. (5) (Willey 1969, 4)

In the *Medicus Politicus,* Hoffmann gives (PIC1R5) *human happiness* as the first and greatest principle of Natural Law. This first principle contains three additional principles. The following is a summary of these principles.

First, the light of nature helps us recognize that God is to be worshipped as the creator and conservator of all things. We owe God love, fear and honor. Second, society is to be preserved. This consists in mutual love and is the basis upon which all the laws of men depend. Maleficence destroys society. Finally, the natural order (including man and all created things) is to be preserved. Thus, man must live moderately and is not easily agitated. The vices flow from violating this third principle. For this reason, the physician must not confine himself to herbs in healing but will give appropriate advice for the patient to restrain the passions of the perverse type. The skilled physician is one who understands all of natural science. Thus, Hoffmann concludes, the physician must not only be a moral philosopher but also a natural philosopher.

2.3 The *Medicus Politicus*

Having acquainted the reader with the author of the *Medicus Politicus*, Friedrich Hoffmann, in the previous two sections, it is now time to look at the work itself. In this section, we look at the historical (Section 2.3.1) and technical aspects of the work. The technical aspects include an outline of the work (Section 2.3.2), validation as a Hoffmannian work (Section 2.3.3) and a key term analysis (Section 2.3.4)

2.3.1 Historical Factors of the *Medicus Politicus*

As previously noted the *Medicus Politicus* contains the lecture notes of Friedrich Hoffmann and was published in 1738 by his medical students at the University of Halle. In Section 2.4.2.1 below, I discuss this title in greater depth. However, I'd like to place Hoffmann's work in its historical context.

Historically, it follows an earlier *Medicus Politicus* (1614) written by Rodrigo de Castro (1550-1627). Castro was born in Lisbon, but migrated to the Netherlands during the Spanish Inquisition. He eventually was forced to relocate to Hamburg (1594) when the Spanish regained influence in the Netherlands. He distinguished himself there during the plague by showing a spirit of self-sacrifice. The full title of his work was the *Medicus Politicus, sive de Officiis Medico-Politicis Tractatus* and focused primarily on medical matters *per se* and complaints about medical incompetence.

It was written during the height of Renaissance medicine and much of the medical writings of that period was aimed at the incompetence of other practitioners of medicine. (Schleiner 2007) In the case of Castro's *Medicus Politicus*, he even dedicated to the Hamburg senate in the hopes that they would take the initiative in regulating medicine. His purpose is clearly stated: "a treatise… expressing not only the habits and virtues of good physicians but also exposing the deceptions and impostures of the bad ones." (de Castro In Schleiner 2007) There is even a chapter in this work entitled "About certain imposters." Castro, like others before him, was urging the Hamburg politicians to

intervene and restrict the practice of medicine to those who practiced a rational medicine.

2.3.2 Outline of the *Medicus Politicus*

The *Medicus Politiucs* is written in three parts. The first part contains five chapters and seventeen rules. It covers the prudential rules for the medical student as regards the development of his personal character. The physician is to be compassionate, philosophical (rational) and erudite. He is also to be competent and confident. The analysis and my commentary of Part One of the *Medicus Politicus* forms my Chapter 3.

The second part covers the prudential rules for the student to prepare for dealing with other medical members of the community, such as, apothecaries, surgeons and mid-wives, who were often his rivals in medicine. It contains five lengthen chapters. This part might be closely connected with the work's title as regards the power relationships between rivals and the account of harmful practices by other medical practitioners. However, this part is not developed in my present work.

Instead, the primary focus of this writing is my analysis and commentary of Hoffmann's medical ethics as found in Part Three. This part contains ten chapters and about 150 rules. The third part (arguably, the most important for medical ethics) is devoted to the patient-physician relationship. Significantly, it provides rules for both the physician and the patient.

2.3.3 Validation of Compatibility of the *Medicus Politicus* with Hoffmann's Documented Views

The *Medicus Politicus* was a compilation of the lecture notes of Hoffmann made by his students. There is therefore a valid concern about the degree of accuracy made on the part of the students in reporting Hoffmann's words. And there is a question on how much student interpretation and filtering occurred. While it is not possible to validate every rule in all three parts of the work, I have chosen several key rules that will be used in the textual analysis of Hoffmann's medical ethics found in my next chapter. These rules have been confirmed using other Hoffmannian texts.

2.3.3.1 Key Rules: *Let the Physician be a Christian* (PIC1R1) and *not an Atheist* (PIC1R3)

These were selected as two key rules because one of Hoffmann's justifications for his concept of a moral character for a physician is based on Christian principles. We ask the question: *Is this a valid Hoffmannian rule*? That question can be determined by establishing whether or not Hoffmann was a committed Christian and if that commitment is clearly demonstrated in his other works.

The first answer is that Hoffmann was, in fact, seriously committed to his Christian (Pietist) beliefs. He was selected for his position at Halle along with

other committed Pietists. This confirms that the rule is at least consistent with Hoffmann's personal beliefs.

However, stronger evidence comes from his other writings. There are references to God as the creator and sustainer of all nature in his early major work, *Fundamenta Medicinae* (1695). More specific confirmation comes from a series of dissertations on theology and religion. Two examples include the *Dissertatio Theologico-Medica de Officio Boni Theologi ex idea Boni Medici* (1702) and the *Meditationes Theologicae quibus Summa Religionis Christianae* (1737). Each of these is an extensive work on the goodness of God and His authorship of the world.

Additional support comes from other researchers on the history of medicine and medical ethics. The strongest documentation and support is provided by Geyer-Kordesch (Geyer-Kordesch 1985) who documented Hoffmann's religious commitments through his correspondence.

2.3.3.2 Key Rules: Christ as the appropriate model for Physicians and for the practice of the Christian virtues of *Compassion* and *Humility* (PIC1R1 and PIC3R1)

A second confirmation of the Hoffmannian character of these rules comes on his emphasis of the virtues of compassion and humility. In the *Summa Religionis Christianae* (1737) alone we find a number of references to these virtues especially as they pertain to Christ or a Christ-like life. One example is provided here:

> Christ himself leaves behind for us the most perfect example of a holy life and what is pleasing to God, always to be imitated. For just as he himself out of an infinite **compassion (*misericordia*)** and out of love a harsh death is suffered for us, restoring eternal salvation to us. (61) (My Emphasis)
>
> The most beneficent God having obtained for us salvation and happiness, he does not want an exalted reason from philosopohizing nor a profound understanding of the thing, but he only requires a simple heart (animum), **humility (*humilem*)**, full of trust (or faith), obedience and love, and gratitude, on account of every good thing, which he possesses from God. (62) (My emphasis)

2.3.3.3 Key Rule: The Physician should be a Philosopher (PIC1R5)

Because this is a central rule in Part One of the *Medicus Politicus*, a review of other Hoffmannian texts is necessary to confirm the rule is truly Hoffmannian.

Much of what is found in this rule is also found in his earlier work, *Fundamenta Medicinae*. For example, the rule quotes Hippocrates on the philosophical physician and here is what is found in the *Fundamenta Medicinae*:

> The true foundations of the art of medicine we must seek in the principles of nature, and thus, according to Hippocrates, the philosophical physician is to be considered the equal of God. (*Fundamenta Medicinae,* Physiology, Chapter 1, Rule 4)

The lecture notes reflected in this rule state that ignorance of true natural philosophy has led to errors and various sects in medicine. Nearly verbatim language is used in the *Fundamenta Medicinae*:

> Uncertainty, and ignorance of true natural philosophy, are the reasons for the various sects in medicine. (*Fundamenta Medicinae,* Physiology, Chapter 1, Rule 2)

One final example from among many found in the *Fundamenta Medicinae* concerns the mechanical nature of the universe, including medicine:

> Like all of nature, medicine must be mechanical. (*Fundamenta Medicinae,* Physiology, Chapter 2, Rule 1)

2.3.3.4 The Physician should postpone marriage until his studies are completed and should even travel abroad after he has completed his medical training (PIC4).

There is a fairly extensive rule that Hoffmann gives to the medical student on the topic of completing one's studies and subsequent travel. During the time of his studies, the medical student must place his entire effort on completing the medical course. Marriage is normally a source of distraction.

After his studies are completed and he has attained his medical degree then he should travel abroad for the purpose of meeting the most learned men of each country. This is to be promoted because it allows the new physician to further his education by conversing with the best minds on a wide variety of scientific topics.

Although there is nothing in his other writings to confirm this rule, it is surely consistent with Hoffmann's own experience. In this sense, he is sharing his personal experience with his students. Hoffmann traveled for nearly two

years and visited centers of learning on the Continent as well as in England. He even had examples of successful contacts to share with his students; for example, he became well acquainted with Robert Boyle during his visit to England.

2.3.4 Key Term Analysis

This work does not claim a philological expertise. However, I have worked with some very good Latin scholars and have benefited from their guidance.

Some of the terminology used in the *Medicus Politicus* requires more than simple translation. In fact, it would not be possible to address all of the terms used by Hoffmann which either are significant to this work or possibly significant to the history of medicine and of medical ethics.

The following two terms are chosen as representative of the larger body of such terms. The first, *Politicus* or *Politic*, is from the title of the work. The second term, *Aeger* or *Aegrotus,* may have some historical significance which needs to be worked out.

2.3.4.1 *The Politic (Politicus) Physician*

The analysis of this term goes in two different directions. First, we try to verify that this is in fact a Hoffmannian term and the sense that he uses the term. Second, we look at the history of medical writings for a clue as to its historic roots.

The first approach is to connect the title of the work to the textual material itself and to the author's use of the term in other contexts. This proved to be very difficult to do. First, the term is never used again internally in the work itself.

The only reference to *politicus* is found in Part One, Chapter One, Rule 6 (The Physician should be Erudite) in which, among a long list, Hoffmann recommends the study of politics. This is one of the longer rules: it covers (in order) language, logic, mathematics, politics, geometry, mechanics, hydraulics, optics, the human body (anatomy then physiology), medical matters, semiotics and pathology.

However, there is no emphasis on the study of politics. In fact, its importance is minimized by Hoffmann in the rule: "It is still an ornamentation that the Physician should not neglect to take a tincture of *politics*. It is not entirely unexpected when he is obligated to converse with those who make their living by this science. This should be said in parentheses." Other than this short explanation for the student to study politics there is no other reference to *politics* in the *Medicus Politicus*.

Nor can we find any evidence of Hoffmann using this in either of his two primary publications: *Fundamenta Medicinae* or the *Medicina Rationalis Systematica*. In addition to these two major works, I have checked several of his minor works and find that there is no other use of this term by Hoffmann.

The second approach was to see if there was some evidence in the history of medical literature which would support this title. In fact, we have

already noted that Rodrigo de Castro had written a work with the same title over a century earlier. More importantly, in his work de Castro specifically has a stated political aim in reforming medicine. He sets up the issue by writing about the harmful consequences of letting the untrained practice medicine.

There is no doubt that the *Medicus Politicus* of Hoffmann shares some of the same goals. Part II of Hoffmann's version of the *politic physician* is devoted to the relationship between the Physician and other members of the medical community—such as surgeons, apothecaries and mid-wives. But, it also addresses working with other physicians, not all of whom are as competent as the Hoffmannian physician himself. In each case, Hoffmann's lecture notes show a strong criticism for every category of medical participant. The apothecaries and mid-wives are especially criticized. All, says Hoffmann, should be subject to a thorough testing—primarily, by trained physicians. In every clinical case, it is to be the physician who maintains control of the diagnosis and treatment of the patient. The patient's welfare is singularly the responsibility of the physician.

An even stronger argument that links Hoffmann to the concept of a *politic physician* is that the Hoffmannian physician had a political mission. Many of the graduates from Halle went directly to key bureaucratic positions throughout Brandenburg-Prussia. The most influential of them sat in the highest government positions found in Berlin. As we noted above (See Sections 1.4 & 1.5.4), this Halle-Berlin axis played a key role in the eventual enactment of laws that institutionalized medicine as a matter of state interest and ensured that strict

licensing procedures were adopted. The seeds of modern medical practice were sown at the Medical School at Halle and the Hoffmannian physician was the product and the new laws were their fruit.

Thus, in one sense there is little to support that this is a term generally used by Hoffmann himself. It doesn't appear in any of the lecture notes and it appears in no other Hoffmannian work.[3] Nor does Hoffmann make any reference to de Castro. As Hoffmann's lecture notes were published by his students as the *Medicus Politicus* (The Politic Physician), there is no reason to expect that the title was even selected by Hoffmann. It is more likely that the title was selected by the publisher.

However, given the historical context we developed in Chapter One, the title appears appropriate and seems to match the motivation and efforts of the beloved professor of medicine at Halle.

Some Hoffmannian physicians would take positions of power in the government bureaucracy in Berlin and elsewhere. There they could implement the changes that would institutionalize medicine and regulate its practitioners. In this sense, the *medicus politicus* was a *political physician*. Others would be placed into positions of power at medical universities and other teaching positions—such as the influential anatomical theater in Berlin. However, most

[3] Several works by Hoffmann were reviewed in this research effort. However, the Hoffmann corpus is so extensive that further research might cause this position to be revisited.

would bring their character and skills to the clinical setting, which was normally the home of the patient. This included medical practice for the rich as well as the poor. In all of these cases the *medicus politicus* was a *politic physician* dealing with diverse roles in which he was usually the weaker member in a power relationship. But, for the Hoffmannian physician there was one sense in which he was the most powerful member in all of these relationships and that was as the medical expert. He was trained to never forget that; even when dealing with kings and the rich. His power, however, was dependent on his reputation. His reputation was gained by the prudential administration of his office as a trustworthy and competent physician.

2.3.4.2 *Aeger* and *Aegrotus*

One of the translation issues which is bound to be controversial is the translation of the Latin term *aeger* (m). The Oxford Latin Dictionary (*Oxford Latin Dictionary* 2003) gives three options—*a sick person, invalid, patient*. However, there is a serious concern about translating this term as *patient*. At issue is whether the term *patient* was contemporary with the publication of Hoffmann's *Medicus Politicus*.

As Hoffmann never wrote in English and rarely in any language other than Latin, it is difficult to arrive at an absolute solution. Our best approach is to determine first whether the *concept* of *patient* was sufficiently developed at the

time that Hoffmann wrote and then is there any reason to believe that this was the concept Hoffmann had in mind.

An argument is made by some leading historians of medical ethics that the term *patient* is not sufficiently developed until a slightly later date: “In sum, the late eighteenth century there was no profession of medicine in the sense of a fiduciary concept and practice governed by reliable intellectual and ethical standards.” (McCullough 1998, 207) That is, the patient-physician relationship did not have a well-developed concept of trust and trustworthiness. “A fiduciary by habit blunts self-interest.” (McCullough 1998, 207)

Supporting this position is the translation of *aeger* in the 1751 French translation of the *Medicus Politicus*. The translator uses *malade* and not *patient*. *Malade* can be translated (primary) as *sick man or woman* (*Oxford Hatchette French Dictionary*, 3rd ed.). However, it does have a secondary definition as *patient* when ‘in medical or hospital settings’.

On the other hand, there are three pieces of information which might support using *patient*. First, the noted scholar Lester King translated an earlier Hoffmann work, *Fundamenta Medicinae*. In this translation, King consistently translates *aeger* as *patient*.

A second English translation of a Hoffmann work which was done nearer the time of Hoffmann’s original publication is found in Andrew Duncan’s translation of the *Medica Rationalis Systematica* (A System of the Practice of

Medicine: from the Latin of Dr. Hoffmann, 1783). Here we see that *aeger* is translated with the English term *patient*.

One might counter-argue that these were translations from English-speaking translators. In the first case, King's translation is fairly recent and the term *patient* has become so common that he may have chosen it to convey to the meaning to a contemporary audience. And, although the English translation by Duncan was more contemporary with Hoffmann, it may only show that the English speaking world was using the term *patient* at a relatively early period and not necessarily earlier in the eighteenth century when the *Medicus Politicus* was published, much less the earlier dates of Hoffmann's lecture notes used for the *Medicus Politicus*.

The third argument in favor of using *patient* comes from a medical student at Halle. Longolius was a medical student at Halle and would have reasonably been expected to have attended lectures by Hoffmann. His work, *Der Galante Patiente* (1727) provides an ethics for patients. It parallels very closely the terminology and concerns expressed in Part III of the *Medicus Politicus*—i.e., the patient-physician relationship. There the patient was urged to act prudentially and honestly when dealing with the physician. She also was to take the medicine prescribed by her physician to include when he was no longer present—i.e., complementing the concern expressed by Hoffmann about patients taking medicine. If she felt the need to change physicians, she was to do so tactfully. And, she was to give a fair 'honorarium' to the physician for his care.

The title of the work incorporates the German equivalent of the term *patient*. It was thus known at the time of the writing of the *Medicus Politicus*. More importantly, the work of Longolius so strongly parallels Hoffmann's lectures that the title would reasonably be expected to use a Hoffmann term as well.

The conclusion of this controversy may be settled when more Hoffmann works are reviewed and/or translated. There is little written in German by Hoffmann and even less translated into English.

Until a better determination is made on the historical concept used by Hoffmann, the term *Aeger* will be translated as *sick person* in the translation of the *Medicus Politicus*. This is a rather cautious and conservative approach to ensure the most original idea is maintained in the translation. This also ensures that the translation of both the Latin and the French are equivalent terms. However, the more contemporary term *patient* will be used in my commentaries and analysis. This will ensure that my terminology is the same as the other contemporary writers I use throughout the analysis. That is, almost every contemporary writer uses the term *patient* and not sick person.

CHAPTER 3: PHILOSOPHICAL ANALYSIS OF PART ONE OF THE *MEDICUS POLITICUS*: THE CHARACTER OF THE HOFFMANNIAN POLITIC PHYSICIAN

3.1 Introduction

In Chapter One I examined at the historical context and contemporary conflicts that informed Hoffmann. These show that the Long Eighteenth Century was intellectually stimulating, socially dynamic—and politically dangerous. The German territories were changing dramatically as they transitioned from weak and divided territories that served as the battlefields for more powerful nations into politically and territorially united entities that could be self-determining. One result of this political drive for unity was the development of absolute monarchies and powerful bureaucracies. Hoffmann's Brandenburg-Prussia followed this pattern of change. There was a parallel change in religion, which had also been a battleground for more than a century. The drive to gain religious unity through force was abandoned in favor of methods to achieve unity (albeit Christian unity) through tolerance and harmony. In Hoffmann's time, Leibniz was the leading German spokesman of this effort. But there were also new dynamics that needed to be included. Significant scientific advances had been made during the past century—and a trend that was accelerating—including discoveries in medicine. This gave respectability to the new evidence-based scientific methods. Hoffmann recognized that the modern physician would have to be a rational scientist. Finally, the old social order was giving way to the emergence

of a modern professional class. In Part One of the *Medicus Politicus* we see how the Hoffmannian physician was being prepared to fill the needs of the new state, the new bureaucracy, and the new professional class.

I also provided an historical view of Hoffmann the man, physician and teacher in Chapter Two. There we identified his two key writings: the *Fundamentals of Medicine* and the *Rational System of Medicine*. In point of fact, he was a prolific writer. However, the two writings we looked at are not mere samples of his writing but they actually represent his two most successful and influential publications. When the *Medicus Politicus* is treated as a Hoffmannian work, it would join the other two as his key publication. The only hesitation is that the *Medicus Politicus* is in a special category. It was a collection of his lecture notes published by his students. Finally, and more importantly, from the viewpoint of my analysis and commentary on the *Medicus Politicus*, the background information helps us to understand which aspects of his life contributed to this writing. In analyzing Part One—*Medicus Politicus* we will see that Hoffmann's commitment to Christianity (especially, Pietism), Natural Law Theory and the new scientific methods will be well represented as he develops the Hoffmannian physician.

In the next two chapters, I will work out the various aspects of the medical ethics contained in Parts One and Three of the *Medicus Politicus*. My goal is to develop them into a serious, significant and consistent theory of medical ethics.

This effort is necessary because the *Medicus Politicus* is a complete set of lecture notes that contains both ethics and medicine *per se.* The ethics is presented in a natural and interrelated way—but easily lost within the context of the discussion on medical procedures. At times Hoffmann may be discussing a clinical situation with his students and he'll include both the medical aspects as well as the ethical aspects.

For example, in Chapter Nine (Part III), he addresses the prudential behavior of the physician in cases of chronic and acute illnesses. Yet, the chapter contains many rules that include a strong ethical element. For example, the title of one rule seems to address an issue of decorum—i.e., a physician should be conversant with patients – but then includes a significant ethical limitation:

> (*The Physician*) *should not only approach the sick person to be seen as to also be conversant*.
> … But on the other hand, very many go wrong in exceeding this rule; they induce great discomfort in the sick by excessive chattering about the news or the weather, or abut a number of his sick persons and of their condition just to pass the time. They lose all trust by this sort of thing….
> (PIIIC1R10)

In other examples, the title of a rule appears aimed at physicians but it also contains a complementary rule for patients. Thus, Hoffmann entitles one rule as: *To arrive in time is the most important thing*. This rule seems like an obvious requirement for the physician to respond quickly—especially, in cases of

serious injury or disease. However, it quickly turns into a prudential rule for the patient as well:

> … Likewise, it is desirable that the sick observe this rule well and by no means should they put off for a long time seeking the help of the Physician, but they should hurry; in fact, frequently the blame for the sadder outcome is not due to the Physician but to the sick person himself delaying…. (PIIIC1R7)

Hoffmann is teaching his students that the practice of clinical medicine requires medical decision-making that includes both technical and ethical elements. Thus, the *Medicus Politicus* was not written as a medical ethics *per se* but rather reflected a series of lectures which fully integrated ethics into the clinical practice of medicine.

This will be the first attempt (at least in the English-language tradition) to comprehensively "pull out" these ethical elements of Hoffmann's work and to develop them into a consistent and more readily understood theory of medical ethics.

3.2 The Educational Process

Remembering that Hoffmann was a medical school professor, one of the interesting aspects of *Medicus Politicus*—Part One is the educational methods that he used to develop his ideal physician. There are four such educational techniques of interest.

First, he develops the physician from the inside out. He does so in two ways: he develops interior qualities and skills before the physician encounters

erudition and experience and he develops the character of the physician before deploying that character into the clinical setting. Second, he uses a building-block approach. Thus, he develops the virtues and skills which are needed to derive the greatest value from education and experience. Third, he moves from theory to integration in practice. And, finally, he outlines a plan of lifelong learning.

The first two methods are similar to those found in other European medical school curricula. However, I find the last two methods unique to Hoffmann. And, in all cases, the content differs from traditional curricula. The first educational technique is found several times throughout Parts One and Two of the *Medicus Politicus*. The first six rules of Chapter One of Part One address the inner qualities that a physician needs to develop in order to become a Hoffmannian physician. Parts of the sixth rule through rule eight address education and experience. Finally, the qualities and skills developed in Part One are deployed in the clinical setting in Part Three.

One of the more significant applications of the second educational technique is the development of basic rational skills and the acquisition of basic sciences before proceeding to erudition and experience.

The third educational technique is unique to Hoffmann. He first develops the ethical theory for the medical student (Part One) and then integrates it into the rest of the curriculum (especially, Part Three). While a review of literature shows that medical schools conducted classes in ethics, there is no indication

that the ethical principles learned in such classes were continuously integrated into classes on clinical practice. Hoffmann's ethics, on the other hand, are woven seamlessly into the rest of his curriculum.

This third technique has merit for our consideration in the modern medical school setting. Many medical schools currently have medical ethics courses and ethics professors teach in clinics and hospitals in which medical students, residents, and fellows train.

The fourth technique is a recognition by Hoffmann that the days of going to medical school and learning a Galenized (or other) understanding that lasted a lifetime had come to an end. Instead, the new physician needed to keep abreast of the changes in his career field. In fact, Hoffmann has the physician keeping current in all areas of natural philosophy. Many of the rules in Chapter Two ("Some aids which are found in the study of Medicine.") of Part One are directed towards this goal. (See Section 3.3.3 below) This technique is normally satisfied in contemporary medicine through professional journals and education seminars.

3.3 Analysis and Commentary on Part One: The Character of the *Politic Physician*

Everything in *Medicus Politicus*—Part One should be read in light of its title: *The rules of prudence concerning* ***the personal qualities or characteristics of the Physician himself****.* (My emphasis) Part One contains

five chapters and a total of eighteen rules. While the rules vary in length, the three longest are Rule 5—Let the Physician be a Philosopher (106 lines long), Rule 6—Let the Physician be erudite (79 lines) and Rule 7—Let the Physician learn clinical and individual practice (66 lines).

These lecture notes show that Hoffmann is concerned with developing the medical student into a moral, rational and competent physician. It might be argued that the physician of the Hippocratic texts contains these elements. However, Hoffmann is the first to update the model (in each of the elements) and to mold it into a uniquely modern physician—the prototype of the modern professional physician. Hoffmann is preparing his students to become the first professional physicians of the new political and social order in Prussia. For this reason, I've called this new, ideal physician developed at the medical school at Halle—the *Hoffmannian Physician*.

In the next three sections I analyze the concept of the Hoffmannian Physician and each of the three elements: moral, rational and competent. Of special note is Hoffmann's providing three parallel justifications for each moral characteristic which he is advocating for the medical student—he uses theological/religious, philosophical/rational and prudential/practical grounds of justification.

3.3.1 Development of the Moral Character of the Physician

The very first lectures of the *Medicus Politicus* are on moral character. They reflect Hoffmann's emphasis on the requirement for the medical student to develop a good and strong moral character. For the medical school student, such an introduction to medical school would have prepared them for the idea that their curriculum was about more than technical knowledge and developing medical skills *per se*. Medical school was a *process of change*. Medical students at Halle came from diverse backgrounds and from a number of the other German territories. Thus, much of their individualism and differences would have to be subsumed into Hoffmann's model of the good physician—their first taste of self-sacrifice in a career that would require much more.

These initial lectures provide both theory and motivation. Hoffmann's moral theory is based on the development of virtues and the avoidance of vices. His approach blends Aristotelian ethics, scholastic virtues and Aristotelianized Lutheranism.[1] The primary virtues that Hoffmann requires are not different than those found in traditional Christian literature but they would not all be endorsed by Aristotle (see Section 1.2.4). Hoffmann provided motivation for the student to become virtuous through a series of justifications appealing to their religious, rational and practical considerations.

[1] For a discussion on the influence of Melanchthon on the development of a Lutheran educational curriculum that included a harmonized version of Aristotelian ethics and neo-scholasticism see Hochstrasser [2000 32-2].

Hoffmann initiated the moral training module by introducing the student to the virtues of compassion, humility and moderation as Christian virtues. These virtues are justified based on a broader requirement that he must be a Christian. In fact, the very first rule given in the *Medicus Politicus* is: *Let the Physician be a Christian.* (PIC1R1)

This first rule goes on to list those elements of the Christian faith that are necessary and those that are insufficient. Three elements of faith are given as necessary: first, it is necessary that the Physician should live his life in accordance with his Christian belief; then, he must imitate the works of Christ; and finally, he will necessarily be compassionate. This list is augmented with two elements that are not sufficient: first, it is not sufficient to merely be knowledgeable about Christian history of what is to be believed and to be done; and second, it is not sufficient to merely profess the faith of Jesus Christ.

The term *Christian* is defined by Hoffmann in terms of behavior and not doctrine. Being such a person required an inner (interior) commitment on the part of the physician to live a true Christian life. That is, he is to incorporate the Christian ideals into his activities as a way of life. The ideal Hoffmannian physician is not merely to give the outward appearance of being a good Christian but he must actually be one. An anachronistic reading might bring to mind the contemporary question: *What would Jesus do*?

The first and primary Christian virtue that the new physician must develop is *compassion*. The best way for the physician to develop the virtue of

compassion, he says, is to imitate the works of Christ. The model of the ideal physician that Hoffmann had in mind was Christ. Therefore, it should not be surprising that his first step is to build his new physician in the image and likeness of Christ. That is, compassion is a natural outcome from imitating Christ: *And if the Physician is a good Christian in this way, he will necessarily exhibit compassion….* (PIC1R1)

The consequence of acquiring compassion is that the sick are benefitted; especially, the poor. The rule goes on to emphasize that the physician's compassion should be directed ... *especially toward the poor, to whom he will never deny (his) free help.* (PIC1R1) Virtue not only perfects the thing itself but also its acts. Just as sharpening a knife has two effects: it perfects the knife itself and everything that it cuts is cut well, so it is that a physician who develops the virtue of compassion has a compassionate character and he will also treat each patient with compassion. It follows then that such a good physician would never refuse aiding the poor even if such service is performed without pay.

Care for the poor was both a traditional Christian concern in general (see Section 1.2.2) and a strong Pietist commitment in particular (see Section 1.2.3). Hoffmann's personal commitment to the poor has been documented in his early and active support of the *Freytische*. This was an organization at Halle that allowed poor students to attend the university by providing free food. Hoffmann worked hard to obtain financial support to help start the program and to keep it going. (Geyer-Kordesch 1985, 192-3)

The justification provided by Hoffmann at this point for the virtue of compassion is religious (PIC1R1). God is the model of benevolence: *... the most benevolent God made the art of medicine gracious* (*gratam*). (PIC1R1) Good Christians in general must imitate this model: *... the Christian exercises kindness*. (PIC1R1) Good Christian physicians, on the other hand, must go even further because *God has determined that (the art of medicine) is to be practiced out of pure benevolence*. (PIC1R1) For it is in medicine that we have the greatest opportunity to imitate the model: ... *nor will an occasion be lacking, indeed, the* ***daily misery*** *of man will remind him to give help to the needy.* (My emphasis) (PIC1R1) Just as compassion is the appropriate form of God's love when dealing with our fallen nature so is compassion the appropriate form of the physician's love for his fellow man in the state of daily misery. Thus, the compassion of God must be mirrored in the life of the physician who freely gives his medical skill to the poor—i.e., a benevolent reflection of the benevolence of God.

Just as virtues perfect or preserve the nature of a thing, vices destroy that nature. Thus, Hoffmann warns the medical student to avoid all vices. Two of the vices that specifically undermine or destroy a compassionate nature are *greed* and *pride*.

The vice of *greed* is mentioned frequently by Hoffmann in the *Medicus Politicus* so one may conclude that it was a real problem in his time. Although he

doesn't provide an extended argument here, it may be filled out by showing that greed is an excess of self-interest.

He gives two versions of the vice of pride ... *one kind dwells in the mind, when he denies conversation to men of an inferior situation, nor does he value them; another dwells in carriage, when he rejoices in the most splendid clothing and many attendants....* (PIC1R1) Pride too is an excess of self-interest. All of these vices, he continues, are *apt to be the most harmful to the Physician*. (PIC1R1)

To counter these vices one needs to develop the Christian virtue of *humility*. Humility corrects the excesses of self-interest because we recognize our true state of affairs as human beings. The art of medicine, Hoffmann says, is in the best position to know this state: *.. where we contemplate what man should be, how transitory, how frail, from where he got everything, he is born between the excrement and the urine. Therefore, what is the life of man? Nothing if not a shadow.* (PIC1R1)

In a second rule on moral character, Hoffmann requires a third Christian virtue of *moderation*. Hoffmann refines his explanation about the behavior of the physician as a Christian. He is to be *moderate* when discussing religion and should never become argumentative: *It is better to demonstrate by a praisworthy life what a genuine Christianity should be, than to point out by reasoning and by arguing.* (PIC1R2)

It seems like the physician will have no end of opportunities to practice moderation in conversing about religion. Hoffmann (Rules Three and Four) identifies and discusses two groups of persons who are not truly Christian. The first group are atheists (primarily he describes Pantheists and Deists) and the second group are the superstitious. Such beliefs undermine the concept of the personal benevolence of a good God who conserves all things and exerts his ongoing influence over a mechanistic universe.

Again, these are traditional Christian virtues and a traditional Christian argument and there is no claim here that Hoffmann is the first to list these virtues as a primary requirement for physicians. What is unique is that Hoffmann now goes on to provide additional rational and practical justifications.

Philosophy is the basis for Hoffmann's second justification for acquiring the virtues. In Rule Five (*Let the physician be a philosopher*) (PIC1R5) he declares that human happiness is the first principle of his Natural Law theory. In Natural Law further principles and applications flow from first principles just as theorems flow from axioms. (Jonsen 2000 253) From his first principle Hoffmann derives three other principles (see Section 2.2) including one which identifies man's social obligation:

> Society is to be preserved. We would be extremely wretched having been abandoned by the fellowship of others, wherefore society should be preserved, consisting in mutual love, upon which the laws of all men will depend, which laws regulate nothing other than that everything should be avoided which destroys society, for in a destroyed society love and any kind of happiness perish. (PIC1R5)

Such preservation, he asserts, consists in mutual or reciprocal love between all men. The student has already learned that on a practical level between men who suffer from the same misrable human condition, compassion is the appropriate form of mutual love and, as a virtue, it strengthens social bonds. The man of compassion perceives each human person as an equal. Thus, even the poor come to be recipients of shared love.

Natural Law provides a rational justification for Hoffmann's ethical theory. For the first time, the medical student is given an insight into Hoffmann's broader goal of harmonizing faith and reason. Traditionally, physicians understood behavior in terms of either religious duties or decorum. In the *Medicus Politicus* Hoffmann ties these traditional justifications to the new modern Natural Law theory. "Natural law theory made explicit the connection between what might be viewed merely as manners/demeaner and morality." (Lindemann, unpublished, 7)

The traditional ethical principle of beneficence can now be derived from our Natural Law obligation to preserve society through mutual love and to attain our teleological end of happiness. Mutual love, as the virtue of compassion, brings beneficence in that it preserves the social relationship between men. But, if that is true then anything which opposes mutual love is a vice and harmful to that relationship. That is, from Natural Law we derive both a principle of beneficence and non-maleficence. Thus, Hoffmann claims, this same Natural Law principle that preserves society is also a principle of non-maleficence that is the foundation of all the laws of man: *This is the basis for the law of men and it*

consists in avoiding that which is harmful to society. Without this law there is neither commitment nor particular happiness at all. (PIC1R5)

In my ananlysis (Chapter Five) of Part Three—*Medicus Politicus* Hoffmann will apply this Natural Law understanding to the development of his concept of the patient-physician relationship. An individual within society who is perceived to express love for his fellow man in its practical or prudential application as compassion can be trusted not to destroy the social relationship.

The virtue of *moderation* is also addressed by Hoffmann under Natural Law theory. As a Christian virtue, Hoffmann had applied moderation as a limit to excess in living out one's religious beliefs. We were not to argue about our beliefs but to demonstrate by an exemplary life what a true religion should be.

Under Natural Law, he derives the need for moderation from his third principle *to preserve ourselves*:

> The natural order is to be preserved…. Following this rule, man himself lives moderately, is not easily agitated contrary to nature, but he acquires a long life and the end proposed by God. Most vices flow as a result of ignoring the truth of this rule, for instance: anger, hatred, murder, [immorality], sexual intercourse with beasts; for the very same reasons, the perverse lusts of the mind arise instead of the moderation of man. Which, if he understands (this), the Physician not only with herbs but with words and advice will check the unbridled evils of most of the passions coming from the depraved desires of this sort. (PIC1R5)

While the virtue of moderation is to be developed for our own individual preservation, Hoffmann adds an important social application at the end of the principle. Specifically, the physician is to ensure that patients are appropriately

counseled on this virtue as part of their treatment plan whenever they suffer from excesses that violate this principle.

A third approach to teaching the medical student the concept of the interior qualities of a virtuous life is developed in Chapter Three: *Rules of the personal virtues necessary to preserve one's highest reputation*. There are four rules in this chapter that describe the virtues and vices that impact on the reputation of the physician. Some of these virutes are the same as we've already discussed. Others are new.

What seems to be different here is that the Christian virtues (compassion, humility and moderation) were to be followed because the Christian is to imitate the life of Christ and the Christian physician is to imitate the life of the most perfect model of the good physician. The Natural Law virtues were to be followed because they preserve society and the individual. Now, in Chapter Three, we are given the virtues that preserve and the vices that destroy the relationship between the patient and the physician.

Chapter Three starts with the virtue of *humility*: *The Physician should be humble and not proud.* (PIC3R1) This virtue was also found in the first rule of Chapter One: *the Physician should not be greedy, nor proud, but (he should be) humble*. (PIC1R1)

The description of pride is also the same. In Chapter One Hoffmann described two forms of pride: *when he denies the conversation to men of an inferior situation, nor does he value them* and *when he rejoices in the most*

splendid clothing and many attendants. (PIC1R1) The description in Chapter Three follows the same two forms of pride: *With those who he makes conversation, he should decently insinuate himself, in a graceful manner equally for the more respected and for the lower classes, and he should not be excessively luxuriant in clothing.* (PIC3R1)

However, the similarity between the two rules ends there. In Chapter One, Hoffmann justifies the virtue of humility by saying that the physician must follow the image of the most perfect physician, Christ. Here he uses the self-image of an ideal physicain as a justification-i.e., one's *highest reputation*.[2] Vices tend to destroy and in this case the vice of pride destroys the reputation of the physician.

By opposing greed, Hoffmann is also preparing his physician to take his place in the new society. For Hoffmann portrays the primary motivation of his competitors as greed and he wants to set his new physician apart from these pretenders on every occasion.

The second rule in Chapter Three addresses the contemporary issue of confidentiality. Physicians should be *discreet* (*taciturnus)*. They should not discuss the diseases of their patients with anyone else. Having their private and sometimes embarassing medical conditions aired publicly rightfullly upsets the

[2] I will save the discussion on reputation until the next chapter where it is dynamically integrated by Hoffmann in the clinical setting.

patient and harms the reputation of the physician. The requirement for discretion by the physician is not new to Hoffmann.

Finally, the fourth rule of this chapter is a very broad requirement: *The Physician ought to do his best by choosing all the virtues from moral Philosophy.* The physician must be compassionate, modest and humane. He must avoid a loose life, obscene language, drunkenness and forbidden games. Under Natural Law, these latter vices would be paralleled by the third derived principle of the duty of man to himself. However, here it is combined with man's duty to society in the sense that such behavior undermines the physician's ability to perform his art in the community because of the loss of reputation.

The rule continues that he should avoid promising too much and avoid criticizing others and bragging about himself. All this and more is required of the physician, says Hoffmann.

3.3.2 Development of the Rational Character of the Physician

The proper development and application of the human intellect is the second personal quality that a medical student must develop to become a Hoffmannian physician. The goal of this portion of the curriculum is for the student to acquire a *right reason*. The development and application of right reason is detailed primarily in Chapter One, Rules Five and Six.

Hoffmann provides several explanations for the importance of developing the intellect in this way. True learning, he says, comes from the intellect and not

from the imagination. (PIC1R5). But the intellect must be properly prepared and developed into right reason. Once it is properly developed, right reason, along with experience, helps the physician choose *true and certain principles*. (PIC1R5)

Before all else, the student must become a philosopher – both a moral and a natural philosopher. In fact, a physician is uniquely required to know and to combine the two: *Moreover, Philosophers are concerned either with moral philosophy or natural philosophy, and it is necessary that each is to be found in the physician alone.* (PIC1R5) Thus, Hoffmann seems to have a concept of the physician as a person who understands both moral and natural philosophy and who can integrate or harmonize the two. However, it gets a little complicated trying to show how Hoffmann ties the two together.

First, in the early part of his explanation of moral philosophy, Hoffmann lists the three primary (moral) responsibilities that are initially derived under Natural Law theory: *I am responsible to God, my neighbor and myself.* He then discusses each of these three responsibilities individually and in greater depth. But, when he gets to the third derived principle of his Natural Law (moral) theory, he changes the wording from *I am responsibility to... myself* to the much broader requirement: *The natural order is to be preserved*. Hoffmann explains that he intends for the student not only to apply the same (moral) principle to man but also to all of nature: *This principle should be pondered concerning either man himself or all created things*.

Initially, Hoffmann applies the principle specifically to man's preserving his own life by ordering his life in accordance with the natural law. We preserve our lives by taking a prudential approach to life and living soberly and controlling our passions. In fact, Hoffmann adds, the good physician recognizes this requirement extends it to his responsibility to preserve society when treating a patient. Not only should he administer the appropriate herbs but also the appropriate advice when the illness is a result of an excess of the passions. (See Sect. 3.3.1 above)

But then the rule goes further in requiring that we must not only follow the natural order as it relates to ourselves but also to *all created things*. However, there is an ambiguity in Hoffmann's ology here. When he says that we have a moral obligation to *preserve* ourselves, he means this literally and morally. But when he speaks of *preserving* all created things, he seems to mean it epistemologically and practically: i.e., the focus is more on the discovery of the essences of all created things so that this knowledge can be used to preserve human individuals. Thus, we are to discover the natural order of each thing so that we can apply that knowledge to the moral requirments to preserve ourselves and, by extension, society.

> I have previously said that this principle extends to all created things; insofar as we consider their nature, for instance: the proper mixture of fire, the qualities of nutrients, and other things, **so that by this method we might seek the things suitable to our nature**. Having been instructed in natural science, the physician understands all these things, following from which he examines the nature of all things and his own nature.

> Accordingly, I conclude that the Physician should not only be a Moral Philosopher but also a Natural Philosopher. (My emphasis) (PIC1R5)

This initially seems like an extremely anthropocentric view of the world and of the purpose of natural philosophy; however, it turns out to be justified by the moral requirements to preserve ourselves and society. Thus, for Hoffmann natural philosophy and moral philosophy are integrated or harmonized in relation to our moral duties. Such an interpretation of Hoffmann is further justified by his concept of a physician as being in a unique position within society to fulfill the natural law requirement to preserve society—this the physician does one patient at a time.

In fact, such a rational physician will be god-like in his ability to understand and apply nature. Hippocrates, Hoffmann says, claimed that the philosophical physician is considered equal to a god. (PIC1R5) In Part Three-*Medicus Politicus*, Hoffmann provides further insight by showing that a rational and competent physician can not only diagnose and treat an illness but can often predict the outcome of the disease as if they had God-like foreknowledge. (PIIIC1R3)

In more practical terms, Hoffmann equates the rational powers of the physician with the capability to accurately determine cause and effect and with choosing the true and certain principles which come from a properly developed right reason:

> Accordingly, I conclude that the Physician should not only be a Moral Philosopher but also a Natural Philosopher. A Natural Philosopher is

> someone who is **able to explain the causes of the effects and the phenomena of nature**.... Before all else, the Natural Philosopher should choose the **true and certain principles, which proceed according to right reason joined with experience**, but he should avoid... the fictions that have for their foundation superstitions and imaginations. For true learning is not a thing of the imagination but rather of the intellect. (My emphasis) (PIC1R5)[3]

The entire text of the *Medicus Politicus* is full of examples that Hoffmann gives to the student in the application of this principle of right reason to the environment. Through right reason and experience we discover: "True Christianity" [*Christianismus verus*] (PIC1R2), "True (versus superstitious) Facial Feature Reading" [*Vera Physiognomia*] (PIC1R4), "True Learning" [*Vera erudition*] (PIC1R5), "True Mechanical Philosophy" [*veram Mechanicam Philosophiam*] (PIC1R5) "True Scholarship" [*veram eruditionem*] (PIC1R6), "True Medical Observations" (PIC1R7), "True Signs" [*Signa vero genuina*] (PIIC2R9), "True Judgment" [*certum judicium*] (PIIIC1R3), etc. It is the reliance on right reason and the avoidance of superstitions and imagination that the rational physician is to be set apart in the new social setting.

In one sense, Hoffmann is setting his new politic physician apart from previous trained physicians and, especially, from the mere empirics who were his competitors. While empirics could claim to derive some knowledge from experience the Hoffmannian physician would be able to counter that they don't

[3] Hoffmann provides a fuller account of his concept of *superstition* in Chapter One, Rule Four: *Let the Physician not be Superstitious*.

have the rational skills necessary to truly benefit from the experience. For example, some apothecaries might observe what a physician prescribed in a certain disease and offer the same in similar cases. The problem is that they were not skilled in diagnosis and that they would only be treating similarly described symptoms.

There is no lack of detail in Hoffmann's descriptions of the *methods* which the medical student is to learn to use in acquiring true and certain principles. The first general method he describes is the physician *qua* natural philosopher learning about all the creatures and elements of nature so that this knowledge might be applied to the preservation of humans: *I have previously said that this principle extends to all created things; insofar as we consider their nature, for instance: the proper mixture of fire, the qualities of nutrients, and other things, so that by this* ***method*** *we might seek the things suitable to our nature*. (My emphasis) (PIC1R5) The second general rule follows from the first: we must understand the *universal* to be able to apply it to the *particular*. For example, gaining knowledge of the human mechanism is insufficient for the physician; he must understand all the machines in the world: … *the knowledge of man is not sufficient to the Physician; he ought to include all of the machines occurring in the world, or, what is the same, of the universal mechanism. For if he doesn't understand the macrocosm, I ask how he is able to examine the microcosm*? (PIC1R5) Finally, Hoffmann describes the rational method by which the physician *qua* natural philosopher is to render the causes of all natural things.

Unaided human senses, he says, are incapable of rendering knowledge of such causes. To understand the innermost essences and constitutions of natural things requires *experimental philosophy*. Experiments often require specialized instruments such as telescopes, microscopes and caustic dyes. Such experiments can give us knowledge of *particular reasons* and from this we can try to prove the *universal reason* or *cause*. The universal reason is like an axiom from which we can demonstrate many things. For example, says Hoffmann, one observes that crushed almonds and water produce a milk-like emulsion. We look for causes with the help of reason and we eventually form the hypothesis that it is the oily parts of the almonds which, when mixed with water, produce this milky color. To test the hypothesis we set up an experiment with some other oils (e.g., anise) mixed with water and we see that it also changes into a milky color. We can now conclude that whenever an oil is released into water it produces a milky color. The physician can apply this to certain extracted juices from patients (e.g., chyle), which is nothing more than a natural emulsion. If the extraction turns into a milky color we know that the extraction is a natural oil.

There are some basic understandings that the rational physician must have. The first is Chemistry. Physicians should be primarily concerned with chemical experiments: *Indeed, Chemistry is most appropriately called the soul of Medicine by certain people, when one knows it is formed from experiments….* (PIC1R5) Then, they must understand mechanics which gives the highest

degree of knowledge about movement. Hoffmann often gives a recommended reading list to his students. On mechanics, he says: *From Mechanics we have in the highest degree a necessary doctrine about movement; where we recommend before any others: Leibniz, in his Theodicy; similarly, Wallis, Borelli, Sinclair on gravity, Tigelius, Gassendi, etc.* (PIC1R5) He provides no further details beyond these general recommendations.

In Chapter One, Rule Six (*Let the Physician be Erudite*), Hoffmann describes certain basic rational skills that the medical student must develop. These skills are necessary if the student is to benefit from his education and training. When the student becomes a physician, these skills will continue to function in helping the physician benefit from experience.

First among these is the study of *logic*. We've already noted that the old curriculum required the medical student to first study Aristotle's argument, logic, rhetoric and dialectic so that he was capable of applying these skills to all of his further studies. However, Hoffmann rejects the logic of the ancients in preference for the study of mathematics.

> But, **in order to acquire a true scholarship, it is necessary to know how to decide with one's reason**; that is to say, to be in a state of making good use of it. This is that which we understand as Logic. Because it is an art which gives the necessary precepts in order to put things forward with order, in order to give them an exact connection and in order to form some clear demonstrations. Besides, when I speak of Logic, **it isn't Scholastic Logic which I intend, but that of Mathematics**, where I wish that the Physician apply himself there seriously; because **Mathematics are the principle, or the mother of all the sciences** and

> without their intervention we cannot have entered into the places of the daughters**.** (PIC1R6) (My emphasis)

Mathematics is the mother of all the sciences for Hoffmann and without studying this science we can never hope to understand all the other sciences. However, as usual, Hoffmann wants the student to start with the basic understandings. Again, the development of right reason from natural philosophy, logic and mathematics is to help form a right reason to work with experience in discovering true and certain principles:

> Or, in order to make some progress from them, it is necessary to begin but studying especially Arithmetic and Algebra. They serve to form the judgment and they render the spirit capable of easily distinguishing the truth from the false and when one is well filled with some small number of principles of these sciences, we can easily do without the lecture of a great number of treatises on Logic. We can thus limit ourselves to Descartes, Malebranche, le Clerc. One will find in their Logic, their Metaphysic, their Pneumatics, everything which is necessary for the Physician to have knowledge as regards Logic. (PIC1R6)

Developing the rational capacity of the student would be important because the new physician would have to be prepared to function in an evidence-based scientific world of medicine. This would be important to the graduates who went to Berlin to fill positions in the new and powerful bureaucracy and the Berlin Academy of Science. (See Sections 1.4 & 1.5.4) It would be equally important to graduates who became part of the international scientific community. And, finally, Hoffmann wanted to set the new physician apart from his competitors who were *mere empirics* througout society.

3.3.3 Development of the Clinically Competent Character of the Physician

In the previous section, we learned that Hoffmann wanted the physician to develop his rational capacity in particular ways so as to attain right reason. Right reason, along with experience, is the way in which the Hoffmannian physician could discover true and certain principles. But, it wasn't just any kind of experience that Hoffmann had in mind.

In this section, we will see how a morally and rationally developed physician develops into a clincally competent physician. For Hoffmann, competence is gained from the application of a highly-developed rational capability to certain types of experiences: Pre-clinically, through scholarship and study abroad; Clinically, through mentorship, patient care and environmental studies; and Post-clinically, through lifelong learning and record maintenance of experiences and experiments. Throughout the process, the physician is to practice the practical virtue of diligence.

The first important experience to which the student must apply his newly-developed rational skills is in acquiring the rest of his medical education and general scholarship. In Chapter One, Rule Six (*Let the Physician be Erudite*) Hoffmann provides a list of learning experiences that the medical student must complete and provides the order in which they are to be experienced. In addition to the rational skills of logic and mathematics, the student is to acquire knowledge of languages, politics, and general physics. In the latter category he

includes geometry, mechanics, hydraulics and optics – these are sciences that give insights into the infinite amount of physical phenomena.

After he has become acquainted with the knowledge of general physics, the student will move on to those areas peculiar to and necessary for the practice of medicine. In this regard, Hoffmann prescribes a series of pre-medical studies of the human body *which is the principle object of Medicine* (PIC1R6) starting with the study of anatomy—both human and comparative, then physiology to learn the functions of the anatomical structures.

Next, comes the study of what Hoffmann terms *medicinal matters*. This series begins with the study of chemistry before moving on to pharmacy. When it comes to medicines, the physician must have a working knowledge of chemistry. In Part Two—*Medicus Politicus* the physician is told that he needs to understand the virtues of each element if he is to become more knowledgeable than the apothecary and if he is to reduce the composition of ancient formulas which contain an excess of ingredients. Chemistry must be studied before the physician is ready to move on to pharmacy.

The areas of study that will most quickly be applied to practice are semiotics (symptoms) and pathology. An interesting note in this rule that reflects Hoffmann's rational eclecticism is his suggestion that Hippocrates and Sennert should be studied for *prognostics* before moving on to the modern writers: *… in studying their (the ancients) works, it is less important to pay attention to their principles than to their precautions and their observations.* (PIC1R6) Yet, even

with this educational background which prepares the student for general practice, Hoffmann warns the student that he is not yet a practitioner until they can apply this knowledge to clinical practice. (PIC1R6)

The second set of pre-clinical experiences was to be developed by the new medical school graduate through travel abroad. These travels have a specific goal and that is to gain access and study with the most celebrated physicians and scientists. Hoffmann advises his students that they should wait until graduation before beginning their travels. A "physician" is more likely to gain access to illustrious personages than a student. Additionally, the graduate is better prepared for such experiences having become more informed of all the areas of his art:

> I have said that he needs to postpone his travels until the end of his academic studies and I have had reason to say this, because then the Physician is more deepened and his judgment is better formed. He is therefore more in a state of conversing with the learned and of profiting from their wisdom; that which one has no place to listen with a younger spirit. (PIC4)

Thus, the new physician furthers his pre-clinical experience by studying with the best scientists and medical personel through travel to foreign universities. Holland, England and Italy are three areas specifically recommended by Hoffmann.

At this point, Hoffmann believes his new physician is ready to initiate an individual or clinical practice. (P1C1R7) There are some things that cannot be taught and must come from experience—here Hoffman cites Galen: *there are*

some things in practice which one is neither able to speak nor to write about. (PIC1R7) However, one cannot learn from experience alone. To be valuable, experience must be studied by a mind that has been properly formed in terms of rationality and erudition.

Hoffmann seems to have two different, albeit complementary, concepts in mind in this rule. First, the physician must study the local factors that impact on health—today, we might refer to these as environmental considerations. Second, he must study the patient himself.

The study of environmental factors must be completed before the physician starts his individual practice:

> So, before being applied to the clinical practice, the Physician will meticulously examine the arrangement of the place where he should train, the type of life of those who live there and the arrangement of the waters and of the inhabitants. As for the arrangement of the place, he should examine the situation scrupuously, which is the disposition of the air, if it is moderated or cold; which is the actual season. Because epidemic illnesses commonly depend on disposition of the air. (PIC1R7)

These factors are studied because they relate specifically to the practice of medicine. In the preceding quote, we note that the study of the disposition of the air and the seasons gives the physician knowledge about the propensity for epidemic illnesses in the area. The same goes for the study of the regional diets which helps the physician make true judgments on treatment:

> With regards to diet, it is necessary to note that it is different in all countries of the world. Some are accustomed to hard foods; others use more soft ones; this includes boullions and milk products. Hard foods assume a vigorous stomach which asks for stronger dosages of medicines, which (dosages) are detrimental to those who have become

accustomed to the softer foods because of the feebleness of the stomach. (PIC1R7)

All of these environmental studies help the physician as he transitions to medical practice where he is to study the patient himself. The patient is in fact the subject of clinical practice: *It is necessary to make his observations on the illness, on the sick person, on the signs which present themselves and to note the changes which occur all the time*. (PIC1R7) Here he recommends that the physician develop case histories on the patients habits and past experiences with illnesses and treatments. Then, he should keep a record of his own experiences with each patient. The best way to develop the habit for doing all these things is to study with a celebrated practitioner or to consult collections of written observations. Hoffmann especially recommends the methods used by the ancients in this area. A key area of early and continuing clinical studies is that of medications. The new physician must stay current in pharmaceuticals. Normally, it is better for the new physician to use the apothecaries for medications but he needs to know enough to be useful to the poor or when there is no apothecary available. (PIC1R7)

Hoffmann may well have been the first medical school professor to realize that medicine had changed radically in terms of the rapidity of scientific development. This change required a contemporary response. The days of a physician going to medical school and learning a Galenized system of medicine (or any other single system) that would last him for an entire career was no

longer a valid educational model. The new Hoffmannian physician would be a life-long learner.

Hoffmann prepares his student to be that life-long learner in two ways. First, the physician is to keep current of the best ideas of his contemporaries by continuously reading the latest treatises (PIC2Aid1). Second, he was to keep journals to benefit from his own experiences and experiments (PIC2Aids2&4).

The physician was encouraged to devleop his own library although it should not be burdensomely large. He could limit his books on the ancients to those of Hippocrates, Celsus and Galen. He should also collect a number of modern authors—again, limitedly. Hoffmann suggests that the physician get to know some booksellers and to first read the new works before deciding on what to purchase: *I am of the opinion that he should get to know some Booksellers, who would be able to procure for him the reading of the new books; where often is found only a few useful things, which one is able to extract from it. If they are judged more interesting, the Physician will purchase them.* (PIC2Aid1)

He should also keep journals of his own experiences and experiments. The journal on experiences based on his medical practice will eventually have practical value: *With these considerations he will amass in a little time a precious treasure, to which he will be able to have recourse when the occasion presents itself*. (PIC2Aid2) The same goes with keeping journals on his medical consults: *I speak equally of consultations, written reports or others which he will have made; and I say that he will be able to make good use of one and the other …*

when he will find himself in cases where he is consulted or in making reports, in some similar circumstances. (PIC2Aid4) The final set of journals kept by the physician are those relating to his experiments—especially, in chemistry and physics. The physician is expected to contribute to the universal knowledge in these areas and should not consider himself too good to get his hands dirty: *That especially he should not fear to get his hands dirty with carbon; a little too white indicates a tenuous Chemist*. (PIC2Aid1)

Competence in medicine is the ability to achieve restoration of health for the patient. The Hoffmannian physician is motivated to restore health by developing the virtues of compassion, humility and moderation. But, desire to heal is by itself insufficient. The physician must be able to actually achieve the healing. The virtue which motivates the physician to become and apply his compentence is that of *diligence.* (PIC3R3)

This virtue is given some considerable emphasis by Hoffmann. Diligence seems to be even more necessary when the physician finds himself with a large or even an excessive number of patients.

Diligence is practiced in four ways for Hoffmann. First, the physician cannot neglect anyone nor can he show preference for one person over another, such as the rich over the poor. Second, when faced with a practical dilemma of too many sick persons, he must be honest with each and advise those whom he cannot attend to seek help elsewhere. That is, Hoffmann wants his physicians to lose business if it is in the best interest of the patient. Next, the diligent

physician will make an appopriate number of visits to each patient. He visits the acutely ill more frequently than the chronic. The diligent physician even makes sure that the patient lacks for nothing during the night. The justification given by Hoffmann for this rule is that “the ongoing course of the correct medications contributes significantly to the patient’s recovery.” This requirement is prudentially balanced to preclude any excess in visitations or medications.

A fourth sense of diligence is found in the physician protecting himself while serving the sick. This is necessary because the very life of a physician is constantly at risk: ... *an old Physician on earth is a rare bird and so that most Physicians are seized by close contact with malignant diseases*. (PIC3R3) Hoffmann then gives the medical student some advice on how to take some precautions when visiting a patient with a contagious disease. Even with such dangers, no Hoffmannian physician would be deterred from performing his duties because the high esteem which results from doing a good job is a strong encouragement to continue. Again, the virtue of diligence is advantageous for both the patient and the physician.

CHAPTER 4: PHILOSOPHICAL ANALYSIS OF PART THREE OF THE *MEDICUS POLITICUS*: THE PATIENT-PHYSICIAN RELATIONSHIP

4.1 Introduction

The third and final part of the *Medicus Politicus* (*MP*) focuses on the object or goal of medicine—i.e., the health of the patient. The medical student has already been guided into developing a specific type of medical character—i.e., that of a moral, rational and competent physician (*Medicus Politicus*—Part One). Because the curriculum that Hoffmann instituted at Halle was specifically designed to develop exactly this type of physician, I called the product of this medical curriculum a Hoffmannian physician.

In the second part of the medical school curriculum the medical student has learned how to work with other members of the medical community in order to meet this objective (*Medicus Politicus*—Part Two). The physician maintains control of all decisions and procedures which support the goal of the patient's health.

Now, in the third part of the *Medicus Politicus* we see that the medical school curriculum focuses on how the student should anticipate functioning in the clinical environment and how to apply his medical knowledge to the shared goal of the patient's restoration of health. Part Three is entitled: [Rules] *of prudence of the Physician concerning Sick Persons*.

Part Three is the deployment of the concept of the *politic physician* in the clinical setting. It comprises ten chapters in which Hoffmann addresses various clinical situations in which the physician might find himself. Four chapters will be singled out in this commentary for their ethical content on the patient-physician relationship. Chapters One and Three provide general rules on physician and patient behavior and are rich in Hoffmann's explanation of ethical as well as practical guidance to the medical student. Chapter Nine is entitled: *The prudence of the Physician in cases of acute and chronic diseases.* It contains much of the foundation of Hoffmannian medical ethics. Finally, Chapter Ten addresses the issue of physician fees. This is the fourth primary chapter on the medical ethics in a patient-physician relationship.

Many of the chapters in the third part of the *Medicus Politicus* provide prudential rules when dealing with various categories of the patient population that require unique skills: Chapter 4 *On Princes and Dignitaries*; Chapter 5 *On Females*; Chapter 6 *On Women in Labor*; Chapter 7 *On Infants*; and Chapter 8 *On Humans at a Different Stage of Their Life*. Even these chapters give some rules which are applicable to special categories of patients or unique situations. On occasion, the commentary will include one of these rules. However, most of the prudential rules found in these chapters are involved with discussions concern medical procedures rather than the ethical dimension of practice and are therefore beyond the scope of this commentary.

Hoffmann's methodology in Part III is very similar to that found in the two earlier parts. The early chapters start off with general rules of prudence for both physicians and patients. This will be followed by a series of chapters on more specific rules of prudence when the physician deals with unique situations, patients and diseases.

4.2 The General Rules of Prudence for Physicians in the Clinical Setting

The patient-physician relationship takes place in the clinical setting. During the Long Eighteenth Century, the clinical setting usually took place at the home of the patient. However, there are several stages in the development of the relationship. Each of these stages has prudential and ethical considerations. Most importantly, Hoffmann's medical ethics is unique in that it provides prudential rules for both the physician and the patient. These rules are reciprocal or complementary and I will draw out a number of important examples in what follows.

4.2.1 Stage One: Pre-Visitation Considerations

In the very first rule of the *Medicus Politicus* Hoffmann described an original state of nature that existed even before the physician and patient met (see Chapter 3). This is the state of the human condition which he describes as follows

> … And if the Physician is a good Christian in this way, he will necessarily exercise compassion … and he determines to practice this out of pure benevolence; *nor will an occasion be lacking, indeed, the daily misery of man will remind him to give help to the needy*…. (PIC1R1) (My emphasis)

At the medical school at Halle, Hoffmann developed his curriculum to respond to this condition. The world needed physicians who had the moral character to devote themselves as servants to the suffering masses, who had developed the rational skills to learn, understand and apply the new evidence-based medical science, who had received the appropriate training and gained the experience needed to be clinically competent, and who had the properly formed moral character.

The moral character of a Hoffmannian physician centered upon the moral virtue of compassion. This required a total commitment to humanity. Hoffmann justified this on both religious grounds (Christianity) and rational grounds (Natural Law). Christianity furnished the ideal model, Christ, who was totally committed in compassion to every member of humanity even at great personal risk and death. (PIC1R1) Hoffmann now asks the same level of commitment from the physician. Natural Law furnished a rational explanation for the obligation to preserve society. This was accomplished by shared love among mankind. By reason alone, says Hoffmann, we can determine the social nature of man and this understanding leads to mutual love. Mutual love forms the basis of the Natural Law to do good (moral principle of beneficence) and to not harm one another

(moral principle of non-maleficence). (PIC1R5) Compassion is the practical application of mutual love among men who suffer daily.

Reason is exercised as the physician gains knowledge of which medical actions will bring beneficence and which will avoid maleficence. Reason achieves this through discovering and following the principles of the Natural Law (PIC1R5), the intellectual virtue of prudence (PIC2R4), the skills of a mathematically-based logic (PIC1R5) and the use of experimental philosophy (PIC1R5).

Competence required the student to be erudite (PIC1R6) and to gain his initial experience through traveling (PIC4) and practicing under the supervision of an experienced physician (PIC1R7). Ultimately, competence is developed as the physician gains experience through clinical practice. For example in the area of prognosis, Hoffmann says: *Wisdom in prognosis is learned not so much from precepts as from experience*. (*Fundamenta Medicinae*, Semiotics, Chapter 4 Rule 4)

The Hoffmannian physician has learned these character traits in a building-block approach. Working backwards, the physician is competent based on education and experience only because he has developed the rational skills to understand and apply that learning. He is motivated to use his competence for all mankind only because he has developed a moral character based on compassion and humility.

Hoffmann originally justified his general requirement for the physician to develop a moral commitment of compassion for every person based on an understanding of the shared misery in the human condition. Now, in the clinical setting, Hoffmann further refines the argument.

The first moral theme in Part Three is that in the patient-physician relationship the compassionate physician shares the patient's goal or end; specifically, in the patient-physician relationship the goal or end is the restoration of the patient's health. This is the goal of the patient, the object of the practice of medicine, and the personal commitment of the compassionate physician.

The requirement that the physician must have a shared goal of patient healing is repeated in several rules. For example: *Indeed he (the physician) has been called for this purpose: that he should examine the sick person and investigate the nature of the illness and scrutinize the causes that need to be removed…* (PIIIC1R10)

However, Hoffmann's strongest and clearest statement on the level of commitment required from the physician to the shared goal of patient health is found in Chapter Three: "… indeed, *he surrenders himself completely to sick persons, it is as if all illness is thrust onto the physician* and in serving the life and the health of others much is removed from his convenience." (My emphasis) (PIIIC3R11)

This is a clear moral mandate based on the model of Christ who took all the spiritual illnesses of the world onto Himself. It is also a rational and complete commitment to humanity in general and satisfies the Natural Law principle to preserve society. The physician realizes that ultimately this commitment will deny him the opportunity to enjoy the normal conveniences of life.

Even when it comes to weighing the physician's entrepreneurial interest against the health of the patient, Hoffmann is clear: *The primary purpose of the physician should be health, not the money of a neighbor.* (PIIIC10R2)

Another general characteristic of the moral physician is that he must be committed to everyone. In *Medicus Politicus*—Part One we saw that Hoffmann draws special attention to the requirements of the physician to look out for the poor in society. In Part Three Hoffmann continues this theme of the physician being required to look out for everyone. He is a strong and early advocate of physicians having an obligation to provide universal access to medical care; for example: "*The physician … ought to watch over everyone*…. He should understand that it is shameful for the physician… to leave the doors closed to those who are knocking." (My emphasis) (C1R6)

4.2.2 Stage Two: Clinical Visitations – Initiation of Patient-Physician Relationship

Hoffmann's first prudential rule is that it is the patient who is to initiate the patient-physician relationship. This general rule has complementary rules for both physician and patient.

Hoffmann places the responsibility for the initiation of the visit squarely on the shoulders of the patient.

To arrive in time is the most important thing

> *…. Likewise, it was desirable that sick persons observe this rule well and by no means should they put off for a long time seeking the help of the Physician, but they should hurry;* in fact, frequently the blame for the sadder outcome is not due to the Physician but to the patient himself delaying and to the tardy assistants. In fact, *He who hinders in the beginning, medicine is furnished late.* (My emphasis) (PIIIC1R7)

Thus, the process of the patient-physician relationship is initiated by the patient. But, Hoffmann means this to be a prudential rule; that is, the patient is expected to act rationally. And, what is rational for the patient is that when one is sick one is to recognize one's medical need and then to act upon it promptly by seeking the service of the physician. The consequences for the patient of violating this rule are often a prolonged illness or even death. Prudence on the part of the patient in this case results in preservation of health and in the prevention of harmful outcomes.

The requirement for the patient to initiate the relationship seems very important to Hoffmann. In fact, Hoffmann chides any physician who takes the initiative in Rule Five:

> *The offering of services by the Physician produces contempt.*
>
> He should neither make this offer through others nor by his own recommendation. Indeed, there are many, whose every concern consists in this: an eagerness for attendance to the sick is manifest…. (PIIIC1R5)

Hoffmann is distinguishing his physician from the competition. The appropriate response by the physician to human need is compassion. The motive from the physician's competition is *greed* and Hoffmann has already warned the medical student that greed is a vice and one which they must avoid. (PIC1R1). Hoffmann also made this distinction on several occasions in Part Two where he discussed the physician's relationships with other members of the community. In each case—i.e. the apothecary, the surgeon and the mid-wife—he attributes a motive of greed to many if not most of them. The theme of greed will continue throughout his discussion of the patient-physician relationship in Part Three as well.

In addition to the prohibition to seek out the patient, Hoffmann furnishes a positive rule for physicians as well. The appropriate action on the part of physicians is to be ready to respond to the needs of patients whenever they do decide to seek his help. This requirement means that the physician must be available to patients at all times if he is to be prompt and timely: "The physician is

a man of all hours … he should be alert, especially in the night time and he should not delay whoever asks his help….” (PIIIC1R6)

The physician can violate this rule in a number of ways; all of which Hoffmann describes in further rules for the physician on the topic of their readiness. One of the most important is that the physician must be moderate with drinking. In Part One Hoffmann described this as a general requirement when he discussed Natural Law as it applied to each individual person (PIC1R5). Now, he applies this general rule to the clinical situation.

It is disgraceful for the physician to be drunk.

> He who seeks fame avoids drunkenness, *sound reasoning is destroyed* by drunkenness, and *it renders him unfit to discharge his appropriate duty, especially if an emergency urgently requires his advice during the night,* when the drunkard, overwhelmed by sleep, can’t be aroused and if finally the drunken one is awakened, he does not know what to say or to write, whereby let him avoid drunkenness like the plague and even devotees of it. (My emphasis) (PIC1R8)

While many previous books on medicine have included drunkenness as a prohibition when listing duties of the physician, Hoffmann goes further and justifies the rule within his medical ethical system. Excessive drinking results in a two-fold violation of the Natural Law. First, it is a violation of preserving the natural order as pertains to the individual himself and, second, it is a violation of preserving society because the physician’s ability to respond to society’s needs is destroyed in that he is no longer rational and competent to perform his duties. (PIC1R5)

4.2.3 Stage Three: Clinical Visitations—Initial Sentiments of Patient-Physician Relationship

The patient responds to the arrival of the physician with the general sentiments of confidence and hope as their initial natural contribution to the relationship. That is, from the patient's view, the arrival of the physician is a significant event in dealing with human misery. The language used in the very first rule of Part Three—*MP* reflects the patient's situation; his illness has cast him in a dependency role that requires that he place himself under the care of the physician. However, this is not all bad for the patient: *… for the presence of the Physician renders the sick person confident* (*confidentem*)…. The general sentiment of hope has a strong medicinal element as well: *indeed the hope* (*spes*) *of recovery that is roused by him (the physician) strengthens the resolve (disposition) (animum) of the sick person*. (PIIIC1R1)

This medicinal importance is repeated and further explained: *Also by this (disposition) the vital spirits (spiritus animales) are rendered more eager and are aroused to overcome the enemy.* So important is this sentiment of hope that without it a patient who might have survived often dies from his illness: *On the contrary, many die from fear of death who would recover if the effect (disposition) had been removed*. (PIIIC1R1)

Compare Hoffmann's view of this medical state of nature with that found in de Castro's *Medicus Politicus*:

> *The sick*, Castro says (following traditional thinking), *are by nature suspicious and fearful,* not only intently listening to each word of the physician, but in their concern also screening the physician's face for clues. *Therefore the prudent physician (medicus prudens) will try to cover or conceal by simulation (simulatione tegere) whatever might add to the patients' fears or perturb their mind.* Since (as he says with Celsus) one needs to make the sick secure, so that they suffer only physically and not mentally, it is best to withhold from them what might upset them. (Schleiner 2007 (1995), 9)

Hoffmann differs from de Castro in that he emphasizes that the first emotion felt by the patient is *trust*—not suspicion and fear. One is reminded of the difference between Hobbes and Locke in their descriptions of the state of nature. In fact, this may be a conscious effort by Hoffmann to separate himself from Hobbesian views of human nature and Natural Law.

The Hoffmannian physician will have a different response than the one envisaged by the Hobbesian-type thinking of de Castro. Castro recommends his physician respond with deception and simulation. Hoffmann's physician, as we've seen in our discussion (see Chapter 3) of *Medicus Politicus*—Part One, will respond initially with compassion.

From an educational standpoint, Hoffmann wants to make sure his students don't miss the importance of the effect of the mere presence of the physician on the patient. The morally proper response from the physician to the patient's sentiment of hope and his dependency on the physician is a committed compassion.

A second moral theme in *Medicus Politicus*—Part Three is that the patient-physician relationship involves a reciprocal commitment. We have already seen that hope and confidence are the first sentiments of the patient. And compassion is the initial sentiment on the part of the physician.

In *Medicus Politicus* - Part One, Hoffmann taught the medical student that true compassion is based on recognition of the general misery that permeates the human condition. Now, in the clinical setting, the medical student *qua* future physician comes face-to-face with the reality of human subjects who are in that state of misery and who have placed their hopes of recovery in his hands. As a future physician, the medical student is advised, he will live the rest of his life with this burden. The total dependency of the patient is matched by the total commitment of the physician. As the patient surrenders himself *completely* to the physician, the physician responds by surrendering himself totally to the patient. It is worth repeating Hoffmann's most foundational dictum: "… indeed, *he surrenders himself completely to sick persons, it is as if all illness is thrust onto the physician* ***and in serving the health and life of others much is removed from his convenience***." (C3R11)] (My emphasis) By surrendering to the sick person's illness, the physician lifts its burden from the patient, an act of profound compassion analogous to Christ taking on the sins of the world.

Hoffmann then identifies a new and critically important patient sentiment, trust, which is also essential to the understanding of the patient-physician relationship: "Those who have been ***entrusted*** (*demandati sunt*), to the care of a

Physician should be treated ***faithfully*** (*fideliter*)." (My emphasis) (PIIIC3R1) This general rule contains complementary rules for both the patient and the physician. First, we look at the rule as it applies to the patient.

From the point of view of the patient, Hoffmann notes that in addition to the renewed confidence and spark of hope that is generated by the arrival of the physician, the patient also places all of their **trust** (*omnem fiduciam*) (PIIIC1R10) in the physician. This is a deeper commitment on the part of the patient and further reflects his dependency on the physician and generates and explains the total commitment of the physician.

Trust has two effects for the patient in the patient-physician relationship. Like the patient's initial sentiment of hope, the patient's trust starts with an unspoken belief that the physician's intention is to help or bring benefit to the patient. This is a reliance on the physician's commitment and compassion to the shared goal. The second effect is that hope and trust anticipate the achievement of the shared goal of real healing. That is, it anticipates that the physician is skillful. The physician's compassion and commitment are necessary but not sufficient. The Hoffmannian physician is also necessarily competent.

From the physician's view, the patient is a part of the medical community in the sense that the patient's cooperation in their treatment is essential if the shared end of restored health is to be attained. The element of trust is the basis upon which the patient cooperates with the physician. In Rule Four (Chapter One), Hoffmann advises the medical student that he can take appropriate

advantage of this trust relationship in the administration of medications: *… the physician being present, arranges all in accordance with his decision*. The dependency of the patient generated from the trust-relationship becomes the basis for the physician to use his position to gain the cooperation of the patient when the patient might otherwise be hesitant: … *and by his authority rouses sick persons to take the medications*. (PIIIC1R4)

Hoffmann has rules that advise the physician of the prudentially appropriate behavior which preserves the patient-physician relationship. He also has rules that warn of inappropriate behavior which destroys that relationship. While the physician can take advantage of a patient's initial trust by using it as motivation to gain the patient's cooperation, Hoffmann recognizes that the unethical physician can use the patient's trust to his own advantage. He might brag or promise too much (PIIIC1R11). Or he might approach the patient with excessive seriousness (PIIIC1R9)

The physician can also lose a patient's trust by violating the trust of another patient. When a physician, for example, discusses another patient's medical condition in front of a patient, the patient validly judges that the physician is not trustworthy: "They ***lose all trust*** (omnem fiduciam amittunt) by this sort of thing…." (My emphasis) (PIC3R2) (PIIIC1R10)

Such abuses are serious violations of the trust element in the patient-physician relationship. The appropriate response on the part of the physician is that he must initially respond with faithfulness: *Those who have been entrusted*

*to the care of a Physician should be treated **faithfully***. (My emphasis) (PIIIC3R1) Faithfulness requires the complete commitment on the part of the physician to the health of the patient.

In one example of the importance of faithfulness, Hoffmann admonishes any physician who would abandon a patient without just cause. They must be especially careful when dealing with patients who seem to be in a hopeless situation. Prudence requires the faithful physician to avoid haste in such a serious decision: *The patient should not be readily abandoned*. *Those who clearly announce that no help remains, much less those who abandon them, behave without reason.* (PIIIC3R5)

Trust and hope are the chief sentiments of the patient. The sicker the person is, the more intense he will have those sentiments. The initial position of the patient is one of dependency which requires an appropriate moral response of compassion and faithfulness on the part of the physician. However, it also requires that the physician bring a high degree of competence to the patient-physician relationship.

4.2.4 Stage Four: Clinical Visitations—Frequent and Timely Visits

Hoffmann advocates that the physician make frequent visits: *Let the Physician not be too stingy in visitations to sick persons*. (PIIIC1R1) Hoffmann justifies this claim on both ethical and competency grounds.

Ethically, the physician must respond appropriately by meeting patient needs with a sustained commitment to compassion and competence. Thus, the first contribution of the physician to the recovery of health for the patient is a very general one; it is the sentiments he engenders in the patient by his very presence.

Now, Hoffmann uses the strongest possible language to communicate to the medical student the clinical duty of frequent visits. This initial spark of hope on the part of the patient can only be kept alive by frequent visits from the physician… *half the treatment consists in frequent visits*. (PIIIC1R1) This is a very strong claim by Hoffmann in that he assigns *half* of the treatment of the patient to the ongoing presence of the physician. Hoffmann is also recognizing the initial step of the psychological dependency of the patient on the physician.

At times, Hoffman defines faithfulness in terms of the appropriate and competent behavior of the physician: "*Faithfulness* should be considered in two ways: 1) *the sick person should be visited diligently* …." (My emphasis) (PIIIC3R1)

That is, the first requirement for the physician in being faithful is to make sure the patient is visited with diligence. I drew attention in the previous chapter that Hoffmann had included an extensive rule on diligence and pointed out its application to clinical competence. Such a response is harmonious with the hope and trust of the patient.

The first aspect of Hoffmann's definition of faithfulness starts with the requirement for visits to the patient. Earlier, we saw that Hoffmann justifies frequent visits on the basis of both commitment and competence. Frequent visits keep the patient's hope alive and allow the physician to perform at the highest skill level. The prudential physician must understand the natural sentiments of the patient and respond in accordance with his concept of Natural Law—in a society, there is an understanding of our mutual needs which generates recognition that the preservation of society is the basis for our need to love one another. But, Hoffman's prudence required a practical solution as well. The physician must do his best to accomplish the goal of healing. "Doing his best" for a Hoffmannian physician was nothing less than acting as one who was well trained, rationally prudential, and clinically skilled.

We have already noted that when a physician visits the patient, there is a natural medically beneficial sentiment of hope and renewed confidence on the part of the patient: "…*indeed the hope* (*spes*) *of recovery that is roused by him strengthens the resolve (disposition) (animum) of the sick person*. *Also, by this (resolve) the vital spirits are rendered more eager and are aroused to overcome the enemy.* (PIIIC1R1)

Hoffmann now goes further in his justification of frequent visits on an appeal to the physician's competence: *A more certain knowledge of the disease and its symptoms emerges from a visitation to the sick person*. (PIIIC1R2) This

is an acknowledgement of the power of a skilled and rational physician in his ability to determine the medical facts from his trained powers of observation.

That Hoffmann means for his medical students to leave Halle with a self-perception of themselves as the irreplaceable master of medicine[1] in the community is clear from his next statement: "*We cannot accurately perceive the constitution of the disease … second hand*." Even the best non-Hoffmannian physician is a mere empiric (a term used by Hoffmann on several occasions in the *Medicus Politicus*). "*Those things which are most necessary are often omitted…. especially if the character* (*persona*)[2] *of the sick person* (*persona aegri*) *remains unknown*." Hoffmann is concerned that the physician not only has competence but also commensurate confidence: *for that reason it is fitting that the Physician visit the sick person, for a single visit is more excellent and useful than a thousand letters*. (PIIIC1R2) Hoffmann is clearly setting out the new standard for the Prussian physician. They are not going to wait for the Prince to pass laws to acknowledge this authority of the physician. The new physician will

[1] Hoffmann uses a similar phrasing in his discussion on how the physician should approach the prince and other important people. In such a case Hoffmann wants the physician to not only be competent but to exhibit a commensurate confidence: *Indeed, he is called the master of the body, he should similarly present himself as such to important people; nevertheless, this will have been accomplished with prudence….* (C4R1).

[2] This emphasis on knowing the person's character as well as his or her medical condition is not made clear by Hoffmann at this point. However, it fits in well with our interpretation that Hoffmann is as concerned with the intrinsic qualities of the patient as he was with that of the physician.

be *in reality* so distinct from the mere empiric that they will be easily identified in the community.

The rule that provides the definition of *faithfulness* for the physician also provides a rule for patients. In the first half of the rule, the patient entrusts his or her care to the physician and the physician must treat the patient faithfully. Now we will examine the second half of that rule. This rule continues the explanation of the trust–faithfulness element in the patient-physician relationship.

> *Those who have entrusted their care to the Physician should be treated faithfully*.
>
> *The custom of certain sick persons who always summon two doctors is certainly improper and should be clearly condemned, from which cause they are often drawing danger to themselves.* Namely, neither is careful in their work; and because that which ought to be done by one, he trusts the other to have already done it or to be about to do it. Thus, the sick person is neglected and he recovers his original health tardily. (My emphasis) (PIIIC3R1)

The second half of this rule requires the patient to invite only one doctor at a time. From the placement of this requirement by Hoffmann as the corollary of the requirement for the physician's faithfulness it is meant to be a requirement for reciprocal faithfulness. Faithfulness on the part of the patient is to actual *entrust their care to the physician*. By summoning other physicians, the patient clearly indicates a lack of such trust having been given to the physician. A lack of trust undermines the reciprocal arrangement in the Hoffmannian patient-physician relationship.

The next requirement in visitation to the patient is the importance of these visits being prompt and timely.[3] Again, Hoffmann justifies the requirement for the physician on both the basis of the power of his presence and the power of his medical skills: *To arrive in time is the most important thing. This (rule) owes its importance partly to his presence and partly though medicine* (PIIIC1R7). This requirement means that the physician must be available to patients if he is to be prompt and timely: *The physician is a man of all hours and he ought to watch over everyone… he should be alert, especially in the night time and he should not delay whoever asks his help….* Hoffmann uses an example to help justify such a tough criterion: *For it is possible for an urgent symptom to appear, which he had not anticipated….* (PIIIC1R6)

4.2.5 Stage Five: Clinical Visitations—Diagnosis, Prognosis and Treatment

Hoffmann next looks at the requirements of a prudential patient-physician relationship when it comes to the medical processes themselves: diagnosis, prognosis and treatment. In stage four we determined that the physician must act faithfully as the appropriate response to the patient's sentiments of hope and,

[3] Hoffmann says something similar in his earlier work: "Foreign to all art, but to medicine above all, is delay. For in medicine delay produces danger to life and therefore you should not put off giving aid." (*Fundamenta Medicinae*, Therapeutics, Chapter 1 Rule 20)

especially, trust. Initially, we looked at the first part of Hoffmann's definition of *faithfulness*. Now, we will look at the full definition:

> Faithfulness should be considered in two ways: 1) the patient should be visited diligently; 2) necessary remedies must be ordered, always adding instructions on their proper usage and he should always carefully consider the effect of the prescriptions. (PIIIC3R1)

Thus, faithfulness takes place when the committed and competent physician properly performs all of his medical duties. Hoffmann spends a lot of time in Part Three describing medical diagnosis techniques – examination of the urine, excrement, the eyes, etc. Although these rules and techniques are very interesting in themselves, they are beyond the scope of a study of Hoffmann's ethics. The key point to be derived from the rules is that the Physician must understand and use the best methods to conduct the clinical examination of the patient.

The physician is also given prudential rules on prognosis. Most of these rules urge caution on the part of the physician.

One rule that the physician should follow in prognosis is being cautious until reason is sure. Here are two examples: *The Physician should not easily promise a recovery in chronic illnesses. Primarily, he should in truth observe the right time, when nature will have worked more than all the medications, if it is helped by him a little.* (PIIIC9R14). *The physician should always be cautious in his reasoned prognosis of health and death in malignant diseases, where the strength grows weak*… (PIIIC9R6)

However, the physician is not to avoid giving his well-formed rational judgment on the outcome of a disease. In fact, for Hoffmann the greatest skill in which the physician can demonstrate his competence comes in medical prognosis. This, Hoffmann says, requires the greatest prudence both in judgment and in pronouncement. It is the ultimate power of the skilled and experienced[4] physician to draw a valid prognosis from his observations of the facts.

> Assuredly, the greatest skill of the Physician consists in showing a remarkable prudence of the soul: that he is able to make a true judgment in (cases of) serious diseases and its outcome for he is dealing with the life and death of a human; and whatever he pronounces, as long as it is assured, even if it is sometimes unappreciated, he displays a God-like mind by having foreknowledge. (PIIIC1R3)

In his earlier work, the *Fundamenta Medicinae*, Hoffmann makes a similarly strong claim but warns the physician to proceed cautiously, for it is just as easy to lose one's reputation from a rash prognosis than to gain a good reputation from a reliable prognosis.

When it comes to treatments, specifically, administering medications, Hoffmann again provides many technical rules on matching medications to diseases, temperaments, etc. These technical issues will not be addressed in this commentary but supply the clerical details of competence.

[4] Wisdom in prognosis is learned not so much from precepts as from experience. (*Fundamenta Medicinae*, Semiotics, Chapter 4 Rule 4).

4.2.6 Stage Six: Clinical Visitations – Termination

The patient-physician relationship is meant to be temporary. There are two ways in which the relationship might come to an end. The normal way is for the relationship to terminate when the goal of the recovery of the patient's health has been achieved. However, there are cases when the relationship terminates before the accomplishment of restored health. This can occur when the patient dies or when either the patient or the physician terminates the relationship early.

Hoffmann provides prudential rules for when the physician has healed the patient successfully. These rules for patients concern the payment that the patient should give to the physician for his services. There are also reciprocal prudential rules for the physician on fees. Hoffmann devotes a whole chapter to the collection of fees and most of these are prudential limits placed on the physician in collecting them.

> When the fee is paid, the Physician should not immediately stay home. It is an innate characteristic of greedy sick persons who send the fee to the Physician as soon as they are free of the illness to a certain extent, lest he should increase it more by frequent visits. (PIIIC1R17)
>
> *It should not be a wage but an honorarium.*
>
> **This rule should be observed more by sick persons than by a physician***;* nevertheless, it will even be possible to be applied by a physician; that he should not ask for a total fee for one, two or four visits and by this agreement he should be the augmenter *(authority)* of his own business no less than of the art of health-giving. It is better moreover to give the gift of labor to sick persons than that person himself to ask or to receive. (My emphasis) (PIIIC10R6)

He who ruthlessly seeks a fee begets contempt.

> To admonish patients of their indebtedness is *shameful and it causes such a hatred for their physicians, so that they might entrust themselves to another, one of the charlatans…* (My emphasis) (PIIIC10R5)

Finally, Hoffmann acknowledges that there are cases in which the physician is advised to terminate the relationship. There are a series of three rules in chapter three which seem somewhat inconsistent. The first rule is a simple statement advising the physician to abandon anyone who does not behave (*Qui morem non gerunt, eos mature deserat Medicus*). It is given in a very brief statement which provides no other explanation or justification.

Whoever does not follow the regimen, the Physician should quickly abandon.

> So that later the blame for any subsequent unfortunate effects should not be publicly attributed to the physician himself. (PIIIC3R3)

The only justification Hoffmann provides in his rule on abandonment is that a person *qui morem non gerunt* is likely to end up having some unfortunate consequences for which the physician does not want to be included in the blamed. This phrase has two possible interpretations: *those who does not have morals* or *those who do not follow the regimen*. Possibly, he believes that a tarnished reputation would affect the physician's ability to perform his service for future patients. They might not bring the necessary element of *trust* into the relationship.

The rule that follows this rule – i.e., rule four – was previously discussed when we considered Hoffmann's view on deception. It advises the physician to use his authority, use substitution, or use deception when he is dealing with someone who is willfully disobedient and uncooperative. In other words, being uncooperative is not a sufficient reason to abandon a patient. The third rule strongly admonishes the physician to not easily declare a patient's illness terminal or, worse, to abandon such a patient. That is, an uncertain diagnosis of the futility of further treatment is not a sufficient reason to abandon a patient. This would seem to justify interpreting the rule three as *those who do not have morals.*

However, if the physician is certain that the disease is incurable he is advised to decline such cases. Although this is especially important when dealing with important persons, even those of a lesser estate should be referred to their ordinary physician.

> *It is better not to touch incurable diseases*. Before all else, this rule should be held in the case of important persons. It is better, likewise, to commit men of a more inferior situation troubled with an incurable illness to the regular physician, if, to be sure, assistance is desired in any way, at least the analeptics should be administered, similarly the emulsions, those which are considered by sick persons in place of the analeptics. (PIIIC4R7)

> *It is not for the physician to cure everyone, nor to succeed in everything by wish, clearly this will not have been his hope.*
>
> What is (more) common than that sick persons neglect to follow exactly the prescription of the physician? Therefore, what a surprise, if that expectation, of which he is not the absolute power of life and health, might be frustrated by the sick having refused obedience. (PIIIC4R10)

> *In the more serious illnesses, the Physician should not give up hope immediately, nor dissociate himself from the responsibility*. Nevertheless, serious diseases should always be approached with careful deliberation with others in consultation. (PIIIC4R11)

However, non-payment by a patient is not a reason for the physician to discontinue visits nor is it a reason to abandon a patient. Quite the contrary, Hoffmann uses this situation as an object lesson in how a physician can keep a patient from a precipitous decision on continuing medical treatment. Hoffmann acknowledges that many patients are *innately greedy* and will pay off a physician as soon as they are feeling a little better. Hoffmann tells the medical student that they should continue their visits even if it is without pay. In this way the patient will realize that the physician is not motivated by money and will learn not to terminate the relationship prematurely. (PIIIC1R17)

There are indications in Hoffmann's rules that the physician often has to deal with patients who change physicians or call in second physicians. Such decisions may be based on the prudential assessment by the patient of the abilities of the physician. However, while the patient is prudentially empowered he is not imprudently empowered. That is, the patient's power comes from acting rationally within the relationship. Hoffmann gives a counter example of an inappropriate abandoning of a physician by a patient.

> *The unrestrained change of patients is to be despised by the Physician. Many are found laboring under chronic illnesses… who immediately appeal to another physician if the promised help is to be distributed in a small amount over a long time. But, this most evil custom is* ***not justified****,*

> *nor is it an advantage to the patients themselves, when they bustle about to drive away the very one to whom the real nature of these things is known.* (My emphasis) (PIIIC3R6)

Hoffmann points out that the patient himself suffers from abandoning his physician too quickly or unjustly. In this case, it is the patient who gains a bad reputation. Again, reputation is used by Hoffmann in the sense that it undermines the general rules of the patient-physician relationship.

4.3 Specific Prudential Rules for Various Situations, Patients, And Diseases

We now follow Hoffmann's methodology and go from the general rules of clinical care examine at how these rules are prudentially applied to a variety of distinctive cases. This includes various situations, patients, and diseases. In most cases the general rules are not abandoned but are adjusted to the situation. The shared goal or end of restoring the patient's health, however, does not change.

I will start by considering three examples that provide insight in how Hoffmann expects the physician to adjust the general rules discussed in his earlier chapters when applying them to specific categories of patients.

Special or Unique Patients and Situations

The first example is the most enlightening – the physician as patient. Hoffmann is very clear that the prudential physician will not treat himself when he

becomes ill but should consult another physician: *The Physician himself when he is sick should likewise in the time of necessity consult others*. (PIIIC3R7)

Initially, when we look at Hoffmann's formula for the physician, it would seem to violate the basic tenet that the best person to treat a patient is the patient himself in terms of his being the most likely person to share the goal or end of being returned to health. But, sharing the health goal is only one criterion in the formula; albeit, a very important one. Another criterion is competence and the (normal) patient is not skilled enough to accomplish the medical procedures required to bring about a happy conclusion. This combination of experiencing the misery of the human condition and not being able to cure oneself is what drives the patient to a dependency role in the patient-physician relationship.

But this would seemingly not apply to the Hoffmannian physician who is not only skilled but who also has a self-image as the master of the body and a confidence to achieve a return to health. However, Hoffmann warns that the problem is that the physician can be subject to overconfidence – an excess which needs to be balanced by prudence: …*being more confident of their own powers than he should be at that point in time….* (PIIIC3R7).

There are two reasons given in this rule to support this claim. First, the physician *does not weigh all the circumstances objectively.* Second, *physicians often experiment with their own illnesses.* The first reason gives the most insight to our analysis in that the otherwise rational, objective physician will not be so when it comes to his own illness. In fact, Hoffmann extends this rule for the

same reason to physicians treating family members: *… when his wife or children are taken dangerously ill, he should not neglect to appeal to another's help, seeing that he himself is unable to consider all things in view of the pain and sadness.* (PIIIC3R7)

One is reminded here of Locke's argument that in the state of nature a rational person could know the law of nature. And, each person would be equal in power and jurisdiction to execute the law of nature. However, the weakness of the system is that we would not be objective in executing the law of nature when the violation was against oneself or a loved one. This would drive rational persons to solve the problem by forming a civil government. The civil government would provide the objective element in executing the law. Hoffmann's reasoning is similar: although the rational physician knows the laws of medicine and is normally capable of executing those laws, he will not be objective when the patient is himself or someone he loves. He can be objective in the normal patient-physician relationship but that rational objectivity is overpowered by our subjective emotions and passions when it involves one's cherished family members. In the patient-physician relationship, one of the members must be objective. The rational response to this unique situation, then, is to treat oneself as a patient and not as a physician.

The second reason is also interesting as it shows the physician as a rational scientist on every occasion. It is also the only reference in the *Medicus Politicus* to human research. It is tempting to read too much into this statement.

If we trust the claim, it would seem that physicians were known to commonly experiment with themselves at a time when human experimentation was not widely popular; possibly, this might even be extended to some experiments with other patients. The following anecdote, in fact shows that some physicians did experiment on themselves:

> From the sixteenth century until well into the nineteenth, most doctors assumed gonorrhoea and syphilis were manifestations of the same disease…. By the mid-eighteenth century, however, a vigorous debate had been generated between dualists arguing for specificity and unicists claiming a single affliction. A series of gruesome self-experiments were initiated to settle the question. John Hunter (1728-93) reportedly inoculated his own penis with pus from a patient with gonorrhoea. When Hunter developed the typical chancre associated with syphilis, he logically concluded that the two diseases were really one, as had often been presumed. He had not suspected, however, that his patient was infected with both gonorrhoea and syphilis, a not uncommon situation given the common mode of infection. Hunter's research left the question of nosology in confusion for another seventy years. (Brandt 1993, 567)

However, it is more likely that Hoffmann is referring more to the physician trying to gain knowledge of disease and cure through experience and observation from modest adjustments in treatments. Hoffmann had earlier claimed that this is the best way for a physician to gain a good understanding of drugs: *The safest way to choose effective drugs is a posteriori, from experience and observation.* [*Fundamenta Medicinae*, Therapeutics, Chapter 2 Rule 15] In another place he says:

> Especially significant in healing is the judgment of the physician, which is most important in. the administration of drugs. And that is the true method of healing [*medendi methodus*], not learned from books but acquired

> through experience and practical judgment. (*Fundamenta Medicinae*, Therapeutics, Chapter 1 Rule 47)

The second unique situation is a comparison of patients based on their erudition and rational capabilities when it comes to informing them of their medical condition. This situation is an example of Hoffmann applying an Aristotelian interpretation of prudence as a practical judgment to determine the mean relative to the individual.

The first sub-group includes those patients who are well educated. Hoffmann recognizes that some patients who are knowledgeable about medicine and can even converse and ask medical questions using the proper medical terminology:

> It sometimes happens that learned sick persons skilled in physical science pursue other books curious about medicine especially about the affects of illnesses that afflict them.… These successfully become acquainted with the medical language… They often propose the most educated questions… (PIIIC3R2)

Hoffmann advises the physician to deal with such a patient with openness and completeness. He should answer the questions of these people with sound judgment and prudence explaining the cause of the illness and the reason for his selection of medications.

The second sub-group is the semi-educated. Again, Hoffmann advises that the safest route is to provide a similar full explanation to this group. Although they may not be able to grasp the details of such information, it

precludes them from judging the knowledge of the physician as more trivial. That is, it is better for such a patient to be over-informed than under-informed.

The final sub-group is the uneducated and ignorant. The physician should not provide such a technical explanation of their medical condition or the selection of remedies in such cases. It is better to give them an explanation in general terms; such as, *the stomach is disturbed, the liver is blocked, etc.* (PIIIC3R2)

In the contemporary issue of informed consent, Hoffmann treats the educated and semi-educated as autonomous agents and the uneducated or ignorant paternalistically. Physicians are to communicate with patients based on their various levels of competence. The advice given by Hoffmann on the prudential determination of the right amount of information here is similar to that which he gives to the Hoffmannian physician in regard to medications:

> The good physician administers drugs prudently, according to the varying constitution of the patients and the state of the disease (*Fundamenta Medicinae*, Therapeutics, Chapter 2 Rule 11)
>
> It is only prudent not to use strong remedies if mild ones would suffice. (*Fundamenta Medicinae*, Therapeutics, Chapter 1 Rule 23)
>
> It is proper to observe gradation in healing, proceeding gradually from the weaker medications to the stronger. (*Fundamenta Medicinae*, Therapeutics, Chapter 1 Rule 29)

The third unique situation I will discuss is the case of the patient being a Prince or some other distinguished person. In fact, Hoffmann dedicates an entire chapter and several other rules to this category of patient.

There are some special considerations given to dignitaries by Hoffmann. For example, the greatest political prudence must be used when treating Princes: *Each illness of the body is greater the more distinguished the person* (PIIIC4R2); *The physician promises nothing rashly* (PIIIC4R3); *He should not rashly contradict the Prince who is a patient* (PIIIC4R4); *In Princes be prudent and cautious in the use of heroic medicines* (PIIIC4R6)*; In the more serious illnesses, the Physician should not give up hope immediately, nor dissociate himself from the responsibility* (PIIIC4R11). What is interesting is that with the exception of rules two and four, the same rules are found in the other chapters of part three and applicable to every patient. Hoffmann appears to be emphasizing these rules for the medical student because they have potentially a huge political impact on them.

However, Hoffmann also provides similar advice on accepting the payments from poor people: *Nor should the gifts of the poor be despised, however often we treat them without payment*. (PIIIC10R7) If we remember that Hoffmann doesn't see the services of the physician as a contract nor the payment as a *wage* but rather as an honorarium, then it might be easier to explain these two rules as similar examples of physician payment based on what the patient has best to offer.

The potential impact of these special patients for the Hoffmannian physician is the alteration it might tend to cause in the (ideal) balanced relationship of the trusting and dependent patient with the compassionate and

competent physician. This conflict doesn't happen for Hoffmann. As the above rules demonstrate, he makes a key political distinction. The Prince or dignitary, when considered outside the patient-physician relationship, requires recognition of their special status and should be given such consideration by the physician. But, within the relationship, Hoffmann reminds the physician that the patient-physician relationship does not change.

Hoffmann's first rule in dealing with Princes and other dignitaries states that *the physician should be judicious (cordatus) and not timid*. Hoffmann clarifies this in the next sentence by reminding the physician that he is *the master of the body* and it is with this self-image and confidence that the Hoffmannian physician is expected to enter into the patient-physician relationship. (PIIIC4R1). Even when he advises physicians not to rashly contradict the Prince as patient, he quickly adds *unless the danger should be urgent.* While the politically prudential physician may show keen practical judgment by recognizing the special status of these dignitaries, in the end they are the patients and the physician is in charge of their health.

Various Categories of Diseases

The rules in part three of the *Medicus Politicus* also cover prudential decision-making when the physician faces diverse diseases. Most of these rules center on the medical procedures associated with each general category of

disease and some specific illnesses. Again, the medical aspects of the rules are beyond the scope of this analysis.

There are, however, several observations on these rules that may add to our understanding of the previous account of Hoffmann's approach. Hoffmann, as we've already seen, places a prudential emphasis on the physician's frequent visits to patients because it allows the physician to make his own observations on the medical condition of the patient. A further justification is that such visits also allow the physician to observe the course of the disease: *Improvement and decline become apparent from repeated visitation.* (PIIIC1R3). This allows the physician to intervene on a timely basis and to provide a prognosis of the final outcome. Here is a comparison between acute diseases and malignancies: Frequent visits allow for changes in the disease: *Particularly in acute diseases when the various ambiguous changes foretell the outcome* and *In malignancies, recognition of the situation should be sought from sleep and from strength*. (PIIIC1R3)

However, prudence means having the ability to reasonably assess the uniqueness of each situation. This applies to the general requirement for the physician to make frequent visits. The different categories of disease have an impact on how frequently the prudential physician is expected to visit: *The physician should frequently visit the sick person in cases of acute illness and rarely in chronic ones.* (PIIIC1R12)

Another discriminatory aspect of frequency of visits is when the critical moments of each disease occurs:

> *Frequently, a neglected point of time is accustomed to place the sick person at the risk of death, particularly evident in the critical days… which times should be properly observed and in which times the sick person should be visited the most frequently, in order to be able to respond to changes, frequently many times within the hour.* (PIIIC1R12)

The importance of the physician's responsiveness and timing has already been noted. Again, the prudential physician will respond differently based on the criticality of the situation: *The physician should be alert on the diseases themselves*. *The greatest quickness is required when an apoplexy attacks someone, a suffocating catarrh or a similar emergency illness…* (PIIIC1R13) Another example is in the case of malignant fevers: *Especially, when he recognizes in malignant fevers that danger threatens, which he should not delay to remove* (*them*). (PIIIC1R7)

CHAPTER 5: PHILOSOPHICAL SIGNIFICANCE OF HOFFMANN'S CONCEPT OF THE POLITIC PHYSICIAN FOR THE HISTORY OF MEDICAL ETHICS AND BIOETHICS

5.1 The Prudential Balance of Responsibility, Interest and Power within the Patient-Physician Relationship

We have seen how the general and specific rules of prudential behavior apply in the patient-physician relationship for Hoffmann. Hoffmann is committed to a Natural Law explanation of human nature, and believes that actions chosen by men should be in accordance with our nature. The principles derived from Natural Law (PIC1R5) reflect his understanding that man is a social being who by the power reason understands the necessity to preserve society; this is most appropriately accomplished by reciprocal love between men. In the properly ordered, i.e., rational world, each of the members of this relationship would follow these rules as they are in harmony with the Natural Law. (See Sect. 2.2)

Hoffmann may be the first writer of medical ethics to offer reciprocal rules for both the physician and the patient in their relationship. Winfried Schleiner, *Medical Ethics In The Renaissance*, describes the emerging concept of medical ethics by the mid-sixteenth century. He defines "medical ethics" as the "ethics of medical doctors" (Schleiner 1995, p. vii). Schleiner's definition may be understandable because this is in fact what his study of the period clearly demonstrates. Medical writers were concerned about the behavior of the

physician. By contrast, Hoffmann looks at the ethics of *all* the members of the medical community—including the patient.

These rules for patients and physicians are not mere lists of do's and don'ts but rather rational (prudential) rules to guide the decisions and judgments of both members of the relationship. The rules center on a concept of medical ethics which is found in each member as well in the overall relationship itself. Specifically, it is a voluntary relationship between moral and rational beings. Practical reason, guided by natural law, can establish both the general rules of behavior as well as the judgment needed for contingent or unique medical situations.

While the overall responsibility and authority for medical care rests with the physician, Hoffmann provides rules that a rational patient should follow to ensure recovery. Again, health care is a shared goal between physician and patient. We have already seen most of the rules of distribution of responsibilities. (See Chapter 4—especially, 4.2.1 – 4.2.6) Patient responsibilities include initiating the relationship, trusting the physician, open communication and submit to treatments. Physician responsibilities include being ready at all hours to respond to that request; being trustworthy, communication and prudential treatment.

The balance of interest has also been discussed. The goal or end of the patient's health is a shared goal. The patient's interest is primary; in fact, Hoffmann calls for the physician's complete surrender to the patient. Yet,

Hoffmann also has rules that demonstrate that he does not intend patient interest to be an exclusive interest. Prudence requires a balance.

What is the prudential balance required of a physician? The following rules are examples of Hoffmann's approach to balancing patient-physician interest.

The first three rules provide prudential guidance when the physician may be at risk in the performance of his duties. Specifically, it is concerned with cases where contagion or irrational and violent patients are involved.

> *He should not heedlessly approach maniacs or madmen or those distressed with a contagious disease*.
>
> For, they are not free from risk. If an infected person must be called upon, the physician should refrain from swallowing his saliva when in their presence, or being situated at the side of the bed, to breathe too deeply the breath of the patient. Since, in truth, the outlets of the contagion are frequently communicated through saliva, it is better to remedy the contagious situation immediately by chewing myrrh or citron in visits to patients. (PIIIC1R14)

> *The Physician ought to protect himself before everything else from the contagion of malignant diseases.*
>
> [The following is a Summary only (PIC9R1)]
>
> - He can defend himself optimally from the plague, as in the case of other diseases, if he keeps a sober life and rid himself from the vice-filled humors….
> - He manages a decent sleep to restore his strength and spirits
> - Takes pleasure in a moderate drink of wine
> - In a word I say: he should be healthy.

Chapter Nine – Rule Ten

Before everything else the Physician ought to be cautious around malignant dysentery even when he will be attending patients with dysentery. (PIIIC9R10)

These three rules have the common thread that a prudential physician takes precautionary actions when attending patients who put him at risk. In the balance test of patient-physician interest, the first requirement is that the physician must always respond to the patient who is in need of his help. Only when the patient's interest is satisfied can the physician look out for his own interest. This includes the important issue of the physician's interest in his own health and life.

The reciprocal rules just discussed would be the ideal balance of responsibility and interest if this was an ideal world. However, Hoffmann also recognizes that the prudential person must know how to rationally judge imprudence. This Hoffmannian interpretation of prudence as an ongoing analysis and judgment of the relationship may be termed *empowerment*.

Prudence empowers both the physician and the patient. While both ideally come to the relationship with the shared goal of the patient's health, each judges the other as the relationship progresses. Neither is held to an absolute agreement to continue the relationship. Where the physician may seem to be so committed to medical service to his fellow man that once begun he cannot extract himself without violating his medical ethics or the patient may seem to be

so dependent on the physician that he is absolutely under his power and obligated to give unrestricted obedience, Hoffmann applies the prudential test to determine the appropriate action. And while Hoffmann makes several strong arguments for neither to readily quit the arrangement, he also provides justification for such termination (see Stage Six above).

The Prudentially-Empowered Physician has made a decision to serve mankind by applying his compassion, reason, training, and experience to the misery found in the human condition. The Hoffmannian physician is committed in the strongest sense to the life of selfless giving of his time and skills to anyone who is in need of his help. He is to be available at all hours, to be as available to the poor as to the rich, and to be prepared to adjust to a variety of diseases, situations, and patient populations. His is a commitment based on both faith and reason—Christianity and Natural Law. Faith provides the ideal model of compassionate commitment and Reason provides him the power of prudential judgment.

In a rational world, the Hoffmannian model of the patient-physician relationship would generate the greatest happiness:

> Philosophers do not agree on the principles of natural law, but it seems that one is able to admit them in establishing this principle that all should relate to the happiness of men; this which requires three things…. II. It is necessary to maintain society. We would be extremely pitied if we were reduced to living alone. *It is thus necessary to maintain society, this which demands reciprocal love between men; and it is the foundation of the law of men, which consists of avoiding all which can be harmful to society,*

> *without which there is neither commitment nor particular happiness at all.* (My emphasis) (PIC1R5)

Within Hoffmann's concepts of Faith and of the Natural Law are contained the basis of all medical ethics. Reciprocal love is the basis of the principle of beneficence found in traditional medical ethical codes. And the *foundation of the law of men*, to avoid bringing harm to society, is the basis of non-maleficence.

The physician's commitment, however, is not absolute for Hoffmann. That is, the commitment must be rational. A prudential physician must evaluate the ongoing patient-physician relationship just as he must evaluate the progress of a disease. Hoffmann provides rules that provide very clear insight into the justifiable reasons that a physician may modify or terminate the patient-physician relationship.

We've just reviewed one way in which the physician can justifiably adjust the relationship. When the patient is acting irrationally, the physician can use his authority (especially, if he is present), or use substitution of medications or even use deception as a last resort. Another way that the physician can justifiably modify the relationship is by bringing in another physician: *If the sick persons are important persons, he should never undertake the treatment in malignant diseases alone, even if he himself should be most skilled. It is likewise better to confer with another physician….* (PIIIC9R7) In another place he says: *serious diseases should always be approached with careful deliberation with others in consultation*. (PIIIC4R11)

Up to this point, we have been discussing the Prudentially-Empowered Physician. However, as we have demonstrated, Hoffmann has not only shown the medical student how the patient-physician relationship is reciprocal in that each party brings something different but complementary to the relationship, but that there are prudential rules and responsibilities for the patient which are equivalent to those he provides to the medical student. It should be no surprise than that Hoffmann also provides for a Prudentially-Empowered Patient.

A significant number of the rules for prudential physician behavior in this section are justified by their impact on the trust of the patient. Hoffmann is clearly concerned that the physician should maintain a good reputation with the patient and the public in that it is his reputation that generates the patient's initial and continued trust. While the patient's initial sentiment is to entrust his or her care to the physician, the patient is not irrevocably locked into the relationship. The prudential patient uses his reason to assess the trustworthiness of the physician.

The following rules are examples of Hoffmann's view on prudential empowerment for the patient. The physician's behavior is under constant observation by the patient and a rational patient has a right to expect the physician to be committed to the share goal of health and to demonstrate the skill to achieve that goal. The prudent patient is constantly evaluating the physician because patients are prudentially empowered to determine if their hope and trust is well-founded.

The offering of services by the Physician produces contempt.

He should neither make this offer through others nor by his own recommendation. Indeed, there are many, of whom every concern is stays with this: in that an eagerness for attending to sick persons is manifest…. It is truly shameful to offer one's services and to disparage another Physician in the presence of the patient, even if they are discovered in the greatest inconsistency…. *at which the sick person will be persuade himself with the most difficulty that the cause for making this warning is his interest rather the patient is induced to believe that the Physician makes this warning for his own advantage; the Physician not only abandons his good name* but also his friendship to the sick persona and to his fellow Physician. (My emphasis) (PIIIC1R5)

He should temper gravity with kindness and put all severity aside.

Gravity in the man himself is not entirely forbidden, but *excess* is, *which deserves the name of peevishness (hard to please).* (My emphasis) (PIIIC1R9)

He should not approach the sick person that he might be seen but also that he might talk.

But on the other hand, very many go wrong in *exceeding* this rule; *they induce great discomfort by excessive chattering* about the news or weather or about a number of other sick persons and about their condition just to pass time. They *lose trust* by this sort of thing. For thus, insightful sick persons *judge* that the chatterer, from the fact that while present he speaks about others, from this they also judge he will speak about themselves once he has departed. (My emphasis) (PIIIC1R10)

He should not hurry his approach more than is suitable.

When he recognizes there is no danger in delaying, he should not hurry so much, lest it should be the cause of a sign of greed. (PIIIC1R16)

5.2 Hoffmann's Patient-Physician Relationship as a Social Contract

Hoffmann's concept of the patient-physician relationship implies an informal contract. It would have to be informal because Hoffmann specifically prohibits the physician from negotiating an agreement with the patient. To this

extent, Hoffmann's social contract theory is actually anti-contract in the traditional sense. Hoffmann says the physician is not a slave who works as an employee; rather, he is a compassionate and skilled servant of the people. Thus it is more closely akin to a social contract than a business contract. A business contract would be an action expected from a greedy surgeon or a charlatan.

The relationship is initiated by the patient sending for the physician. The physician is not permitted to offer his assistance without such a request. Again, Hoffmann justifies this rule by stating that the physician should not be seen as greedy. And by this rule he means to separate the physician from the empiric or charlatan.

The contract is formed by the initiating action of the patient complemented by the voluntary response by the physician. The Hoffmannian physician makes himself available to anyone who needs his services. He cannot be drunk or lazy. He must never refuse to answer his door when someone seeks his attention. When the patient requests and the physician responds a social contract is formed.

Medicine is a mutual contract that is implied and breakable if either of the parties violate the implied terms.

What are those implied terms? It is simply that the patient is in a desperate, almost Hobbesian, situation. The world, as described by Hoffmann is a state of misery. Patients come desperately to the bargaining table seeking medical resolution of their illness. They must give up something at the

bargaining table if they expect to get something in return. That something, for Hoffmann, is not money. Instead, they must give up their right to determine their own course of medical remedy. In return, they get the commitment and competence of the Hoffmannian physician. There is the reciprocal trade: the physician offers commitment and skill and the patient offers trust and obedience. The physician's competence and compassion also remove the patient from a Hobbesian world in which the physician would otherwise have to be regarded by the patient as a potential predator, physically and fiscally.

However, whenever there is a violation of this contract, the other party is free to terminate the contract. That is, Hoffmann leaves the Hobbesian model and agrees more with Locke that we would not bargain away our natural rights even when the situation is desperate. Instead, prudence would require that we retain the right to abandon the contract when it became obvious that the participants didn't really share the same goal or were incapable of fulfilling its terms. However, Hoffmann counsels both sides of the relationship not to abandon the other too readily. He gives examples of such abandonment by both sides and concludes that it is an ill bargain for either to walk away from the contract without great effort first having been expended.

Prudence requires three things for Hoffmann: first, it requires the understanding of and commitment to the terms of the contract; then, it requires an ongoing evaluation of the fulfillment of the terms of the contract; and, finally, it requires a rational exhaustion of all possibilities before terminating the contract.

Like Locke, Hoffman declared that the first law of nature was a prohibition against harming one another (PIC1R5). However, Hoffmann adds a very strong principle of beneficence as a positive natural inclination. In Part One, he discusses Natural Law and states that by reason alone we can understand that in even the most simple society that we are dependent on each other is such a way that we are to love each other (PIC1R5). In Hoffmann's state of nature, everyone (ideally) would share the miserable human condition equally. From this, we would apply our skills and goods to care for each other. I would envisage him saying something to the effect that if you needed my cloak and I had two that I'd give you one.

In fact, this seems to be exactly how the fund raising for the poor students of Halle would have worked. They had nothing and they needed an education, so Hoffmann and the others met those needs through sharing in the goal and sharing the resources. Everyone is equal morally in Hoffmann's state of nature just because we share the same miserable human condition. The proper response to this is to care for each other. We have mutual needs and mutual sharing of our natural inclinations and sentiments. In this sense, Hoffmann is more Humean than Lockean.

5.3 An Internal Conflict in Hoffmann's Medical Ethics: The Issue Of Deception

In Section 4.2.5 (Stage Five: Clinical Visitations—Diagnosis, Prognosis and Treatment) I addressed what *normally* happens in the patient-physician

relationship during the early stages of a clinical visit. In the area of treatment, just as in the areas of diagnosis and prognosis, the physician must act faithfully (PIIIC3R1) as a proper response to the patient's trust. The patient is expected to respond by cooperating with the physician's proposed treatment. Hoffmann's account is based on both the patient and physician acting rationally in trying to achieve their shared goal of the return of the patient's health.

However, Hoffmann recognizes that not all patients are this cooperative. In a series of rules, he describes the options for the physician when he encounters various levels of the "uncooperative patient." These options range from the assertion of authority a relatively *mild coercion* by the physician, taking advantage of his position of authority and his physical presence to get the patient's cooperation to the more extreme option of using *deception* to get the patient to take the prescribed medications.

However, to be fair to Hoffmann we must place his approval of deception in its proper perspective. My analysis of the *Medicus Politicus* shows that Hoffmann did *not* mean to justify deception on a broad scale; the text provides several examples where clear communication with patients is required. In Chapter One (PIIIC1R10) Hoffmann requires the physician to communicate with his patients and not wait until they ask questions. In Chapter Three (PIIIC3R2) Hoffmann refines this rule by requiring that the physician communicate openly with the patient proportionate to his level of education and understanding. In these two rules we see Hoffmann's anticipation of the contemporary bioethical

concern for patient autonomy—specifically, the informed part of informed consent.

Hoffmann also advocates the prudent physician to practice truthfulness when it comes to prognosis. The physician should not cause either premature hope or despair for patients when it comes to discussing their prognosis with them. In Chapter Nine we find two such rules. Rule Five (PIIIC9R5) warns the physician not to promise too much in the case of acute or malignant diseases. And in Rule Fourteen (PIIIC9R14) the physician is given the same warning in the case of chronic diseases.

Nor is it only in communication that a physician is not to be deceptive, non-deception is also required in the diligent performance of his clinical duties. This is clearly stated by Hoffmann in Chapter Ten (PIIIC10R8): *It is disreputable to prolong a treatment with the motive of a greater profit*.

A review of the full text shows that Hoffmann very consistently requires the prudential physician to act in such a way as to gain and maintain the trust of the patient. And that is why it is so significant that he makes only one exception: in the area of the treatment of the uncooperative patient.

Hoffmann's approval of this exception leads to the greatest internal philosophical tension within his medical ethical system. The tension is between Hoffmann's concepts of trust-trustworthiness as foundational to the patient-physician relationship on the one hand and Hoffmann's approval of the physician's acting in a seemingly untrustworthy manner (by deception) on the

other. Deception seems like a violation of both the patient's trust and autonomy—specifically, both the patient's psychological dependency and his rationality.

To address this seeming inconsistency, we must first recognize that Hoffmann distinguishes two senses of deception. The first, and the more serious of the two, is deception as treating the patient against his wishes and lying to him about it. The second sense is deception by speaking incompletely including keeping silent. Their nature and Hoffmann's defense of them differ in philosophically and clinically important ways. Each therefore requires a separate discussion and philosophical analysis.

5.3.1 Deception as Treatment against the Patient's Wishes and Lying to Him About the Deception

To analyze the philosophical tension in Hoffmann's system of medical ethics it is best to start by trying to *understand* what Hoffmann had in mind in approving deception. In the next few sections, I provide the reader with the rules from the *Medicus Politicus* that apply to this issue. I then analyze those rules by looking at Hoffmann's concept of a proportioned response to patient uncooperativeness and the general justification given by Hoffmann. Finally, I examine the history of medical ethics to describe the moral landscape that informed Hoffmann at the time, in which deception was accepted. After we have attempted to understand Hoffman's concept and philosophical and clinical

justification for deception, I critically assess his justification and provide an alternative justification that seems consistent with Hoffmannian thinking.

5.3.1.1 Hoffmannian Texts on Treating the Uncooperative Patients

The manner of using and the ease of taking medications depend on the direction of the Physician and his presence.

It is not unusual that those attending (the sick person) are less anxious about the vehicle of administering medications; thus, and in this they err when giving a liquid medicine whereas the physician is generally accustomed to add something to correct the unpleasant taste, especially in the case of bitter acids. Therefore, the Physician, being present, arranges all on a par with his decision, and **by his authority** he rouses the sick person to take medications, especially among infants and the elderly; **he censures their impatience if they refuse to regulate their conduct**.

To be sure, some by their nature shrink back from remedies from the apothecaries, **for these a tea concoction or infusion will be able to be prepared in accordance with the custom of the day**, because they are able to prepare them from appropriate herbs. Indeed, many, from **a preconceived opinion**, are adverse to the most excellent medicines prepared in pharmacies; but, those things prepared by themselves, although by far they may be **inferior as far as agreeableness of the taste**, however, nevertheless, they take them with a greater enthusiasm. (My emphasis) (PIIIC1R4)

*In the presence of the stubborn, **now and then frankness and deception/trickery** (fallacia)**is useful.***

The Physician should **present himself in a serious manner** when facing sick persons of this kind. Indeed, many fearing the authority of the Physician quickly and most willingly receive that which in the Physician's absence they refuse. Among commoners, in fact, he should not fear to make use of scoldings especially if there should be no aversion between themselves and medicines.

Sometimes deceit/trickery (*fallacia*) is required: when sick persons refuse because of fear to take emetics (vomitories), purgatives, mercurials, they are able to be drunk under the appearance of other medications. And if they beseech the Physician

with a begging expression that he should not order these kinds of things; at which time he should respond: God forbid! I'm not presenting such a thing, such a thing will not be given at all; but, nevertheless, I hope that you will not refuse an analeptic or other strengthening remedy. Thus, they become accustomed to taking these things, which they abhor without regard to reason, under the species of analeptics, which at another time they reject because of a wrong-headed fear or from inexperience (ignorance).

But when they abhor the remedies prepared in the apothecary shops, supposing everything produced from an apothecary to be unpleasant, for these let the familiar and simple be ordered, or certain herbs placed in tea, which they can mix and prepare themselves. This is often the best method, because under the species of familiar remedies, the sick persons themselves sometimes thus mix the most wonderful remedies, which if they were brought in from shops, they would, as it were, reject with nausea. (My emphasis) (PIIIC3R4)

5.3.1.2 Hoffmann's Progressive Physician Response to Various Stages of Patient Non-cooperation

Hoffmann was very clear: deception was to be neither the only response nor even the first response by physicians. In fact, he provides future physicians with a scale of responses based on the level of uncooperativeness by patients. He intended the prudential physician to resolve cases involving an uncooperative patient at the lowest level of intervention and by responding proportionately to the degree of difficulty encountered.[1]

Deception was the last step after every other more reasonable option had been tried and it was to be limited to those who were irrationally uncooperative.

[1] An analogy from contemporary ethics is that a law enforcement officer may only respond with the minimum force necessary to resolve a given situation.
the best way to get the cooperation of the patient in these cases is to improve the taste of the medicine with an additive.

The general limiting rule might be phrased: The physician may only use deception when it is absolutely necessary, i.e., proportionate to the uncooperativeness of the patient of the shared goal of the return of the patient's health. This interpretation would be consistent with traditional concepts of justice as proportionality in distribution, punishment and rewards.

We can analyze the two rules cited above in terms of the levels of physician response to the stages of patient uncooperativeness.

Stage One: Patients who are rationally hesitant to take medications: The first quoted rule is from Chapter One of Part Three that addresses the prudential rules which a physician must follow in his clinical practice (i.e., "visitations to the sick"). The seventeen rules in Chapter One apply to situations that the physician would probably encounter rather routinely. Rule Four applies to patients with mild or moderate resistance to taking the prescribed medications because of their taste. Normally, patients refused because the medicines of that day were unflavored and harsh. This is a reasonable aversion especially in the case of medicines which contain bitter acids.

Level One Response: The appropriate response for the physician is to address the problem of the harsh taste. Physicians, unlike attendants, know that

Stage Two: Patients who need further urging: However, some patients might still be hesitant—Hoffmann singles out the young and the elderly. Here he points out to the medical student that the physician has a better chance of overcoming this hesitation if he is actually present when the medicines are

initially taken, a form of reassurance, which encourages the trust of the patient in the proposed medication.

Level Two Response: Usually, the physician merely needs to use the authority generated by his presence to “rouse the sick to take their medicines”. The physician is to be encouraging and directive, but not coercive. Sometimes the very young and very old may even need a mild verbal chiding to gain their cooperation.

Stage Three: Patients who have an aversion to apothecary-prepared medications: For those who have an aversion to any medicines prepared by the apothecary, Hoffmann recommends they use the *substitution* (Level Three Response) of appropriate herbs in a tea concoction. Hoffmann says that in truth they may be missing out on an excellent medicine prepared by the apothecary and that their own mixture might be inferior in taste, but patients will be more enthusiastic because they are making the tea concoction themselves. It is important to note that this rule does not advocate deception as the patient cooperates in the substitution.

Remembering that we have been discussing a rule from Chapter One that described cases of routine care, we now turn to the second quote which is from Chapter Three. Chapter Three starts by defining the physician’s need to be trustworthy (Rule One) and then addresses the more difficult cases, including considerations of deception and abandonment.

The difference between the two rules starts with the patient. Those in the first rule are hesitant to take the medication. In most of the cases Hoffmann describes their hesitation as reasonable in that it is due to the unpleasant taste of the medicines. The case of the natural aversion to the apothecary is not explained in sufficient detail other than it comes from the "nature" of the person and from a "preconceived opinion" which may not be rational. That is, some patients may not regard apothecaries as clinical authorities, as they might physicians. However, the discussion ends with a comparison between the apothecary's mixture and the patient's own mixture as it relates to the taste of the medicine.

Stage Four: The "Stubborn" Patient: In the second rule the patient is immediately identified as "stubborn." This is a description of the patient who has not responded to any of the previous efforts of the physician.

Level Four Response: There is a difference now in the physician's response. Initially, the physician is "frank" and presents himself as "serious," i.e., a stronger, more directive assertion of authority. The physician is attempting to appeal to the rational state of the patient, as a way to discipline the patient's emotional response. By being frank and explaining the seriousness of the situation to the patient the physician is acting in a trustworthy manner and relying on the rational response by the patient. By presenting himself as "serious" Hoffmann is appealing to the patient's emotional state as well. In fact, Hoffmann is very clear that the physician is no longer trying to rouse the patient to

cooperation but is playing on the patient's *fear* of the physician, much as a physician now might use vivid descriptions of lung disease to persuade a patient to stop smoking. The goal is for the physician to generate enough fear of the physician to overcome the patient's fear of the medicine. This seems to be sufficient to gain the cooperation of a number of these stubborn patients—but not all.

Stage Five: The "Irrational" Uncooperative Patient: Some patients do not respond to any of the previous steps taken by the prudential physician. They continue to refuse treatment and the clinical judgment of their decision making and behavior is that they occur "without regard to reason", or through "wrong-headed fear", or "from ignorance/inexperience."

Level Five Response: In these rare, extreme cases of an irrational uncooperative patient, the physician is permitted to use the extreme measure of deception and even lying about the deception. The specific type of deception that Hoffmann has in mind is to substitute medicine that the patient has refused for medicine that the patient has agreed to use, without informing the patient about the substitution.

5.3.1.3 Analysis of Hoffmann's Concept of and Justification for Deception in the Treatment of Uncooperative Patients

The only justification given by Hoffmann in these rules is that it is appropriate for the physician to respond with deception in the limited situation of dealing with an *irrational uncooperative patient*. In fact, Hoffmann seems to

believe that deception is a *rational* response because it repairs a plain defect in the patient's decision making and behavior. Specifically, he says that the irrational patient often suffers from inexperience or ignorance. By tricking the patient into trying the medicine the patient gains the experience that will help him to make a more rational decision in the future: *Thus, they become accustomed to taking these things, which they abhor without regard to reason*. (PIIIC3R4)

The difficulty with this justification is twofold: (1) How does (the patient) acting irrationally justify (the physician) acting in a way that appears to be unethical? And (2) Why doesn't (the physician) acting untrustworthily undermine the patient-physician relationship?

The first question may hinge on Hoffmann's understanding of the role of deception in human activity and whether he considers it unethical in all cases. We may turn to the history of the concept of deception in medicine (up to the eighteenth century) to get some idea of how Hoffmann might have understood its morality and past/contemporary usage.

5.3.1.4 Historical Concept of Deception in Medical Ethics

The approval of various forms of deception and lying by physicians is not uncommon in the medical literature—from the Ancients to the time of Hoffmann. A variety of terms have been used to describe deceptive acts but historically the most common were *simulatio* (simulation) and *dissimulatio* (dissimulate). The distinction between these terms was not always clear. Even as late as the early

seventeenth century, the distinction was still being discussed: "…*the somewhat technical distinction some of (de Castro's)*[2] *contemporaries made between simulatio (pretending the presence of something that is not there) and dissimulatio (pretending that something that is present is not there).* (Schleiner 2007(1995), 9)

Schleiner, in his *Medical Ethics in the Renaissance*, cites several examples from the Hippocratic medical texts and from Galen's works to demonstrate the approval and use of deception by physicians. In the Hippocratic text, *On The Epidemics*, there is a case of simulation where an earache is "cured" by inserting wool dipped with oil into the ear then removing it and immediately casting it into the fire. The patient is deceived into believing that the source of the earache had been removed from the ear and destroyed and that therefore a cure had been obtained. (Schleiner 2007(1995), 9)

Schleiner cites the work of de Castro who uses Galen's commentary on Hippocrates to justify his own approval of deception. Physicians were not only required to do the right thing themselves but were responsible for getting the cooperation of the patient and the attendants.[3] To accomplish this, the physician might exaggerate the seriousness of the disease: *"… Galen's view that the sick*

[2] Rodrigo de Castro, author of the *Medicus Politicus* (1614). For my previous discussions on de Castro see Sections 2.3.1 Historical Factors of the *Medicus Politicus*, 2.3.4.1 *The Politic (Politicus)* Physician, 4.2.3 Stage Three: Clinical Visitations—Initial Sentiments of Patient-Physician Relationship.
[3] In ancient times, it was considered deceptive (but acceptable) for the physician to add a sweetener to hide the unpleasant taste of the medicines.

should be made to obey by amplifying their maladies (maiores fingenda vitia) and, where the truth does not do the job, even by threatening, scaring, and evocation of danger." (Schleiner 2007(1995), 144)

Patients themselves often practiced deception. The physician needed to be able to identify patients who were feigning their illness. Although it is not clear that this was meant to justify physician deception, medical literature often referred to the fact that the physician could respond by feigning treatment in the giving of placebos.

Castro's *Medicus Politicus* contains a number of entries that discuss the history of medical deception and which approve various forms of deception. In fact, de Castro unlike Hoffmann (see Section 4.2.3 Stage Three: Clinical Visitations—Initial Sentiments of Patient-Physician Relationship), believes the first emotion of the patient in the presence of a physician is *fear*. Thus the physician should from the very beginning of the relationship conceal (*simulatione*) anything that might add to the patient's fear.

However, in a more significant case and one more akin to the one we are discussing in Hoffmann, Galen is reported to have given a woman *scammony* but told her it was *whey*. (Schleiner 2007(1995), 144) This is the same concept of deception that we find in Hoffmann's cited rule: to administer one drug (which the patient does not want) but call it another (one which the patient agrees to take). Hoffmann would have been well aware of the Galen text as well as the de Castro text (which was published in Hamburg). Approval of physician deception

and lying that contributed to the health of the patient had deep historical roots. De Castro gives three reasons why the physician should be allowed to lie. First, the physician remaining silent about the truth is not only *not* blameworthy but is actually laudable if done at the right time and place. Second, the appropriateness of lying is based on the *intent* of the physician; thus, lying to heal is not the same thing as lying to harm. Third, that some deception has historically approved roots. For example, one may lie if one is doing so to protect oneself from an enemy or a robber. (Schleiner, 2007(1995), 11-12)

The writings of Dr. John Gregory, ethical positions were heavily influenced by Hoffmann, also reflect a generally accepted concept of limited deception and lying by physicians in eighteenth century medicine. Gregory believed that in general all mankind is attracted to whatever has an air of mystery and concealment. (McCullough 1998, 115) On a more practical level, Gregory believed that a prudent physician will weigh the safety of the patient in determining the appropriateness of the mystery—i.e., the ethical principles of beneficence and non-maleficence are applied to patient interest. This even applies in the case of physician error; if it is determined that the revelation of the error would cause alarm or a loss of confidence then a lie or deception can be justified. (McCullough 1998, 106) Gregory does not take the physician's responsibility in these matters lightly:

> A physician is often at a loss in speaking to his patients of their real situation in respect to hazard to their lives. A deviation from truth is sometimes in this case both justifiable and necessary. It often happens

> that a sick person is dangerously ill, who, if he was to be told of his danger, would be hurried to his death. It sometimes happens again, that a man, who has made no settlement of his affairs, is seized with a dangerous illness and yet perhaps the future subsistence or happiness of his family may depend on his making such a settlement. In this and other similar cases, it may be proper for a physician, in the most prudent and gentle manner, to warn his patient of his real danger, and even solicit him to execute the necessary settlements. But, in all cases whatever, it is a physician's duty never to conceal his real situation from the relations. (McCullough 1998, 107-8)

Even the American Medical Association Code of Ethics allows for exceptions to the generally-accepted policy on informed consent:

> Section 8.08 [Informed Consent] The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination of treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a basic social policy for which exceptions are permitted: (1) where the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent; or (2) **when risk-disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated….** (AMA Code of Medical Ethics 1997, 120)

It must be readily acknowledged that the AMA's policy differs from Hoffmann's in that Hoffmann advocates the principle of risk-disclosure should be applied to both a serious *physical* threat as well as to a serious *psychological* threat. Time may have redefined the landscape of paternalism but the more general principle of a physician making a decision based on protecting the well-being of the patient from the patient's impaired decision making and behavior remains intact.

Thus, the answer to the question we posed earlier— How does (the patient) acting irrationally justify (the physician) acting unethically?—when viewed from a history of medical ethics is that Hoffmann in all likeliness did not see his limited concept of deception [i.e., for the health of the (irrational) patient] as *unethical*. This helps us *understand* why Hoffmann would take the position he did—but it does not *justify* it.

This leads to the second problem we had with Hoffmann's justification for deception: Why doesn't (the physician) acting untrustworthily undermine the patient-physician relationship? To answer this question, we need to analyze Hoffmann's concepts of *trust* and *trustworthiness*.

5.3.1.5 Trust and Trustworthiness in Hoffmann's Medical Ethics

In Section 4.2.2 (Stage Two: Clinical Visitations – Initiation of Patient-Physician Relationship), I established Hoffmann's emphasis that it must be the patient and not the physician who initiates the patient-physician relationship. If the physician tries to initiate the relationship, he engenders contempt on the part of the patient. Hoffmann recognizes that it is only when the patient seeks out the physician that he (the patient) recognizes the recovery of his health exceeds his own capabilities. That is, the patient is acting *rationally* in assessing his situation and seeking help. In Section 4.2.3 (Stage Three: Clinical Visitations—Initial Sentiments of Patient-Physician Relationship) we saw that this recognition of need by the patient leads to the initial sentiments of confidence, hope, and trust upon the arrival of the physician. But such sentiments will continue only if the

physician proves to have the characteristics that support these initial feelings. Again, the *rational* patient does not hold these sentiments in blind faith. The characteristics of the physician that best support the sentiments of confidence, hope and trust are, in Hoffmann's view, a strong moral character, rationally skilled, and clinically competent.

So, when we try to *understand* the philosophical tension in Hoffmann's position on deception in view of his position on the proper patient-physician relationship, we must be careful not to treat the responsibility of the physician in communicating with the patient in isolation from Hoffmann's account of the physician-patient relationship: Hoffmann's relationship is a reciprocal arrangement and it is the reciprocity that must be addressed.

A concept of reciprocity starts with a (rational) trust and for Hoffmann that trust seems to entail a responsibility on the part of the patient. A rational patient would remain committed to the shared goal of the return of his health even if it meant the inconveniences of the effects of the medicine, because they will be offset by the greater clinical benefits of effective clinical management of the patient's disease. In fact, I have already shown that Hoffmann has been very specific on this point by establishing reciprocal rules for patients throughout the *Medicus Politicus*. This is why I concluded in the Section 5.3 (Hoffmann's Patient-Physician Relationship as a Social Contract) that what Hoffmann has in mind is a social contract based on rational principles. It is an informal contract and continues only as long as both sides are fulfilling their part of the contract. In

the case of the patient, his part is to cooperate with the physician in treatment, by self-administering drugs over time, even when the physician is not present and even when the drugs have an unpleasant taste.

I also showed in Section 5.3 that both the patient and the physician used their judgment throughout the contract period to evaluate the performance of the other party. In fact, Hoffmann allows that the physician can terminate further visitations to a patient who totally ignores the prescribed regimen (PIIIC3R3).

This option—i.e., that the physician should terminate the relationship if the patient is not fulfilling his part of the contract—is extremely important to the discussion on the understanding and justification of deception. When one examines the limited options available to the physician who is confronted with the irrationally uncooperative patient, it becomes apparent that there are *no* options available free of ethically challenges. Nonetheless, the physician must choose the the ethically justified option.[4] One option then is that he may terminate the contract. Another is to continue the visitations without further attempts to get the patient to take any medications. Both of these options are compatible with our contemporary understanding about physician's discontinuing futile care. This gives rise to a third option: deception in the form of giving unwanted medications

[4] These options are based on the assumption that the physician has tried all the other levels of response (see Section 5.4.1.2 Hoffmann's Progressive Physician Response to Various Stages of Patient Uncooperation above) and has not been able to gain the patient's cooperation,

disguised as acceptable medications, which avoids both unnecessary abandonment and administration of futile treatment, both of which are harmful to the patient and therefore ethically unacceptable alternatives.

Options one and two clearly do not pursue, much less achieve, the shared goal of the recovery of the patient's health which was the basis of the social contract. However, option three does achieve this goal. Thus, given the options available to the physician, deception becomes the ethically acceptable option in the context of the rational aims of the physician-patient relations that in their social contract, both the physician *and* the patient accept. In this case, the recovery of the patient's health justifies risking the reputation of the physician.

There is some textual evidence to support this interpretation of Hoffmann. The order in which he presents these rules may shed some light on this. In Rule Three (PIIIC3) he lays out the first option: *Those who do not follow the regimen, the Physician should abandon these quickly.* In Rule Four (PIIIC3) he addresses option three: *In the presence of the stubborn, it is useful to be frank and sometimes deceptive*. And in Rule Five (PIIIC3) Hoffmann expresses concern that the young physician not interpret abandonment as some type of general rule: *The patient should not be readily abandoned.*

Even within Rule Four, Hoffmann ends by reminding the physician that it is better to gain the patient's cooperation:

> *But when they abhor the remedies prepared in the apothecary shops, supposing everything produced from an apothecary to be unpleasant, for*

> *these let the familiar and simple will be ordered or certain herbs placed in tea, which they can mix and prepare themselves.* ***This is often the best method****, because under the species of familiar remedies, the sick persons themselves sometimes thus mix the most wonderful remedies, which if they were brought in from shops, they would, as it were, reject with nausea.* (My emphasis) (PIIIC3R4)

The answer then to the question "Why doesn't (the physician) acting untrustworthily undermine the patient-physician relationship?" has two possible answers. First, Hoffmann might disagree that deception is an untrustworthy act. The patient's primary trust is in the ability of the physician to accomplish the healing. Given that the nature of the relationship is one of reciprocity, the irrational patient abandons any claim on an unlimited concept of trustworthiness on the part of the physician. If the physician is acting to restore health then he is fulfilling the terms of the social contract. Irrationality on the part of the patient in refusing proper treatment nullifies any claim by him to hold the physician to a one-sided commitment. Second, we might agree that deception is not a *good* option but it is better than any other option available to the physician. The physician is committed to his natural law (rational) responsibility to protect society.

5.3.1.6 Critical Assessment of Hoffmann's Approval of Deception in the Sense of Administering Unwanted Medicines

I'd like to explore an argument for Hoffmann that he does not state explicitly but which is based on textual material. I propose, on Hoffmann behalf,

that the use of deception by a physician is analogous to the use of heroic treatments and medicines by a physician.

Throughout Part Three of the *Medicus Politicus* there are rules warning the medical student that he must exercise the greatest caution when he is dealing with the strongest medicines or treatments, which were then called "heroic." Heroic medicines often had what were described as "violent" effects, e.g., uncontrolled vomiting and involuntary defecation, which would be experiences by patients as unwelcome, if not alarming. Heroic treatment is addressed individually in the chapters on women, pregnant women, children, the elderly and special patients (such as the Prince). Rule Fifteen (PIIIC9) provides a more general application of this rule: *The physician must exercise the greatest prudence in administering heroic medicines, if he wishes to obtain his proposed end.* In one example, he shows that a medicine that is heroic medicine is not to be used without regard to the nature of the patient and the nature of the disease.

Similarly, deception is not for everyone and prudential judgment on the part of the physician is required. Some strong medications should not be made available to the general public but society should only entrust them to the physicians; making them what we now call *controlled substances*. In the same way, deception is what we might now call a *controlled response*. It is not to be used indiscriminately but must only be *entrusted* to those members of society who have a valid need to have access to it. In this sense, deception becomes an *essential clinical tool* entrusted to the physician and to be used only for the good

of the patient, when all else fails to gain the patient's cooperation in self-administering drugs. Healing is not only about the medicines *per se* but also about the judgment of the physician. In this way, we measure the morality of the act both on its consequences and the physician's intentions—intentions based on a shared goal and competent judgment that together define the physician-patient relationship.

Schleiner notes a similar argument is advanced in the *Medicus Politicus* of de Castro:

> For that reason, he reports, **lying has been compared to hellebore: taken without necessity and without utmost discrimination, it is deadly; but in the circumstance of a deadly disease, it is salutary**. According to Castro, lies should similarly be used "like a medication or a condiment"…. (My emphasis) (Schleiner 2007(1995), 11-12)

Renaissance medical writers believed they found some support for their positions on deception from Plato. There is a philosophical argument from Plato that addresses lies as a medicine. In the Republic he says "…we must surely prize truth most highly. For if we were right in what we were just saying, and falsehood is in very deed useless to gods, but to men useful as a remedy or form of medicine (*pharmakon*), it is obvious that such a thing must be assigned to physicians (*iatroi*) and laymen (*idiotai*) should have nothing to do with it…." (Plato Bk. 3, 329B; Loeb ed., vol. 1, p. 213. in Schleiner 2007 (1995), 6] In addition to physicians, Plato concludes that as a form of medicine, the rulers of the city may lie if it brings benefit to the state—e.g., when dealing with enemies. In

Hoffmann's time the physician could not depend on the state so that the *politic physician* had to be doctor and prince when administering medicine.

We might be tempted to critique Hoffmann's position from twenty-first century perspective. However, we might want to keep in mind that the physician of Hoffmann's era also served the roles currently saved for the hospital ethics committee and a court judge. Today, we have a system of safeguards on the process of declaring a patient incompetent. But in the eighteenth century physicians were self-regulating and were autonomous in their clinical decision making; neither the patient nor the physician had a system of recourse in such circumstances. Add to this an understanding that the mortality rate from diseases was high and a delay in treatment not only meant complications but also, often, death. Only the physician had training and experience to understand and weigh these grave circumstances.

A contemporary analogy might be a surgeon performing an operation only to discover something else seriously wrong during the procedure. Should he perform the new surgery or wait to get the patient's permission? The physician alone will have to weigh the consequences of each option; ethically, he should view the decision from the best-interest-of-the-patient perspective. Hoffmann may be saying something similar in his justification of deception. While the analogy may be weak in that the patient in Hoffmann's case may be conscious, there is the analogical aspect that the physician is in a clinical moment of crisis

and dealing with someone who in his clinical judgment is incapable of making a rational decision.

5.3.1.7 Conclusions on Deception in the Sense of Administering Unwanted Medicines

I have characterized Hoffmann's rules as a scale of physician options in relation to the degree of uncooperativeness of the patient. And I believe the rules of the *Medicus Politicus* support this characterization in general. However, when we deal with the degree of uncooperativeness that justifies deception for Hoffmann, he uses the specific terminology of patient "irrationality." In a previous step the physician was encouraged to substitute with the patient's knowledge. This indicates to me that Hoffmann is not saying that all patients who refuse treatment (at least initially) are irrational. The question is whether Hoffmann considers someone irrational who refuses to take *any* medication?

There would seem to be two possible options: (1) *all* who refuse *any* medication are automatically deemed irrational or (2) *some* who refuse *any* medication may be irrational. If Hoffmann intends the latter case, then I would both understand and agree with his justification. That is, in those cases where the patient is deemed in the judgment of appropriate medical authority to be irrational for additional factors—and not just simply because they refuse medication—then a physician in Hoffmann's day would have been just such a medical authority. The analogy of a physician being entrusted with prudential use of heroic medicine as a form of justification for deception is stronger. The

physician, acting as a surrogate decision-maker, could make the rational choice he would expect a rational agent to make in like circumstances.

If, on the other hand, Hoffmann is implying that any refusal of treatment should be automatically treated as irrational (option #1), then I don't believe his justification is sufficient. For example, a patient who sees further treatment as futile care or a patient who is not yet fully trusting of his physician might be justified in refusing such treatment. In this case the analogy of heroic medicine fails because it is just such types of medicine that may be more rationally rejected.

Unfortunately, the text is not clear on Hoffmann's construal of the concept of "irrationality". However, he was an experienced clinical physician and it is likely he encountered both types of refusal. If he said the patient's refusal was "irrational" then we might expect he knew the difference and really meant the patient was acting irrationally.

5.3.2 Deception as Speaking Incompletely

This is the second sense in which Hoffmann approves the physician being deceptive. As I did previously, I will start by providing the reader with the rules from the *Medicus Politicus* which apply to this issue; then, I analyze those rules and look at the history of medical ethics to see the moral landscape which informed Hoffmann at the time. After we have attempted to understand

Hoffman's concept and justification for deception, I critically assess this justification.

5.3.2.1 Hoffmannian Texts on Treating Uncooperative Patients

In the *Medicus Politicus* Hoffmann advises the medical student that a prudential physician will have to know when to keep quiet. There are two relevant rules:

> *The Physician should not **contradict unless necessary** a Prince sick person, nor even his other Physicians; he should, with his permission, make him aware that there might be an imminent danger.*
>
> Princes do not like to be contradicted, thus he should listen quietly to their explanations; because **who does not know how to conceal does not know how to treat**. It is also necessary to protect oneself from contradicting other Physicians who attends the Prince…. (My emphasis) (PIIIC4R4)

> ***Whoever does not know how to pretend (simulare) also does not know how to cure.***
>
> The physician should neither scorn nor order differently everything which is administered by others. Often foolish women are more liberal in providing advice, who, **if only they should not be inflicting an obvious injury**, should be permitted, especially if something is being applied externally, nevertheless in principle, he should be responsible to add to this or that type. Likewise, sometimes at the home of important men some learned Surgeon discusses a contribution in the case of an illness, which **he should not publicly condemn**. (PIIIC4R8) (My emphasis)

5.3.2.2 Analysis of Hoffmann's Concept of and Justification for Speaking Incompletely

Hoffmann's position is too clearly and forcefully stated to try to minimize his approval of simulation. In two different rules he repeats the advice that *whoever does not know how to simulate does not know how to cure*. However, both of these rules are from Chapter Four which primarily addresses the unique situation of a physician dealing with some other important personage (such as a Prince) or the physician dealing with his colleagues.

In the first rule Hoffmann is addressing the prudential rules for a physician who is dealing with a sick Prince and with his medical colleagues. The Prince is a person of great social standing and is a powerful man. In his social role as a Prince, he does not want to be contradicted by his subjects. They need to recognize his authority.

Hoffmann is indicating that people of a socially and politically superior position bring something else initially into the patient-physician relationship—i.e., an expectation of their higher social standing being recognized. Princes and powerful people have a difficult time separating their social roles from their role as patient.

The prudential (politic) physician must recognize this new dynamic of having to deal with power relationships. The appropriate response is to *listen quietly* and to *not contradict*.

In the second cited rule (and to some extent even in the first rule) Hoffmann is addressing the appropriate behavior of a physician when dealing with his medical colleagues. In the first rule these colleagues are other physicians attending the Prince (or some other important person). He notes that in some cases these physician have already gained the trust of the Prince and he should be careful not to undermine that trust. In the second rule, Hoffmann is extending this application to other non-physician competitors, such as *foolish women*. In each case, the Hoffmannian physician will not contradict them in their treatments.

However, Hoffmann is clear that this tolerance towards Princes, people of influence, colleagues and competitors is not absolute. Such tolerance limited by the health interest of the patient, despite his socially and politically superior position and power. The physician therefore should not contradict the Prince *unless necessary*. He may have to ask permission from the Prince but he must *make him aware that there might be an imminent danger.* He may be silent about the medications prescribed by his colleagues and he can even be tolerant of his non-medical competitors, *especially if something is being applied externally*, but *only if they should not be inflicting an obvious injury*. He should not contradict his colleagues in public *nevertheless in principle, he should be responsible to add to this or that type (of medicine)*.

Earlier we saw that a physician *simulates* whenever he pretends that something is present which is not. In this case, the physician's silence gives

credence to his assent in another's action; an assent that is not really there. We have also seen in the earlier discussion on the history of medical ethics that the ancients, de Castro and Gregory all had supported a limited concept of lying in this sense—i.e., if it was done at the right time and in the right circumstances.

Hoffmann's concept and justification for this type of deception does not undermine his overall ethics in that the physician must place the health interest of the patient first. It does allow that, in a limited context, the physician must understand that the trust-trustworthy relationship is more complex in the case of important people and when dealing with colleagues.

5.3.2.3 Critical Assessment of Hoffmann's *Deception as Speaking Incompletely*

It is my position that when Hoffmann is talking about simulation as *speaking incompletely* he is not talking about the physician acting in the role of physician *per se*. Instead, the prudential physician is being instructed in how to be sensitive to the various roles he plays in society. He also recognizes that from a practical position his ability to function in society as a physician often rests on his ability to fulfill his other social roles. However, simulation is not meant to be a broad principle and in no case can a physician act other than as a physician when there is serious danger to the health of a patient.

So far, this dissertation has examined the role of the physician *as physician*. But, in analyzing the text and critiquing his concepts and justifications on simulation, we must look at Hoffmann's prudential rules in a more general

sense—i.e., as guidance for the physician to function in the society of his day. This meant that the physician must recognize that he had several social roles as a member of society. Sometimes, those roles might come into conflict and Hoffmann is providing the new physician with prudential rules for just such an occasion.

Hoffmann limits the application of simulation to two specific situations—each corresponding to two different social roles. First, he provides the prudential rules of simulation for a physician who has a Prince (or other important personage) as patient. Second, he addresses the prudential rules of simulation when the physician is acting in collaboration with other medical attendants.

In the case of a physician who has an important person as a patient, Hoffmann makes a distinction between the physician's social standing in that relationship along with its corresponding role and the physician's standing as a physician *per se* with its unique role.[5] The appropriate (prudential) behavior between a physician and a patient who is superior in power is for the physician to balance his two roles. As a social subordinate, the physician assumes the social role of a subordinate and listens without objection to his superior. Hoffmann seems to be applying a psychological analysis to the situation: people in power will only listen to you after you've acknowledged that they are the people in power.

[5] See Section 4.3 for my earlier discussion on the physician dealing with Princes.

Hoffmann seems to be introducing a new element into Stage 3 of the development of the patient-physician relationship (See Section 4.2.3 Stage Three: Clinical Visitations—Initial Sentiments of Patient-Physician Relationship). Important and powerful people do not surrender their authority or give their trust as easily. They do not readily ignore their social status—nor do they readily allow others to ignore it. So, before the physician can act as physician *per se* he must fulfill his other social duties by acknowledging the superior social standing of the patient. He does this by listening attentively to that person and by not contradicting him. Once this additional step has been taken, Hoffmann expects the important person to be ready to surrender his well being to the medical authority of the physician. The conflict in the power relationship can now be resolved: the physician is acknowledging the limited scope of his authority to the more powerful personage and that person is acknowledging the limited scope of authority from the physician.

However, this accommodation is not an absolute principle. Whenever the health interest of the patient is threatened, the physician must be ready to assume the role of physician *as physician*. He can only play the role of physician *as subordinate* as long as there is no medical contra-indication. He must stand ready to divest himself of every other role when he is in a clinical situation. Whenever there is danger to the patient's health, then the physician must resume his social responsibility *as a physician* and must protect the life of the individual. The appropriate (prudential) action of a physician when acting *as physician* is to

assume control. Hoffmann firmly reminds the medical student that in these circumstances he is the one in authority: *The Physician should be hardy and not timid. He is justly called the master of the body. Consequently, he should present himself at the home of the great with the firmness necessary to this title….* (PIIIC4R1).

There is something similar going on when the physician is dealing with his medical peers (or competitors). The physician must be ready to balance his role as a physician with his role as a collaborator with peers. Hoffmann clarifies and emphasizes this duality when he discusses the role of the physician who is called in as a second or consulting physician:

> *The Physician who is called by a sick person (along) with one of his confreres, who has already begun to treat him, must pay attention to three things.*
>
> (1) He should not take charge of the drafting of the formulas, unless the Physician asks him for it in that instance. (2) He should order nothing but in concert with his confrere. (3) He should not give a prognosis without having consulted each other instead of finding himself of a contrary sentiment. (PIIIC9R17)

In the two rules cited above (See Section 5.4.2.1), the prudential physician responds to the role of collaborator by not undermining the recommendations of the other medical people in attendance. This is especially to be followed by not contradicting them in public.

However, just as the physician must be ready to respond to the patient's needs even in a situation involving men who are socially superior, he must also be ready to do so in the face of his peers. He can keep quiet but *only if they should not be inflicting an obvious injury*. Whenever the health of the patient is in

danger, the physician must act *as physician*. He can no longer be silent or pretend to agree as he is morally obligated to fulfill your duty.

There is also a practical aspect. When the physician undermines or destroys the reputation of his colleagues, he is undermining the public trust in physicians in general. Additionally, the reputation of the criticizing physician can be destroyed and his ability to do his job in the future compromised. The prudential patient is always assessing whether or not the physician shares his interest. The prudentially-empowered patient judges the motives of the physician who has undermined his colleague and might determine that such a physician is only concerned with his own point of view and possibly his own financial interest.

In both of the situations just discussed, the Hoffmannian physician has been prepared to recognize his non-medical social roles. Simulation out of respect for a superior and simulation out of respect for peers does not undermine the physician's primary social responsibility to society. Satisfying his other social roles has a priority in sequence and time; but satisfying his medical social role has a priority in the Christian and Natural Law ethical hierarchy. Keeping focused on the medical teleology of a shared commitment to a patient's healthy helps the physician to make prudent decisions in a wide variety of situation. This is another example of Hoffmann trying to harmonize seemingly diverse interests. In contemporary terms, Hoffmann is approaching the power-relationship conflict so as to resolve it as a win-win solution.

Section 5.4 Conclusions and Summary: Dr. Friedrich Hoffmann's Contributions to Medical Ethics

Dr. Hoffmann was an internationally well-known and highly respected physician in his own time. He was mostly known through his prolific writings on medical science and medical practice. I have established (Sect. 2.1.4) that his medical works were highly influential in Scottish medical society; this influence is found most significantly in the medical science writings of William Cullen (1710-90), a famous physician and professor of medicine at the universities at Glasgow and Edinburgh. I have also traced Hoffmann's influence in French medical society. In fact, there is little doubt that Friedrich Hoffmann was considered one of the most renowned physicians of his own day.

His medical ethics were just as important and influential. The medical ethical writings of such historical luminaries as John Gregory (1724-73) were also influenced by Hoffmann. (See Sect. 2.1.4) While the *Medicus Politicus* may not have been translated into English directly, its effects were. Gregory "wrote the first philosophical, secular, clinical medical ethics in the English language" (McCullough 1998, 1),

Even today, the National Library of Medicine has over 400 works of Hoffmann available to the public. This is one of their largest collections and vastly exceeds their holdings for most of the renowned physicians of modern history. If my review of literature is any indication, Hoffmann seems to be gong

through a period of being “re-discovered” by German writers. So, the question is: Why isn’t Hoffmann currently being discussed in the English-speaking world?

My claim is that Hoffmann is a significant historical figure in medical ethics and his concepts and methods inform our current biomedical ethical environment. I believe the single most important reason he is not currently being discussed is that his ethics has never been developed and has never been translated into English.

To develop his medical ethics has been a monumental task. First, the *Medicus Politicus* is a large work—written in Latin. Second, the work is a series of lectures and, although the ethics is concentrated at times in a group of rules, overall the ethics has been incorporated into discussions on other purely medical clinical situations throughout the text. Also, the theoretical and the applied ethics are meant to be complementary. This dissertation is the first comprehensive effort to extract all of the medical ethical elements and to organize them into a philosophically cohesive and consistent theory of medical ethics.

The contemporary English-language literature on Hoffmann is vastly incomplete and his concepts frequently misrepresented. A pattern emerges that most of the “rules” quoted by other writers refer only to rules taken in isolation and from the rule “headings”—Hoffmann’s ethics cannot be understood outside the full content of the rule itself. Having spent several years myself doing Latin and French translations followed by organizing the pieces extracted into a system of ethics, I can understand (but cannot justify) such expediency. This

dissertation sets the record straight in many areas and opens up to the English-reading researcher an opportunity to engage Hoffmann's historically significant contributions in contemporary discussions.

One of the more important findings of this research is that a very comprehensive and modern understanding of medical ethics was being taught in the medical school at Halle during the late seventeenth and early eighteenth century (i.e., the first half of the Long Eighteenth Century). This significantly moves the start date of the history of modern medical ethics; previously, it was believed that no such system had been developed or practiced prior to the last half of the eighteenth century. (See Sect. 1.4) My research also establishes Hoffmann's influence in the development of medical ethics in the English-speaking world.

Modern medical schools might also benefit from studying Hoffmann's curriculum. The curriculum at Halle started with theoretical concepts of ethics in medicine and then moved on to its practical application. (See Sect 3.1) Today, this may be incorporated into a single class for one semester; often, the theoretical concepts and justifications are neglected in favor of application. Hoffmann, however, did not treat ethics as a "subject" to be added to the curriculum. Ethics was incorporated throughout the curriculum and exemplified in a variety of clinical settings.

Medical schools in the U.S. are being criticized for their failure to turn out a complete physician—i.e., one who has compassion to go along with competence:

> In the growing litany of criticism to which our profession is increasingly exposed, there is one that in many ways is more painful than all the rest. It is the assertion that physicians are no longer humanists and that medicine is no longer a learned profession. Our technical proficiency is extolled, but in its application we are said to be insensitive to human values. We are, in short, presumed to be wanting as educated men and as responsive human beings…. But most painful of all, the assertion strikes at the reality that alone gives authenticity to our profession—our unique charge to answer the appeal of a sick and anxious person for help that is both competent and considerate. The criticism is especially poignant for medical educators, at whose door much of the responsibility is laid…. They decry the lack of compassion they perceive in the care of patients. (Pellegrino 1974, 1288)

Hoffmann thus anticipates the major, ongoing effort in the U.S. medical schools to weave ethical themes of professionalism throughout medical student classroom and clinical education. (ABIM Foundation 2002, 136)

Hoffmann's new physician—new in the sense that he was preparing his medical students in anticipation of a world that was still developing—has sometimes been referred to as the *politic physician* or the *prudential physician*. The *Medicus Politicus*, when taken in the context of the historical changes that were occurring in Brandenburg-Prussia (See Sections 1.1 – 1.4), shows that this new physician was being optimistically prepared in anticipation of a better world. But, the Hoffmannian physician was not only to be the recipient of this change; he was to be the agent of change. Hoffmannian physicians went out into society as models of the ethical and competent physician—from Berlin, throughout Europe, and to America. Within the German states, Hoffmannian physicians took positions of power in government and universities (See Sect. 1.5.4) that changed the laws and the course of their medical history.

The new ethical physician would also be an agent of change throughout society. The current state of affairs was that the physician was not a professional in any sense of the term; in fact, he was rivaled by untrained competitors. (See Sect 1.1) The physician was the only graduate of the university who had to enter society as an equal with non-trained competitors. The new physician would develop the highest standards found in other university graduates—specifically, theology and law. By setting the standards high, the new physician would be set apart from their untrained and unvirtuous competitors. The goal was to transfer patient trust—already, a rare commodity in a world of conflicting medical claims—from these competitors to the cadre of Hoffmannian physicians—themselves trained to be trustworthy agents. (See Ch 4)

The model developed by Hoffmann also anticipated other changes in "German" society. The world had become more scientific and medicine was at the forefront of such changes. The new physician would have to be rational and scientific. (See Sect 3.3) Hoffmann may well have been the first to recognize that for the first time in history, the medical training received by a physician in medical school would be insufficient to last a lifetime. The new physician needed to become a life-long learner—Hoffmann recommends travel to have personal contact and training from the best scientists and medical minds; to keep up to date with correspondence, journals, scientific societies and new publications. These practices continue to shape excellence in medical practice and research.

The Hoffmannian physician was being developed during a period of transition to the modern professional physician. There would be minimal help from the State which had done little to establish medical regulations to safeguard the practice of medicine and which had little power to enforce the regulations that were in place. This meant that at the highest levels of government the Hoffmannian physician would have to play a major role in furthering state interest in medical practice; my research shows that this is exactly what they did thanks to the Halle-Berlin corridor whereby many Halle graduates went directly to positions of influence in the Brandenburg-Prussian capital. (See Sections 1.4 & 1.5.4) It also meant that at the lowest levels of the practice of medicine in society the physician needed to be self-regulating; again, my research shows that this is exactly what Hoffmann was training the Halle medical student to become.

A major result of the philosophically joining together of the various rules of the *Medicus Politicus* is a fully developed system of ethics in and for the patient-physician relationship. (See Ch 4) The patient-physician relationship was the deployment of his theoretical concepts into the clinical environment. Hoffmann recognized the unique role of the physician in fulfilling the Natural Law obligation to other members of society. He portrayed the state of nature in society as one of constant misery requiring mutual support if any or all were to gain their teleological goal of happiness. The appropriate response of all members of society was sympathy; the appropriate response for the physician was compassion. The physician was obligated to act to address the clinical

dimensions of the social problem of human misery as a moral agent and a rationally and clinically skilled physician.

In Hoffmann's ethics of patient-physician relationships, he recognizes the balance of power and interests between physician and patient; he has rules for both physicians and patients; he recognizes the psychological and emotional elements in patient dependence; he develops a modern concept of the fiduciary bond of trust and trustworthiness; and he provides appropriate responses at each level of the relationship as a harmony of emotions and rational evaluation. This system of medical ethics in the patient-physician relationship is so comprehensive that it may stand alone in the history of medical ethics; as a minimum, it provides much to inform current bioethics.

Hoffmann does recognize the prudential limits of practicing medicine in the clinical setting. There are times when patients cannot afford to pay for their medicines; the Hoffmannian physician responds by knowing the cost of medicines at the local apothecaries, by mixing his own medicines or prescribing simple medicines. There are times when the patient is beyond the help of the physician; in many of these cases the physician should call in other physicians for consults; but if further treatment is medically ineffective, then the physician may terminate his visits—anticipating the contemporary debate over futile care. However, even in these cases, the physician is encouraged not to abandon the patient too readily, to recognize that a physician is incapable of curing all illnesses and to provide palliative care if the patient requests it.

Another huge achievement by Hoffmann is the harmony that he brings into his ethics. The politic physician lives in a world of conflicting theories and interests. He requires prudence to navigate through these troubled waters. The prudence that Hoffmann advocates is a non-traditional employment of this virtue as a selfless giving by the physician to society. He is to be available to all (even the poorest) on an equal footing and available at all hours—i.e., self-regulating universal health care. Triage in medicine is to be practiced based on the seriousness of the illness and not the importance or paying ability of the patient. The physician is to be the servant of the sick and to take on their illnesses—often being more concerned than the patient himself. The physician's self-interest is recognized in the areas of maintaining his own health and his entrepreneurial interests—but never at the expense of the patient's health interest.

The prudential physician was being prepared to take his place in society as a powerful force—quietly powerful—an agent of harmony. He was to be a problem-solver and not a problem himself. Hoffmann provided many prudential rules that defined this role for the physician: don't argue about religion; don't disagree unnecessarily with the Prince and other powerful people; don't argue about fees; don't seek out patients, don't undermine other medical personages, etc. In Brandenburg-Prussia there was arguably no other profession that was more a force for harmony in society. Physicians were to gain power but not wear it or wield it primarily for self-interest.

Hoffmann founds his ethics of harmony upon a Natural Law tradition with roots going back to Hugo Grotius' attempts to establish international law. (See Sects. 1.3 – 1.4) But, he even harmonizes Natural Law with traditional theological (Christian) principles and practical clinical considerations—there is room in the system for religious, scientific and rational thinkers. This interdisciplinary harmony was undoubtedly influenced by Hoffmann's contemporary, the German master of harmony, Gottfried Leibniz. This drive for a universal and harmonious system played a significant role in international law but not in international ethics. Hoffmann's universal and harmonious medical ethics was initially readily adopted within Europe. With arguably the exception of the issue of deception (see Sect. 5.3) Hoffmann's ethical system stands harmoniously in the middle of a long tradition from the Hippocratic Oath to the current AMA Code of Ethics.

Much of his modern medical ethics has survived but the spirit of harmony and universalism has seemingly become lost. Whether this was caused by an imbalance in the patient-physician relationship, an imbalance in physician entrepreneurialism-patient priority, or an imbalance between the religious and the secular is a study beyond the scope of this dissertation. However, what we can say is that Hoffmann's universalism and harmony is still a fundamental quest of contemporary Global Ethics:

> Although the title of this volume is *Global Bioethics*, this is not a book just about bioethics. It is a disturbing study of the contemporary moral predicament. More than that, it is an analysis of the human moral

> condition. The volume brings us to confront the circumstances that the culture wars that fragment bioethical reflections into contending partisan camps are grounded in intractable moral diversity. It is not just that there is a failure of consensus on all the major issues of human life,,, but that no resolution of our controversies appears in sight. This state of affairs brings into question the ways in which Western Europeans have regarded morality for more than a millennium…. The cultural diagnosis offered requires us to determine how we can understand free and responsible action when there is disagreement about the nature of the good, the right, the virtuous, and the nature of human flourishing. (Engelhardt, Jr. 2006, 1)

Dr. Hoffmann knew this description well; it was a perfect description of the world in which he lived—he knew it better because he lived in a period following devastating wars and pestilence. People then lived at a time (following the *three* wars of the thirty years war) when they did not know if or when the next war would start. As Hobbes astutely points out, the period in which there is no peace is a state of war. Hoffmann also lived and practiced at the time during which mortality and morbidity rates were frightful, compounding the miseries of war and poverty. And just for a brief moment in history, a medical school professor in a small university in Brandenburg-Prussia found a way to harmonize the diverse elements of his time. He was (optimistically) preparing physicians for a better world. Hoffmann has earned a seat at the contemporary table in the discussions on global bioethics.

Dr. Hoffmann's contributions to the history of medical ethics have been overlooked by the English-reading researcher but deserve considerable attention. Further translations of his other medical and theological works should

fill out the account this dissertation has started. My greatest hope in this endeavor is that my research will spark others to continue this project.

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