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UPDATE

The physician and the patient: the vulnerability paradigm in Emmanuel Levinas

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Abstract

Scientific advances have been changing physician-patient relations, revealing the need for new ethical thinking and action, with emphasis on reestablishing the subjective elements of communication. To this end, this text focus on the thought of Emmanuel Levinas and bioethics, particularly its branch concerned with biomedicine, health care and the principle of vulnerability. This perspective proposes that bioethics surpasses the paradigm of autonomy, reaching towards the paradigm of vulnerability, focusing on the patient, whose fragility challenges and demands embracement.
Keywords: Bioethics. Ethics. Health vulnerability.

Resumo

O médico e o doente: paradigma da vulnerabilidade em Emmanuel Levinas

Os avanços da ciência modificaram a relação médico-doente, revelando a necessidade de novos modos de pensar e agir eticamente, com ênfase no resgate de elementos subjetivos da comunicação. Para fundamentar essa relação, este texto parte do pensamento de Emmanuel Levinas e da bioética, sobretudo em sua linha voltada à biomedicina, ao cuidado e à vulnerabilidade. Propõe-se que o paradigma da bioética passe da autonomia à vulnerabilidade, com foco no doente, cuja fragilidade interpela e exige acolhimento.
Palavras-chave: Bioética. Ética. Vulnerabilidade em saúde.

Resumen

El médico y el enfermo: paradigma de la vulnerabilidad en Emmanuel Levinas

Los avances de la ciencia modificaron la relación médico-enfermo y revelaron la necesidad de nuevos modos de pensar y actuar éticamente, con énfasis en el rescate de los elementos subjetivos de la comunicación. Para fundamentar esta relación, este texto toma como base el pensamiento de Emmanuel Levinas y de la bioética, sobre todo en la línea dirigida a la biomedicina, al cuidado y a la vulnerabilidad. Se propone que el paradigma de la bioética pase de la autonomía a la vulnerabilidad, con foco en el enfermo, cuya fragilidad interpela y exige amparo.
Palabras clave: Bioética. Ética. Vulnerabilidad en salud.

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With advances in science, the technoscientific revolution and the dynamism of contemporary reality, medical *praxis* and, consequently, the physician-patient relations have changed significantly. Abundantly documented in the literature, these changes showed the need to rethink professional performance. What took place, then, was the reestablishment of subjective elements of communication towards the patient, as opposed to approaches based solely on objective and technical-scientific data.

According to Cardoso [1], patients want their individuality recognized, which requires medical skills beyond instrumental knowledge. Therefore, *the challenge lies in validating this relationship as an effective moment of personalized attention* [of which] *information, because of communication*[,] *serves as its foundation* [2]. This allows broadening horizons in search of new attitudes.

In this context, we must dive into an eminently human reality at the very moment of greatest fragility and vulnerability – when the illness is experienced on a personal level, by family members or relatives. Inside hospitals, clinics, or any other health care environment the cruel fact, which does not go unnoticed by the attentive observer, is: the patient is alone.

This article reflects, therefore, on the patient-physician relationship based on the thoughts of Jewish philosopher Emmanuel Levinas, especially in his work *Totality and infinity* [3]. Bioethics will serve as a second starting point, which has been split into at least two aspects throughout its development: one more global, reflecting on science in general; and another dealing with ethical conflicts raised by the use of technology in biomedicine. This work adopts the latter perspective.

By focusing on Levinas, we aim at reconstructing subjectivity no longer from the centrality of the Self, but otherness. In this article, his ideas will serve as the philosophical *locus* that substantiates a new way of thinking and acting ethically, developing a bioethics that moves from the paradigm of autonomy to the paradigm of vulnerability.

The foundations of ethics of care

Produced by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, in the United States, the *Belmont Report* [4] shaped a distinct conception: the bioethics of principles. This principled approach rests on respect for people, beneficence, and justice to resolve ethical dilemmas in health care. However, this trend has suffered much criticism, with alternatives being proposed, like those relying on a greater emphasis on an ethics of care, such as the protectionist, personalist, and deliberative currents.

Proposed by Latin American researchers, the bioethics of protection considers that principlism hinders confronting problems inherent to the public health, and thus proposes an additional principle, precisely that of protection [5]. Its ethics is that of social responsibility, whose elements are gratuity, bonds, and the satisfaction of the person's essential needs. The current focuses mainly on "vulnerably exposed" [6] patients, those who are unable to protect themselves, and not simply "vulnerable" (in fact, all living beings). Its focus lies particularly on health problems and individuals whose health and well-being are impaired by situations of scarcity [7].

Based on anthropological foundations, the personalist current targets the relativism resulting from the breadth of the bioethics object, stating that the first issue to be resolved concerns the essence of the human being, connected to the spiritual dimension [8]. From this perspective, Sgreccia [8] proposes the principles of defense of physical life; totality (or "therapeutic"); freedom and responsibility; subsidiarity; and solidarity to pursue a comprehensive vision of the human person, without ideological or biological reductionism. Personalism highlights, by its principle of solidarity, *the being sharing the world with others* [9] and the self's ability to establish a relationship with the other, as this relation prevents subjectivist individualism and abandoning the sick to their pains and anguishes.

Deliberative bioethics, in turn, presents a hierarchical system of values in which the principles of non-maleficence and justice are above those of autonomy and beneficence, as they represent the common good [10]. Founder of this trend, Gracia [11] currently proposes a decision model complementary to the hierarchy of principles and centered on values. According to Siqueira [12], this perspective moves away from imposing norms as a deontological model and privileges the dialogical relationship between doctor and patient.

These currents point to care as a task fundamental to the human condition. When caring, the person put in practice his/her own humanity; when they are cared for, they reach its fullness. This touches the innermost aspects of humanity – more than the heritage of a profession, it is everyone's duty. Comprehensive care is a health professional's

moral obligation – watch over the patient's wellness, adopt an empathetic posture, walk alongside them, provide unobtrusive help, and prevent them from perceiving the difficulties they create for others. Caring for someone is opening up to the perspective of "us" [13].

It takes availability, concern for the other, and a fraternal approach with willingness to serve. The principle of justice, which requires overcoming prejudice, must preside over care. Conquering physical and ethical distance, turning the "other" into a "neighbor," "someone close," is essential for proximity to be expressed in humanity.

From dialogue and responsibility, humans desire and seek for a meaning to live humanly. This thirst for meaning is also metaphysical, dignifying the human being, as their fulfillment depends not only on biological but also symbolic and spiritual aspects. This search becomes even fiercer in contexts of maximum vulnerability.

Suffering catalyzes searching for the meaning of life. Patients feel the need to build meaning, and for that they question themselves about new existential possibilities. Caring for a person who suffers consists in constructing the meaning of existence both dialogically and responsibly. This leads to an education focused on the other, on the "neighbor," on the different.

The various faces of the relationship

Since Hippocrates, medical ethics revolves around the idea of order, which led to understanding that the patient-physician relationship should also follow this precept. Over time, this established the paternalism, based on dominance and submission. This is the *logos* of classical Greek ethics, constant throughout the history of medicine [14].

According to Gracia [14], in 1803 Thomas Percival's *Medical ethics* gave rise to the break with the old Hippocratic paternalism. Inspired by the oath's beneficence criterion, the author proposed that the patient should have more autonomy. Regarding patient-doctor communication, he recommended telling the truth; but in unfavorable prognosis, he proposed that this communication would be made exclusively to family members.

In the United States, the judicial system became one of the main agents in replacing paternalism, as legal ethics eventually imposed the principle of autonomy. Initially, court actions dealt with medical negligence or malpractice, later establishing "technical aggression" – when the doctor intervenes in the patient's body without consent. The offense and the notion of consent were also specified by legal demands [14].

For Jean Clavreul [15], the medical discourse excludes elements such as suffering, anguish, changes in sleep and mood due to being unable to treat or interpret them in a scientifically acceptable manner. Eliminating any other discourse, including the patient's, the doctor maintains a totalitarian view of wanting to know nothing. There arise all the elements of a scientific project both objective and objectifying, in which the disease increasingly separates itself from the one who suffers from it, distinguishing between the *patient's disease* and the *physician's disease* [16].

The structuring of public and private services prevents the patient from knowing their diagnosis, with the technical vocabulary impairing the relationship and widening the gap [17]. Physicians' efforts towards their unity seeks to hide the dehumanization it establishes. According to the logic of this discourse, humanizing hospitals seems to have no other effect than creating specialists, while patients miss their "family doctor," despite their poorer reputation regarding competence and specialization [15].

Current teaching, rooted in Cartesian rules, has a partial view of the disease, fragmenting knowledge and disregarding the human being in its entirety. The Brazilian model, in particular, has been unable to offer broad education committed to fundamental values. Recently graduated doctors will not meet patients isolated from the social context and, thus, should engage in facing the problems imposed by the country's reality. Obstacles such as extreme poverty prevent not only enforcing assistance, but an even more fundamental right: the right to life [18].

A study carried out in Brazilian medical schools indicates that the subjects of ethics or bioethics occupy less than 1% of the total curriculum workload, and their content is usually restricted to deontology [19]. However, article 23 of the *Universal Declaration on Bioethics and Human Rights* [20] establishes that States should spare no effort in advancing training in this field.

Education must give rise to moral duty towards others, a duty that undertakes personal connection according to the principle of valuing the other for who they are [21]. Being able to help and recognize differences is face the fragility and demise of justice

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within the contemporary man's conscience. This call to practice defines our subordination, responsibility, and obligation to the other. For this is the character that distinguishes justice: being a relationship with others, which takes place, first, in external acts. Such acts demand not only intention but commitment and determination to approach the most vulnerable.

Vulnerability: a principle

The history of bioethics reveals its strengthening, its application to life, and its growing influence on society, which has manifested itself on two levels: that of reflection (discourse), and that of action (practice). The first leads to a clear vision of the issues without exactly solving them, and the second acts by proposing rules of conduct derived from fundamental human principles, contributing to decision making.

Bioethics is not limited to rights and duties [22], and traditional principles (respect for autonomy, beneficence, non-maleficence, and justice) are insufficient to deepen reflection. Others are necessary, such as the principle of vulnerability, first raised to this condition in 1998 in the *Barcelona Declaration*, as Neves explains [23]. "Vulnerability" derives from *vulnus*, "wound," and should be considered a priority, as it expresses a constitutive and universal reality of the human being, threatening other principles, such as autonomy, dignity, and integrity [23].

Since the 1980s, the notion of vulnerability began to encompass a broader meaning due to the reflection of European philosophers which were later assimilated by bioethics, such as Levinas. According to him, vulnerability is a universal human condition, calling for a non-violent relationship between "I" and "the other." Face to face, the vulnerable "self" presents itself as a non-violent response to the election of the other, bringing the "self" into existence. Subjectivity, presented as vulnerability and ethical responsibility, is the human condition [23].

Vulnerability is not a differentiating factor for people and populations, nor can it be eliminated by reinforcing autonomy or consent [24]. It is a constitutive, inalienable, and irreducible reality of humanity, to whom responsibility is imposed as the norm of ethical action. Thus, as Neves states, (…) *qualifying some groups and people, vulnerability begins to* [describe] *the common reality of man; both contingent and provisional, it becomes a universal and indelible condition; from differentiation factor* (…) *it becomes an equality factor among all;* (…) *From the scope of human experimentation, it translates* (…) [into] *the plan of clinical assistance and health policies; from a demand for autonomy and the practice of informed consent, it reaches the request for responsibility and solidarity* [25].

The susceptibility to being hurt establishes the obligation not to hurt and enforces ethics as a non-violent relationship with emphasis on the need to care. This statute brings something new, since a principle is imposed on conscience as a duty, and vulnerability begins to formulate moral obligation. In its particular sense, it obliges [the strong] to protect the fragile – that is, a positive action – and in its universal sense, compels [the strong] to recognize that all people are vulnerable, demanding, thus, a contrary action – abstain from any harm –, besides the solicitude to safeguard human dignity. This is the sense of care that permeates Emmanuel Levinas' philosophy.

Searching for the Levinasian infinity

At the end of the 19th and throughout the 20th century, authors such as Nietzsche, Freud, Heidegger and Foucault questioned modern philosophy and its concept of subjectivity, centered on the self. According to Miranda [26], Levinas identifies this subjectivity with selfishness, self-interest, and self-permanence, as well as the inability to recognize that the other is not the subject's *alter ego*.

Dialoguing with Husserl, Heidegger, Rosenzweig, and Descartes, Levinas sets the philosophical categories developed in *Totality and infinity* [3]. Here, he does not aim at writing a new ethics, but demonstrating that ethics must be the starting point of all philosophy, denouncing the configuration of a world that depersonalizes, silences, and controls. The consciousness brought to life by this world ignores alterity, only listens to itself and erases humanity, encompassing all beings in a faceless existence.

Totality submits people to an impersonal and inhuman universality, and Levinas [3] points out the issues with trying to shape the other, giving rise to a multitude of "equals." This violence results from a solitary reason that approaches the world from a scientific standard, turning it into an object of knowledge. And this self-sufficiency, or mystification of reason, turns out to be a philosophy of power.

In his phenomenological analysis, Levinas [3] reconstructs subjectivity as a welcoming to the other and develops the notion of infinity to break

with totality. Conceiving the other from this point of view means accepting them as "otherness," no longer thinking from the centrality of the self, but from a space of welcoming and hospitality.

It is through language that the other is perceived by the self as outwardly, a complete separate being. To bridge the gap separating them, one must build a bridge for communication that allows exchange and dialogue. It is through this dialogue that the patient becomes a face claiming unconditional responsibility, without any normative justification.

The Levinasian infinity in the patient-physician relationship

The suffering face calls on us and, when the self is called, the space for the ethical relationship arises, *which begins in the dialogue inaugurated in the presentation of the other, through the unveiling of the face* [27]. Levinas proposes the unconditional responsibility for this other as a path to rediscover the meaning of human existence, and the current work aims to reflect on this rediscovery based on the patient-physician relationship.

According to Nodari*, the core of Levinasian ethics is the denunciation of the neglect of the face* (…), *a meaning that escapes all context and founds ethics itself* [28]. And, to Neves, *it is Levinas who first philosophically addresses vulnerability* by defining it as subjectivity, that is, *a relationship with the other, dependent on the other that allows them to be* [29]. The other reveals itself in the relationship in a way that not only means knowledge for the physician but also proximity and acceptance.

Closed in on itself, the self can only be led outward, beyond itself, through sensitivity, becoming responsible for the one it faces. Only through this opening can a new self come to life; a me-for-the-other self, that motivates individual and social transformation. Subjectivity can be rebuilt in freedom because it is through subjection to the other that the self is not alienated or enslaved, but freed. Humanity is born from a one-way departing from the ontological dimension towards the other, without returning to itself. Subjectivity carries the weight of infinite responsibility regarding the other, and *the only way* (…) *to confirm the unicity and uniqueness of subjectivity is to say, "here I am"* [30].

Proximity engenders a relationship in which the other is no longer just a face, but arises as a neighbor. Thus, the face is no longer a face; it is the neighbor, who must not only be seen, but welcomed. To Ribeiro Júnior [31], dwelling on the other's suffering only makes sense if they appear as the one who reveals themselves through this pain; otherwise, any discourse risks being superficial.

Only the other can reveal the extent and scope of their pain. Therefore, the indifference of medical discourse can only be transcended by the epiphany of the face and proximity. Doctors must break with the rationality fossilized throughout the history of medicine. The desired proximity yearns for the look, the caress, the touch, the listening, categories indispensable to clinical practice. In this proximity, the self is always the servant of others; it is a brother, leading to a fraternity [32].

Levinas' thinking, like that of many philosophers, is developed as a dialogue with tradition [33]. In *Totality and infinity* [3], the author questions Heidegger's and Husserl's ontology, stating its insufficiency given the complexity of existence and, even more, its relationship with otherness. This reveals the need to welcome, to approach, to seek the "infinitely other," the face-to-face relationship and sociability, that is, ethics.

The other reveals itself and erupts in the face, and it is from this opening that the subject, the patient, effectively reveals themselves. Vulnerability is unveiled within Levinas' philosophical horizon [3] in the proximity and asymmetry of every relationship, seen no longer as the being's essence that opens up to show itself, but exposed skin, in the wound and offense. The subjectivity expressed in the vulnerability of the self (physician) raises the metaphysical desire of the other (patient) and asks for proximity and infinite responsibility.

Here, the doctor's relationship with the patient is no longer expressly dual, including third parties (family, institution). The professional is then socially responsible for all those close to their "neighbor." This level includes all those who orbit the patient, so often neglected in medical practice.

Based on Emmanuel Levinas' philosophy [3], which contemplates the other in their infinite otherness, a new way of being presents itself to the physician. It takes proximity, availability, and fraternal concern for the patient. The principle of justice must be heeded, requiring overcome prejudices and detachment so the patient can become a neighbor, treated with humanity. The face is fundamental in this effort, showing the other in its absolute nakedness [31]. Thus, as proposed by Ribeiro Júnior [31], the bioethics of vulnerability meets with

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Levinasian thinking in search of new ways of caring and acting ethically. According to the author,

goodness, therefore, is expressed and realized in the concrete acceptance of others and the fight against the horror of evil. It is thus, amid ambivalence, between the manifestation of the gratuitousness of evil and the eruption of the sanctity of the face; between the violence of freedom and the kindness aroused by others within the subject; that a fruitful space is opened for the recovery of vulnerability as a fundamental ethical category [34].

Levinas' philosophy strips contemporary anti-humanism, based on selfishness and satisfying individual needs. Through the subjectivity thought as "being for the other," the author presents openness to others as vulnerability – the heart of this article –, underlining the responsibility implicit in this notion. Perceived as such, sensitivity enables conditions for an ethical concept of the subject, conceived not from universal principles, but from the sensitive contact made through proximity. Levinas' thinking is, therefore, an invitation to change, which proposes the search for meaning by opening to the other.

Final considerations

This article proposed to discuss the patient-physician relationship from Emmanuel Levinas' work, who understands vulnerability as openness to the other. When recognizing itself as vulnerable, the self understands the vulnerability of the neighbor and the need to care, take responsibility, and be supportive, instead of exploiting them because of their condition.

This perspective reveals subjectivity as susceptibility to being hurt, sensitivity, disinterest, closeness, and implies welcoming alterity in the face-to-face encounter. That is why the face is essential: it cries out and demands justice, denouncing a society that denies the human condition and stating the discovery of otherness, which brings about a new self, the me-for-the-other, for whom the neighbor is a brother.

Emmanuel Levinas' thinking reveals the anti-humanist reality of contemporary times. By approaching the bioethics of vulnerability, he may help rebuild subjectivity, conceived as a welcoming to the other, a space where proximity leads to justice, as pure responsibility.

Humans are social beings by their own condition and do not exist in isolation, which *requires a specific way of acting in the non-violent response of each to the other, a responsible and solidary action, establishing an ethics of anthropological foundation* [25]. As an alternative to the perspective centered on individual autonomy, this view recovers the symbolic condition of the human being and emphasizes emotions, feelings, and desires – issues related to life, but which remain marginalized by the bioethical reflection. All this should lead to mutual help to face the insufficiencies of the other's absolute nudity, recognizing this apparently paradoxical reality that Paulo de Tarso formulated when he wrote: *for when I am weak, then I am strong* [35].

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