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Prolonged life and good death in Antiquity[1]

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Abstract

This paper studies the connections between the notions of prolonging life and a good death in Antiquity. It is demonstrated that while prolonged life generally meant forestalling the human constitution's death, ancient philosophers also pointed to the limitations of prolongation. The paper shows how philosophers welcomed prolonged life when it was shown to foster movement toward the good, such as self-realization and social usefulness. Yet, they rejected prolongation when it led to the perpetuation of evil, such as social uselessness and suffering. We ask whether a contemporary good death is a mercy killing or an improvement of prolonged life, as the ultimate end of "goods practicable for man".

Keywords: euthanasia, good death, prolonged life, the end, physician, medicine, social usefulness, self-realization, Hippocrates, Plato, Aristotle

Introduction

What is a prolonged life? It is a life supported by a combination of lifestyle, medication, and technology. A person chooses how to take care of, or indeed neglect, one's own body. We can develop a healthy lifestyle to prevent the body from losing its functions. We can strain every sinew and stimulate every nerve via medication. We can amputate limbs in order to save the body as a whole and fit a prosthesis as a replacement. Today, it is possible to extend human life for a substantial amount of time through gene modifications, immunization, organ transplantation, and so on. It is an issue of gerontology. Aubrey de Grey suggests that contemporary humans aged 50–60 could live for 1,000 more years. This goal is said to be reachable by incrementally renovating the human body every 10–20 years in parallel with the advent of new technologies (de Grey, 2017).

But the prolongation of life raises some thorny questions for and about humanity. Research in bioethics addresses the issue of supporting human life by all means. For instance, Gluchman deems it immoral to prolong human life simply at the level of biological survival (Gluchman, 2005, p. 617). Indeed, we agree that to prolong life without appealing to some notion of human dignity is not good for human beings. That is, without a conception of human self-realization and social activity, a prolonged life is seldom worth living.

It is precisely such a situation that may be the reason behind the recent growth in discussions about euthanasia. The loss of social activity and self-realization leads to problems in clearly delineating what constitutes death. As such, we think it is worth asking: Should we accept the absence of social activity and self-realization? Do we have a moral right to return to the natural limitations of life, to the death of a person? Why is it that many attempts to prolong life are being rejected nowadays, and is this leading to an increase in instances of euthanasia (mercy killings)?

In the contemporary context, euthanasia refers to a mercy killing. Euthanasia entails the decision on the part of a patient and a physician to bring an end (either passively or actively) to human suffering and to have a good death. In earlier times, the term euthanasia

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(from Greek: εὐθανασία) also meant a good death, yet this was not linked to the idea of providing ongoing medical support to the patient until his death. As van Hoof notes, in its varied historical and linguistic uses, "euthanasia and its derivatives conveyed the idea of a comfortable, happy and noble end" (van Hoof, 2004, p. 976). Despite its mutations over time, euthanasia has long been discussed in relation to the connection between a prolonged life and a good death.

In Antiquity, Hippocrates and Plato partly rejected the necessity of life's prolongation in medical practice. Prolonged life was a delaying of the body's death. According to them, a good death occurs without the prolonging of life. Aristotle offered a different perspective in this regard. For him, life's prolongation was possible after the time of one's natural death. For euthanasia (a good death), nobody needs to refuse life's prolongation. The purpose of this article is to research the connection between the rejection/acceptance of prolonged life and a good death (euthanasia). Our first step toward this end is to explain the possibility for people today to decide to undergo euthanasia (a good death) by themselves in the face of a potentially prolonged life.

To research the rejection of life's prolongation in order to have a good death, we refer to Hippocrates' and Plato's texts. We explore Hippocrates' conception of a good death as a result of a physician's acceptance of the impossibility of prolonging life. We then refer to Plato's idea of a good death and his critique of prolonged life. To study the acceptance of a prolonged life without contradicting the notion of a good death, we refer to Aristotle's thoughts, which can help not only to explain euthanasia as an instrument to restrict the prolongation of life today, but also to highlight the necessity for individuals to have the opportunity for self-realization and social activity.

Hippocrates' conception of the tasks of medicine, physicians' prognoses, and a good death

In the existing literature concerning the issue of euthanasia in ancient texts, Kuře examines Hippocrates' view on the topic. According to Kuře, Hippocrates' relation to the notion of a good death is based on the sanctity of life. Life is given by the gods and the end of life is not within man's command. As a result, a good death is one without any medical intervention (Kuře, 2011, p. 8). From this, one might think that refusing to influence the patient also involves deciding to prevent any prolongation of life. Yet, does such a view mean that a physician may not prolong life in other cases? Does a physician stop prolonging life in order to secure a good death?

Some researchers suppose that prolonged life was not a goal of Hippocrates' medical practice (Shneiderman, 2000, p. 6). In our view, prolongation was not particularly evident in Antiquity because Hippocrates focused on the cosmetic tasks of medicine and the physician's skill in returning functionality to the patient (the sick returning to health). In addition, he spoke of the need to preserve one's health, promoting bodily strength. To obtain these results, he preferred to discuss gymnastics, ptisans, and so on (Hippocrates, 1959d, p. 71).

We think that it is necessary to explore prolongation and its limitations (when it made no sense when confronted with death) in Antiquity. The decision to prolong life was an essential part of physicians' practice through surgery. The physician cared for sick people with wounds, brain injuries, and so on. He had to use special instruments to solve problems and, as a result, exerted a major influence on the patient's longevity of life. For example, Hippocrates discusses removing dry bones from a skull (Hippocrates, 1959b, pp. 39–41), gangrene, a special method for severe fractures (Hippocrates, 1959a, p. 127), wooden tools for severe fractures and dislocations of legs (Hippocrates, 1959a, pp. 129–131, 135–137, 145, 165–169), dead parts of flesh and bones (Hippocrates, 1959a, pp. 157–163), mechanical instruments (Hippocrates, 1959a, pp. 169–175), and the severing and extraction of dead bones (Hippocrates, 1959a, p. 179).

The decision to stop the prolongation of life was undertaken by a physician in some cases. To understand when this was possible, we need to appeal to the physician's duty to define the state of the body and to prognose a person's death. According to Hippocrates, a physician defines the state of the body in order to ascertain whether or not it will live. Hippocrates writes that the physician has to observe diseases and "how much they exceed the strength of men's bodies […] you will be blameless if you learn and declare beforehand those who will die and those who will get better" (Hippocrates, 1959c, pp. 7–9).

The loss of the powers of the constitution affects the physician's decision about treatment and prolongation. Hippocrates says that a physician should leave bad cases of fractures and not intervene in them (Hippocrates, 1959a, p. 181). Moreover, if a man suffers from tetanus, the physician should cease performing mechanical actions in vain (Hippocrates, 1959a, p. 175). All these cases speak to the loss of the powers of the constitution and impending death. As such, in these cases the physician decides to do nothing with the patient's constitution; he does not try to prolong life by way of intervening with the body. Indeed, it was usual practice for a physician to not partake in the process of dying (van Hoof, 2004).

The rejection of a prolonged life was connected not only with the loss of the power of the patient's constitution, but also with the latter's age. Hippocrates traces linkages between the age of patients and the influence of diseases on their well-being and death. For example, he discusses types of empyema for the dying old or young (Hippocrates, 1959c, pp. 39–41). He notes that pains in the bladder are fatal for seven- to 15-year-olds (Hippocrates, 1959c, p. 41). He observes that in deaths from acute pain of the ear, younger patients die in less than seven days, while older patients die later (Hippocrates, 1959c, pp. 45–47). Hippocrates notes that depositions in joints are common in persons under the age of 30, but are less common in those over the age of one (Hippocrates, 1959c, pp. 49–51). In instances of vomiting in people, he notes that while convulsions are harder for children under the age of seven, those over this age experience fewer convulsions (Hippocrates, 1959c, p. 53). Some ages were used as a reason to make a statement about the coming of death. Since a physician did not intervene in the dying process, they were advised to ignore the patient if he/she was of an age at which it was not appropriate or feasible to resist the disease. The option to prolong life was not possible for someone who could not be healthy due to their age.

Thus, we can conclude that Hippocrates' conception establishes a different view on the prolongation of life for two categories of people. A physician would opt to delay the onset of death if the patient was able to become healthy again. Prolongation was forbidden for dying people and for those who could not return to health on account of their age. According to Hippocrates, it was impossible to change anything in the divine order (the diseases could not be removed). Thus, a physician had to accept this order, recognize the patient's impending death, and leave him to make his death good.

Plato's idea of a good death and his critique of prolonged life

Kuře points to the difference between Plato's and Hippocrates' explanations of the good death. While Plato continues to think about a good death as being in the gift of the gods, he nevertheless makes some exceptions. It is better to die than to live in cases of the need to die (Socrates' death), shame of extreme suffering, poverty, or disaster, incorrigible maleficence, irredeemable crime, terminal illnesses, and so on (Kuře, 2011, p. 9). This view differs from that of Hippocrates who maintained the sanctity of life and did not suppose that it was possible to interrupt life.

Plato's view of the prolongation of life was quite disapproving. In light of a good death, the prolonging of life makes no sense; indeed, it may even stand in opposition to it. In *Phaedo*, Plato recounts Socrates' good death and the possibility of him prolonging life before death. Socrates is against this because it makes no sense. Moreover, the embodiment of the soul in any

body is a kind of imprisonment. So, according to Plato, prolongation is detrimental to death. It restricts the soul's chances of being free (Plato, 1966, 84a–84b). As Georgios Anagnastopoulos underlines: "prolonging life is prolonging evil" (Anagnastopoulos, 2001, p. 263).

Plato comments on the foolishness of prolonging life for the sake of a good death in *Timaeus*. Plato's thinking here is in accordance with Hippocrates' idea about the inevitability of death as a cause to stop the prolongation of life. Plato writes: "For not the whole race only, but each individual – barring inevitable accidents – comes into the world having a fixed span, and the triangles in us are originally framed with power to last for a certain time, beyond which no man can prolong his life" (Plato, 1969b, 86b–90d). A man has to accept the limits of his life and does not try to prolong what is coming to an inevitable end. Human life is in the possession of the gods, and as such prolongation is senseless.

There is a contradiction between a good death and prolonged life in Plato's *Republic*. To tease out this contradiction, we need to consider Plato's various positions both for and against prolonged life in this text.

Prolonged life serves to forestall the death of the human constitution. Plato welcomes prolonged life in some cases. Like Hippocrates, Plato thinks that it is good to undergo treatment and prolong life in the case of trauma or seasonal diseases. Plato writes about treatment and the prolongation of life by way of medicine: "that for those who were by nature and course of life sound of body but had some localized disease, that for such, I say, and for this habit he revealed the art of medicine, and, driving out their disease by drugs and surgery, prescribed for them their customary regimen" (Plato, 1969a, 407d).

Plato speaks against prolonged life in the next fragments. In Book 1 of the *Republic*, Plato discusses unnecessary prolongation in relation to Gerodic who, having an incurable malady, stretched out his death and did nothing more.[4] Plato appeals to Aesculapius, and notes that "for all well-governed peoples there is a work assigned to each man in the city which he must perform, and no one has leisure to be sick and doctor himself all his days" (Plato, 1969a, 406c). According to Plato, Gerodic's prolongation was bad because it supported a man who was not able to be healthy and useful to society. Such a prolonged life leads to weakness, suffering, fear, and the supporting of disease and social exclusion. Instead of prolonging his life, it would have been better for Gerodic to have died.

There is one more fragment in which Plato speaks about when it is right to refuse to prolong life. Plato appealed again to Aesculapius, writing: "when bodies were diseased inwardly and throughout, he did not attempt by diet and by gradual evacuations and infusions to prolong a wretched existence for the man and have him beget in all likelihood similar wretched offspring. But if a man was incapable of living in the established round and order of life, he did not think it worthwhile to treat him, since such a fellow is of no use either to himself or to the state" (Plato, 1969a, 407d). In this fragment, life's prolongation is also interpreted as bad because it supports a man who was unable to be free from the illness and to be of use to society. Plato adds one more component to this thought: utility for himself. This refers to man's inability to move toward knowledge and the good. This fragment, like the previous one, shows that it is better to move toward death than to support an ill state.

Here we ought to observe that Plato's view in the *Republic* on the inability to be healthy differs from the concept of coming death. In the cited fragments, Plato mentions incurable and longstanding diseases inside the body. According to him, both types of disease are similar insofar as it is impossible to be cured of a longstanding disease. Moreover, Plato is not interested in diseases *per se*, but rather in how they are evaluated and accepted by an individual (that is,

[4] As Plato notes: "for living in perpetual observance of his malady, which was incurable, he was not able to effect a cure, but lived through his days unfit for the business of life, suffering the tortures of the damned if he departed a whit from his fixed regimen, and struggling against death by reason of his science he won the prize of a doting old age" (Plato, 1969a, 406b).

recognizing the reality that the disease can be cured). The inability to be healthy is a bodily state (incurable illness) and/or man's agreement with his bad state and his caring about this state (a man is not able to think about or do anything other than delay the onset of death). Plato points to this as a reason to stop life's prolongation. To prolong this state is not just senseless; it is also bad because of the spreading of diseases, fear, suffering, and man's social uselessness.

According to Plato's thinking as presented in the *Republic*, prolonged life in some cases establishes what a good death denies – weakness, diseases, suffering, poverty, and uselessness for society. This contradiction is no accident. There are two options open to man when he feels himself bad and cannot take part in social life: the prolonged life and the good death. A man may agree to the prolongation of life that supports illness and fosters uselessness for himself and for society as a whole. Or he may choose a good death and avoid these bad things. Plato supposes that when faced with such a choice, man must prefer a good death. Man should reject prolongation for a good death and prevent the spread of evil.

We can conclude, then, that Plato criticizes the notion of prolongation, since it makes no sense in light of the fact that a human life depends on the power of the gods. Prolongation leads to evil as it stops the soul from being free from the body (Socrates' case). Prolongation may also lead to evil as it supports the spreading of diseases, suffering, and uselessness. Plato's idea of the good death as surrendering to the power of gods, alongside the need to die and avoid suffering, chronic diseases, poverty, disaster, maleficence, and crime, conflicts with the idea of prolonged life. For Plato, we should reject prolonged life so that we may reach a good death.

Accepting prolonged life without contradicting the notion of a good death: Aristotle's conception

Aristotle's view on death is different from that of Plato. Aristotle thinks that in all cases, death stops the spreading of goodness. Death is the worst thing in the world because it is the end and it makes it impossible for the dead to have a relationship with good or evil (Aristotle, 1934, 1115a).

To understand how man can best approach death, and especially seek to secure a good death, we may appeal to the conception of the end, since death is also an end (like health, being well off, and so on). Aristotle discusses the notion of the end in *Eudemian Ethics*. He supposes that while nobody is able to choose their end, one is able to choose the means to reach it. For example, a man may take a walk in order to be healthy or have a business so as to be well off (Aristotle, 1981, 1226a).

In this vein, we may suppose that there are different means to reach the end of death (active duty, suicide, "natural" causes, life's prolongation). And what about a "good death" as the end? Do some of the means lead to a "good death"? Aristotle supposes that it is possible to reach a good death by special means. As Kuře emphasizes, in Aristotle's works, a good death occurs in situations when a courageous man is able to meet death resolutely and without fear (Kuře, 2011, p. 9). However, it is not easy to be such a man. As Matthews notes, Aristotle separates the spontaneous acts of man from his habit of being courageous. It is not enough for a courageous man to act spontaneously. Rather, he must foster courage as a constant virtue; it is the result of man's work with his own desires, fears, and so on. Matthews concludes: "To ask what motivates an already brave soldier to perform an act that leads to a noble death should not, therefore, be to ask simply what goes through the soldier's mind at the moment he made the decision to perform the action Aristotle would honor him for" (Matthews, 2012, pp. 197–198).

We propose one more means through which to have a good death with reference to Aristotle's notion of the "good end". The good death or good end occurs when a man is able to fulfill his deals and obligations, and to complete what he has started during his lifetime. Man

bears these deals and obligations according to his physical and mental health.[5] Aristotle writes in *Eudemian Ethics*: "There is also evidence of the opinion that a person is not happy for one day only, and that a child is not happy, nor any period of life (hence also Solon's advice holds good, not to call a man happy while he is alive, but only when he has reached the end), for nothing incomplete is happy, since it is not a whole" (Aristotle, 1981, 2019b). Aristotle proves that a happy man should reach the end and the whole by completing everything he has started. According to this logic, death could be good if man completes all his deals and obligations by the time of his death. In particular, death is good if man can attain the absolute good. As Aristotle puts it, "the Absolute Good would be this – the End of the goods practicable for man" (Aristotle, 1981, 1218b).

What does Aristotle think about the notion of prolonged life? Does it contradict his opinion about the good death? Stambler focuses on some of the different ways to prolong human life: a gentle and friendly environment, economical heat expenditure, a diet rich in "heat and moisture". However, Stambler is certain that we cannot speak in favor of radical prolongation by way of Aristotle's conception. Immortality is not Aristotle's task (Stambler, 2017, p. 217). We agree that there is no defense of radical life extension to be found in Aristotle's philosophy. We would add to this an explanation of the purposes of prolonged life, as well as its specificity and its correlation with a good death.

We think that the idea of prolonged life lies in Aristotle's conception of different stages of life.[6] Aristotle writes that "youth is the period of the growth of the primary organ of refrigeration, old age of its decay, while the intervening time is the prime of life" (Aristotle, 1995b (1), 479a29–31). Furthermore, Aristotle distinguishes between violent death or dissolution, natural death, and death in old age. The cause of violent death is the exhaustion of vital heat; the cause of natural death is the exhaustion of heat over time; the cause of death in old age is an inability of the body to produce proper refrigeration.

Why are these stages important for our study of life's prolongation? We can see that death in old age is not the same as a natural death, because they have different causes (in one case it is the loss of heat, and in the other it is the loss of refrigeration), and death in old age comes after a natural one. So, there is a passage from a natural death to death in old age. This passage is determined by a saving and increasing of heat in the body because death in old age occurs without the loss of the heat.

In some works, Aristotle points to heat as a condition of longevity (Aristotle, 1995a). So, supporting and increasing the level of heat in a body is a form of prolonging life. As Aristotle distinguishes between natural death and death in old age, prolonged life is a supporting and increasing of heat in the body until a man is unable to produce adequate refrigeration in old age. This means that prolongation is an instrument for a patient to reach old age beyond the bounds of his possible natural death. Reaching old age is a task of prolongation.

What about the specificity of prolonged life in Aristotle's conception? Aristotle develops Hippocrates' and Plato's view on prolongation and underlines the importance of life's prolongation during life itself. The definition of prolonged life as being out of natural death can lead to the illusion that the prolongation of life is possible only after a loss of heat. Yet, this is wrong. The loss of heat is not obvious to the young, but it is a problem in old age. So, the heat should be preserved and increased in the human body during one's life in order to protect

[5] One could view vice as a mental illness. Müller supposes that the vicious agent lacks any real principles of action or conception of the good (Müller, 2015).

[6] It is not a problem that Aristotle makes this statement in relation to animals, for what he writes about animals also holds for human beings. Medicine is for every living organism. The statement that medicine is a "knowledge of what makes for health in animals and men" is misleading because a man is also an animal (Aristotle, 1995c, 141a19–20).

against its loss in old age. The process of properly accumulating and protecting heat becomes a lifestyle.

We have noted that Ancient philosophers have developed different views on prolongation. If Plato and Hippocrates use it as a treatment for traumas and seasonal diseases, no prolongation is seen to be necessary for a man moving towards death and who has weakness and chronic diseases. Meanwhile, Aristotle considers the case for prolonging human life without these conditions being met. In his view, prolongation is a fight against the body's natural exhaustion.

In this way, we just need to determine the connection between a good death and prolonged life. We have set out above the differences between Ancient views on the correlation between a good death and prolonged life. In Hippocrates' and Plato's conceptions, a good death is opposed to prolongation. For them, we need not extend the bout of diseases, suffering, the soul's imprisonment, man's social uselessness, and so on. By contrast, according to Aristotle, prolonged life does not contradict the notion of a good death. The reaching of old age via life's prolongation is appropriate for man's rightful tasks: to fulfill all duties, to complete all deals, to become brave. Thus, the prolongation of life may be useful for attaining a good death.

Conclusion: Euthanasia because of prolonged life today

In our contemporary context, prolonged life is based on a patient's desire to live longer and the doctor's agreement with this. Euthanasia (mercy killing) is not just a doctor's decision. Nowadays, it is a patient's decision, too. Euthanasia is undertaken in response to a patient's acute suffering. In our view, today euthanasia may be committed and for other purposes. Social activity and self-realization are ignored in the case of life's prolongation. The use of euthanasia may revive some of the ancient limitations of prolonged life. Euthanasia may weaken the case for prolonged life and resurrect certain historical criticisms of it (as in Plato's tradition, for instance).

In this vein, might a recovery of the ancient perspectives on the limits of prolonged life help us to understand euthanasia as an attempt to resolve this issue? Martin Gluchman argues: "Death would be the manifestation of humanity in the case of escaping suffering when terrible pain is born by a terminally ill patient. On the contrary, death is the manifestation of inhumanity when killing, as a crime in its proper meaning, happens" (Gluchman, 2019, p. 87). Indeed, euthanasia as a method to replace prolonged life is not the best solution when prolonged life may be useful for good things and may be without pain and suffering (in accordance with the level of technological capabilities).

In our view, it is possible to achieve a good death not only by way of euthanasia (in the modern sense), but also via prolonged life. Ancient philosophers offer support for this position. While they did not like the idea of a radically prolonged life, the philosophers of Antiquity welcomed prolonged life when linked with movements toward the good (self-realization, social usefulness, etc.). Some of them even maintained that the idea of prolonged life need not contradict that of a good death (Aristotle). Philosophers were against the prolongation of life when it correlated with evil (suffering, uselessness, diseases, crime), in which case it was rejected in favor of securing a good death. Of course, nowadays, we have different opinions about what constitutes good and evil. But it is important to define how it is possible to have a good death in light of the possibility of prolonged life. Is it a form of euthanasia (as in a mercy killing)? Or is the prolonging of life perhaps better understood as improving the "goods practicable for a man"?

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References

ANAGNASTOPOULOS, G. (2001): Euthanasia and the physician's role: Reflections on some views in the Ancient Greek tradition. In: M. G. Kuczewski & R. Polansky (eds.): *Bioethics: Ancient themes in contemporary issues*. Cambridge, MA: MIT Press, pp. 251–291.

ARISTOTLE (1934): Nicomachean Ethics. In: *Aristotle in 23 Volumes*, vol. 19, trans. H. Rackman. Cambridge, MA: Harvard University Press.

ARISTOTLE (1981): Eudemian Ethics. In: *Aristotle in 23 Volumes*, vol. 20, trans. H. Rackman. Cambridge, MA: Harvard University Press.

ARISTOTLE (1995a): On length and shortness of life. In: *The complete works of Aristotle in two volumes*, vol. 1, trans. G. R. T. Ross. Princeton, NJ & Chichester: Princeton University Press, pp. 740–744.

ARISTOTLE (1995b): On youth, old age, life and death, and respiration. In: *The complete works of Aristotle in two volumes*, vol. 1, trans. G. R. T. Ross. Princeton, NJ & Chichester: Princeton University Press, pp. 745–763.

ARISTOTLE (1995c): Topics. In: *The complete works of Aristotle in two volumes*, vol. 1, trans. W. A. Pickard-Cambridge. Princeton, NJ & Chichester: Princeton University Press, pp. 167–277.

COOPER, J. M. (1989): Greek philosophers on euthanasia and suicide. In: B. A. Brody (ed.). *Suicide and euthanasia: Historical and contemporary themes*. Boston: Kluwer Academic, pp. 9–38.

De GREY, A. (2017): Can humans live for 1,000 years? Rejuvenation biology says Yes. In: *Rejuvenation biology: How aging is changing*. [online] [Retrieved December 27, 2019] Available at: https://www.youtube.com/watch?v=EGZzHfXCyXQ

GLUCHMAN, M. (2019): Different approaches to the relationship of life and death (review of articles). In: *Ethics & Bioethics (in Central Europe)*, 9(1–2), pp. 87–97.

GLUCHMAN, V. (2005): Miesto humánnosti v etike sociálnych dôsledkov [The place of humanity in the ethics of social consequences]. In: *Filozofia*, 60(8), pp. 613–623.

HIPPOCRATES (1959a): On fractures. In: *Hippocrates*, vol. III, trans. E. T. Withington. London: William Heinemann Ltd. & Cambridge, MA: Harvard University Press, pp. 95–200.

HIPPOCRATES (1959b): On wounds in the head. In: *Hippocrates*, vol. III, trans. E. T. Withington. London: William Heinemann Ltd. & Cambridge, MA: Harvard University Press, pp. 1–52.

HIPPOCRATES (1959c): Prognostic. In: *Hippocrates*, vol. II, trans. W. H. S. Jones. London: William Heinemann Ltd. & Cambridge, MA: Harvard University Press, pp. 1–56.

HIPPOCRATES (1959d): Regimen in acute diseases. In: *Hippocrates*, vol. II, trans. W. H. S. Jones. London: William Heinemann Ltd. & Cambridge, MA: Harvard University Press, pp. 57–126.

KUŘE, J. (2011): Good death within its historical context and as a contemporary challenge: A philosophical clarification of the concept of "Euthanasia". In: J. Kuře (ed.): *Euthanasia: The "good death" controversy in humans and animals*. London: InTech, pp. 3–44.

MATTHEWS, G. B. (2012): Death in Socrates, Plato, and Aristotle. In: B. Bradley, F. Feldman and J. Johansson (eds.): *The Oxford handbook of philosophy of death*. Oxford: Oxford University Press, pp. 186–199.

MÜLLER, J. (2015): Aristotle on vice. In: *British Journal for the History of Philosophy*, 23(3), pp. 459–477.

PLATO (1966): Phaedo. In: *Plato in Twelve Volumes*, vol. 1, trans. H. N. Fowler. Cambridge, MA: Harvard University Press. [online] [Retrieved December 23, 2019] Available at: http://www.perseus.tufts.edu/hopper/text.jsp?doc=Perseus:text:1999.01.0170

PLATO (1969a): Republic. In: *Plato in Twelve Volumes*, vols. 5 and 6, trans. P. Shorey. Cambridge, MA: Harvard University Press. [online] [Retrieved December 23, 2019] Available at: http://www.perseus.tufts.edu/hopper/text.jsp?doc=Perseus:text:1999.01.0168
PLATO (1969b): Timaeus. In: *Plato in Twelve Volumes*, vol. 9, trans. W. R. M. Lamb. Cambridge, MA: Harvard University Press. [online] [Retrieved December 23, 2019] Available at: http://www.perseus.tufts.edu/hopper/text?doc=Perseus:text:1999.01.0180:text=Tim.
SHNEIDERMAN, L. (2000): *Wrong medicine: Doctors, patients, and futile treatment*. Baltimore: The Johns Hopkins University Press.
STAMBLER, I. (2017): *Longevity promotion: Multidisciplinary perspectives*. Rishon Lezion: Longevity History.
VAN HOOF, A. J. L. (2004): Ancient euthanasia: "Good death" and the doctor in the Graeco-Roman world. In: *Social Science & Medicine*, 58(5), pp. 975–985.

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Dying in dignity[1]

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Abstract
The question of what might constitute "good dying" is a sensitive subject that is being discussed and is socially and politically controversial. My contribution discusses whether a reference to concepts such as autonomy and dignity in the debate over suicide and euthanasia is in fact convincing. Important impulses for the train of thought stem from Kantian philosophy. I will argue that suicide, as presented by Kant, is not an expression of autonomy, but exactly the opposite: an expression of heteronomy.

Keywords: autonomy, dignity, euthanasia, Kant

I.

The question of what might constitute "good dying" is a sensitive subject that is being discussed and is socially and politically controversial. We encounter reference to the "dignity" of man, from which completely diverse consequences are drawn, and also reference to our "self-determination", especially in the last phase of our life (Hoffmann & Knaup, 2015).

For example, it is being discussed whether suicide can also be *dignified dying* to escape hopelessness and a painful situation: "Today is the day I have chosen to pass away with dignity in the face of my incurable illness, this terrible brain tumour that has robbed me of so much [...] but which would have taken away so much more" (Todkranke Amerikanerin, 2014). This is from the Facebook page of 29-year-old Brittany Maynard who killed herself on November 1, 2014. She was in the final stage of cancer and had moved with her family from California to Oregon where medically assisted suicide is permitted under the Oregon *Death with Dignity Act*. There was also much sympathy in Germany with the fate of the young American. A controversial discussion came up about her personal decision and even more about the public announcement of her death.

In connection to this, it is also being debated whether others should be allowed to help people commit suicide who request it and are no longer capable of performing it by themselves. Norbert Hoerster, a German philosopher of jurisprudence, is not only concerned about "death on demand". He also wants to look at situations where people are no longer able to articulate their wish to die. If we could assume "with a degree of probability bordering on certainty" that the person in question is physically able to express the desire, then the act of assisted suicide would be admissible. (Hoerster, 2018)

According to Hoerster, we should be "very careful" with such an assumption. However, he feels that in principle there is nothing wrong with it, and he calls it "completely inhumane to deny such a person any assistance from the outset" (Hoerster, 1998, p. 70). It should also be mentioned that in September 2017, a Catholic order in Belgium reaffirmed its position to no longer categorically deny assisted suicide to patients in their own hospitals for patients in a non-terminal state of a

[1] The paper was presented at the international conference *End of Life and Euthanasia – Intersection of Issues and Questions* held in Prague (Czech Republic) on 4–5 November 2019.

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physical illness (Sterbehilfe-Streit in Belgien, 2017).[3] After all, they said, it would be a matter of dying in dignity.[4] It becomes apparent here that the group of persons involved is being constantly enlarged: Already, people in the early stage of dementia and people "tired of living", seriously ill children and mental patients are counted as belonging to the group. In Belgium, children and youths can request assisted suicide while other important decisions and activities are left until the age of majority.

In the Netherlands in the meantime, dementia is now also regarded as an "unbearable suffering" and thus a sufficient prerequisite for assisted suicide. The road from killing on request to killing without request is not very long. "The more professionalized and standardized such 'acts of assistance' are performed, the closer they come to active killing which physicians commit by their own hand through injections" (Fuchs, 1997a, p. 87).

It is also being discussed how far human self-determination extends and whether suicide in the face of a bad diagnosis can be an expression of autonomy. In the debates, we find, again and again, statements according to which everyone has the "right" to die according to their convictions. They want to leave the stage of life with "self-determination". The time of one's death is to be in the realm of one's own discretion. We ought to be masters of our own time until the end. No illness is supposed to have the last word, and we should not lose control of that at any cost. Some philosophers also talk about the right of individuals to govern their own dignity and autonomy. This is also said to include the possibility to determine our own end.[5]

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[3] During a conference in November 2017 of the Academy for Life, recently formed by Pope Francis, an advocate of euthanasia was invited as well. With regard to that, see the following critique by the John Paul II Academy For Human Life And The Family (2017).

[4] That violence against oneself per se is by no means legitimate was formulated as follows by Augustine: "Who kills himself also kills nothing but a human being" (Augustine, *De civitate Dei* I, 20). This seems to be no longer self-evident in theology. Characteristically, the fundamentalist theologian Magnus Striet of Freiburg, who constantly repeats that theology cannot go "back beyond Kant" and who chants the term "freedom" as if his mouth were a prayer mill, does not agree with Kant when it comes to suicide. "Here, we have to think beyond Kant" (Striet, 2015, pp. 99 ff.). He says that Kant was only a child of his time in that regard (Striet, 2015, p. 101). "Since God gave us the greatest gift possible, namely to be free, He also gave us an opportunity to freely determine whether we should end our life, to return it into the hands of Him who has bestowed it" (Striet, 2015, p.105). Striet ignores that suicide does away with freedom and that Kant mainly saw heteronomy at work. Probably Kant would have told this theologian: "A person committing suicide […] antagonizes his creator's purpose; he arrives in the other world as one who has left his post; he is therefore to be regarded as a rebel against God. […] We humans have been placed here as sentries and must not leave our post until another charitable hand can relieve us" (Kant, 1990, pp. 166 f.).

In several publications, the Swiss theologian Hans Küng has advocated that we should be able to take our own life. He thinks he can justify this with his belief in resurrection; since he believes in the continued existence after death, he can decide when and how to die. (Küng, 2014) However, he cannot invoke the New Testament's Easter Message. Küng, who dedicated all his life to his project of World Ethics, is now abandoning a fundamental conviction of the Abrahamic religions.

According to Thomas Aquinas, suicide is also contrary to the duty we owe to ourselves, to the community and to God. (Cf. Thomas Aquinas, *Summa Theologiae* II–II, Qu. 64). And Pope John Paul II, himself already old and feeble at the time, wrote in his Letter to the Elderly: "Surely it can happen that in cases of serious illness with unbearable suffering, the afflicted are tempted to give up completely. Then it can happen that their relatives or caretakers – out of misunderstood sympathy – feel motivated to regard 'gentle death' as a reasonable solution. In that connection we must remind you that moral law allows the abdication of so-called 'therapeutic zeal' and only demands the treatment required by means of normal medical care. But […] directly causing death is another matter altogether! Regardless of the intentions and circumstances it remains a malfeasance per se, a violation of divine law, an insult to the dignity of human beings" (Brief von Johannes Paul II., 1999).

[5] For example, this is the position Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon and Judith Jarvis Thomson take in their *Philosopher's Letter* (1997); (Sandel, 2015, pp. 170–174; Charlesworth, 1997). This point of view is also succinctly formulated by J. C. Wolf: "Those who want to live and can make some sense out

In that sense, radio and television author Wolfgang Brosche compared the suicide of Udo Reiter with the behaviour of a Western hero and then advocated "autonomous dying" (Brosche, 2014). As an example, we can also refer to the American film romance "*Me Before You*", in which a caregiver and her paralyzed patient fall in love but that does not stop the patient from seeking assisted suicide in Switzerland. In October 2017, the German TV station ARD broadcast an evening on the subject of autonomous dying. Christiane Hörbiger, in the role of Katharina Krohn, suffering from arthrosis and chronic pneumonia, plans to end her life with the help of a Swiss euthanasia society – causing her two daughters to have very different reactions.

While assisted suicide is not criminal in Switzerland under section 115, Swiss Criminal Code (StGB), it is possible to accept the services of private societies who promise to provide "self-determined dying in dignity".[6] In Austria, a cross-party Parliamentary Inquiry at the end of 2015 concluded that every form of assisted suicide remains prohibited. In Britain, assisted suicide was rejected in September 2015 by a clear majority. In Germany, in November 2015, a new section 217, *StGB* [German Criminal Code] was enacted that prohibits the "commercial" promotion of suicide. (Cf. Knaup, 2016)

There is no such thing as the right to commit suicide.[7] It is an act that eludes the legal sphere. (cf. Spaemann, 2002, p. 432) The end does not just "belong to me" since I am not simply an object or my property. Persons committing suicide destroy themselves as moral persons; they see and treat themselves as objects by disposing of their life as if it were their property. However, we are not allowed to treat ourselves or others as a mere means. We cannot have the right to our own death or to assist in an act of killing. The dignity of man is manifested in that others must be recognized as legal persons. The existence of a "legal peer" must not be put at one's disposal; the state must protect the life of all "legal peers":

> "The idea of the law as a code for the coexistence of free people [...] directly excludes the authority of private persons to violate the conditions of coexistence or even to cause each other to die. The law itself can only refrain from the prohibition to kill when (as in the right of self-defence) it is a matter of maintaining the state of law against open injustice [...]. A society that kills without a legal reason or allows killing is therefore engaged in burying the idea of law itself and the rule of law" (Hoffmann, 2015, p. 9).

It is therefore particularly regrettable that in the Netherlands there is no protection for the conscience of nursing staff. The result is that they can be obligated to kill. In Belgium, there was a broad discussion about the question whether hospitals owned by religious institutions can be held accountable in terms of offering assisted suicide (Cf. Hoffmann, 2009, p. 69).

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of their own life must not be eliminated by others who have a different evaluation of life. Thus, the internal evaluation of life must be recognized with authority. This blocks every attempt of legitimizing a centralized political decision about life or death as in the racist ethnic genocide committed by the Nazis. But respecting the will of an individual also had the effect that those determined to commit suicide must not be prevented from killing themselves if they are unable to have others assist them voluntarily. Thus, the right of individual euthanasia is based on the same principle as respect for autonomy which collective "euthanasia" denies" (Wolf, 2000, p. 224).

[6] These two terms are encountered directly by visiting the homepage of *Dignitas Schweiz*: http://www.dignitas.ch/ (Retrieved March 4, 2018).

[7] The German Federal Supreme Court (*BGH*) talks about an "unlawful act" (BGHSt 6,147,153; 46, 279, 246). On the legal dimension and in reference to the philosophy of jurisprudence (Hillgruber, 2015, pp. 115–140; Rothhaar, 2015, pp. 101–114).

II.

Let us find out whether a reference to concepts such as autonomy and dignity is in fact convincing. First of all, there is the question: To what extent are our demands in that respect actually the manifestation of a balanced consideration? What role do our worries, our illnesses and the resulting disabilities play? In what life situation does someone express the desire to live no longer? In a situation of suffering or in a marginal situation? What are the effective motives of someone who articulates the desire to die with "self-determination"? Not wanting to be a burden for others? Is there perhaps a hidden fear of pain and loneliness? The work of professional palliative physicians and hospice workers seems to clearly substantiate that when pain is taken away and attention is paid, the wish for a "self-determined" end disappears in most cases.[8]

We don't want to overlook that the desire for death on demand can soon lead to another "drive". In Flanders (in Belgium) in the year 2007, 32% of euthanasia cases were without consent (Cf. Chambaere, Bilsen & Cohen, 2010, pp. 895–901). A look at the official statistics of the Regional Control Commission for Assisted Suicide in the Netherlands shows that the number of killed dementia patients has quadrupled in the last five years. Evidently, we are faced with a new variety of medical paternalism instead of self-determination.

A study at the University of Zurich and the Zurich University for Applied Sciences was dedicated to people who were diagnosed with a severe illness. Their initial reaction to this discovery was grief, hopelessness, fear of the future and the worry they would have to give up their independence. According to the study, there would have been a possibility of therapeutic help for some patients, but they wished to end their life with self-determination. (Sterbehilfe für Lebensmüde, 2008).[9] Around 30% of the people affected came to the conclusion to end their life with the help of a "suicide organization"; that makes us think.

People do not only suffer physically. In the past, it was a common fear to wake up again in the coffin after being buried alive. Today we sometimes worry about high-performance medicine that may prevent us from dying. Such worries and thoughts should be taken seriously in the context of high-tech medicine, which places man in his finality and vulnerability at the center. Needles and medication are very important for fighting physical suffering, but we cannot treat anxiety or existential crises that way. "We know today that in the overwhelming number of cases the suicide wish is not due to physical ailments but due to a situation where we feel abandoned. A study from the Netherlands shows that in only 10 out of 187 cases pain alone was the reason for wanting euthanasia. In less than half of all cases did pain play any role at all" (Spaemann, 2013, pp. 32 f.)

It is an understandable desire to design our life as we wish right up to old age but when that is no longer possible, when we can no longer walk with ease but require a helping hand, life is not yet at an end. We depend on others from the moment we are born. There seems to be much fear of being dependent in old age, of no longer holding the reins in our own hands. That fear should be

[8] However, it is not always easy – even in a hospice – to accompany a patient in the last stage of life and to pay him/her the proper amount of attention, as shown for example in the five TAZ discussions with people who are spending the end of their life in a hospice. There can be too much and too little attention paid by people who accompany patients. The woman in the first talk emphasized that it was important for her to have no pain and no help from others. She had told her children not to visit her to avoid seeing her. In the same breath, the 72-year-old repeated; "Take your time if you have children. Make time for your parents". The third patient emphasized that she did not want to be a burden to her children, and that she did not want too much attention. "The fact is that my children are suffering, and that bothers me. My three daughters are making it a little difficult for me because they [...] pay an excessive amount of attention to me" (Kurz vor dem tod, 2018).

[9] A study in Basel was able to show great flaws in the Exit Organization: for more information, visit http://www.nzz.ch/aktuell/startseite/article7KHGS-1.464198

taken seriously and should not be falsely interpreted as a call for freedom and autonomy. For example, freedom could manifest itself by turning away from the misbelief that we can do everything by ourselves and that in the final analysis we can get along in life without others (Cf. Maio, 2014, p. 179).

Obviously, the call for suicide assisted by a physician and for the "autonomy of the patient" depends on a certain view of life: Death is regarded as the work of man. Death is not expected, not understood as a given, but interpreted as something we can do, control and design ourselves (Cf. Maio, 2012, p. 360). This gradually changes our view of man who elevates himself to the "Lord and Master" over the living and the dead. It is precisely this wish to control everything right up to death that can very quickly turn us into our own slave. In that sense we can read what Johannes Rau, Germany's former Federal President, said: "What appears to strengthen our self-determination, can, in fact, let us fall victim to blackmail" (Rau, 2001, p. 24).

The two terms, autonomy and dignity already have a long tradition. The Greeks located the former in political philosophy and used it when they talked about man's morality. In many discussions, autonomy sounds virtually like a conjuring spell. When we listen carefully, it gives us not only the idea that we are removed from any moral obligation, but autonomy does not mean that we can do whatever we want; it doesn't mean freedom of arbitrariness. Also, to respect the autonomy of our opponents does not mean to meet all their demands. On the one hand, the term means that humans, regardless of empirical circumstances and motives, can shape their own lives. It also means that they can commit themselves to moral law. Suicide based on evaluating life situations ("balanced suicide") cannot be justified with autonomy in the sense of a moral self-obligation and bound to moral law.

Thus, a sick person's autonomy cannot mean that physicians or the nursing staff should try to do everything the patient imagines. (See also Pöltner, 2006, p. 266) Instead, the patient must also respect the autonomy of the nursing staff and the physicians, who are subject to moral law as well. Their work should always be for the benefit and for the sake of the patient which – last but not least – also distinguishes them from medicine men. In European medical ethics, this has been firmly rooted since antiquity: The Hippocratic Oath states: "I will give no one a product of lethal effect at their request, nor will I give any such advice" (Hippocrates, 2007, p. 54). The first sentence in the *Grundsätze der Bundesärztekammer zur ärztlichen Sterbebegleitung* [Principles of the Federal Medical Association on Physicians' Care for the Dying] gets to the point as follows: "It is the physician's duty to keep the patient alive while observing the patient's right of self-determination, to protect and restore health, to alleviate suffering and to assist the dying until death" (Grundsätze, 2011). Death cannot be a medical service. "The physician who kills a patient upon request enters, with his action, an orientation and disposition which in the last analysis must abolish his respect for the person" (Fuchs, 1997b, p. 86).

Good dying can include not wanting to exhaust all options of high-tech intensive medicine, to do without medical interventions or not to continue a therapy.[10] That means allowing the dying process to continue. Death is *not* the goal but a good and humane way of saying farewell. "One omits everything that could prolong the dying process in a way that would be contrary to the dying patient's will and dignity; at the same time, one does everything to make this process tolerable" (Beckmann, 1998, p. 149) One agrees to the patient's dying, his death is not self-inflicted.[11]

[10] The Federal Supreme Court Bundesgerichtshof justified this with patient autonomy (BGHSt pp. 11,111, 113–115).
[11] "The direct objective is […] pain control which liberates the dying of constant unbearable pain; and as possible (not certain) side effect we must put up with the risk that the onset of death may be hastened, for example because the painkilling medication leads to respiratory depression. But we can only accept this evil of indirect killing as long as

Today, pain can be very well controlled in palliative medical care. The concept of palliative care is being expanded. Ideally, it involves physicians, nursing teams, psychologists, clergymen, physiotherapists and volunteers hand-in-hand to accompany the seriously ill, to maintain their quality of life as well as possible and to allow good symptom control and pain therapy. Accompanying others in situations characterized by pain and illness is a challenge for the companions who must allow issues of finality and fragility to arise in their own life and who must find time for talks with the patient.[12] Respecting the autonomy of patients means to recognize them as persons and not to place their existence at disposal. The purpose must be to take away the patients' fear and pain, not their life.[13]

Today, people live longer than ever. In financial terms, the last stage of life is expensive, especially when it is characterized by illness and the need for care. A study by the University of Cologne indicates that there are presently about 600,000 people in Germany older than 90, with the tendency rising. We can at least assume that discussions about assisted suicide have again ignited for financial reasons. In a novel with the significant title, *Der moderne Tod. Vom Ende der Humanität* [Modern death: The end of humanity], we find the following view about death and dying that makes us pay attention:

> "When there are inadequate funds for saving everyone who could be saved by purely technological means and with modern treatment, we either have to leave it to chance who must die, or we must make a rational selection that depends on a comparative evaluation of human lives; there is no third option because there simply are not enough funds to save everyone" (Wijkmark, 2001, p. 31).

Now, about the dignity of man. The *Universal Declaration of Human Rights* begins with the statement that "all human beings [...] are born free and equal in dignity and rights". Of course, this Declaration must be seen against the background of the 20th century's bestial reigns of terror, but the idea of human dignity is much older. In the schools of the Stoics, in the Christian Middle Ages, in the Italian Renaissance and in classical German philosophy, there was distinctive reflection about this ethical, politically practical and legal term.

Man is a creature of dignity not due to income, knowledge, social status, sex, religion or race. All human beings are entitled to dignity regardless of all the differences which exist and have always existed in mankind; human beings are equal in that they are born of humans and simply are humans. The deciding factors are not mental abilities or special characteristics such as being able to suffer or being social.

The term "dignity" means that humans have an "absolute value". In other words; Man is superior at all costs. Things around us have a value and can be replaced by other things which have the same price tag. There is nothing that would be an equivalent for dignity. Therefore, ideas as those in the novel cited above are impermissible. Dignity is not something awarded by others or that could be lost again – not even in the context of a serious illness. Human dignity is considered something

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this side effect is not foreseeable with certainty. If we choose the doses of the medication so high that the patient's death is inevitable, we can no longer speak of an unwanted side effect (Schockenhoff, 2013, pp. 275 f).

[12] Pain and suffering are experienced as unpleasant. Quite often, our own body is experienced as foreign in this context. The concept of time changes as well. Questions of purpose enter our mind, and we do not always succeed in finding the answer (on the context of suffering see Bozzaro, 2015a, pp. 13–36; Bozzaro, 2015b, pp. 93–106).

[13] On Nov. 5, 2015, the German *Bundestag* passed a law concerning the upgrading of palliative possibilities and the better care of patients with a serious illness.

given. If dignity were awarded for some special achievements, not all human beings would be carriers of human dignity. Some would be dignitaries and others not.

We cannot observe human dignity under the best of microscopes. It is related to our actions as persons and not to naked events. Dignity cannot be weighed. Human dignity does not mean life without worries and physical disabilities; it is rather life with enough chances for all, i.e. possibilities of communication, care and other social goods and characteristics.[14] It means that life is inviolable. The term "dignity" means man's unavailability.

> "We cannot attach the inviolable in man to one or more ensembles of characteristics. It only makes sense to talk about the "inviolable", i.e. about the dignity which everyone keeps, no matter what characteristics have been taken away or stolen from him. If dignity were not based on circumstances but – such as health – on characteristics, property or processes, we would lose it to the extent in which it is violated" (Schweidler, 2001, pp. 11 ff.)

As we read in Kant, probably the most important "master coiner" of this term, dignity means that humans must not be handled like objects. We must treat them with respect. Here is what the "Königsberg Philosopher" wrote: "Respect, which I have for others or which others can expect of me, is the recognition of dignity in other human beings, i.e. a value that has no price, no equivalent against which the object of evaluation may be exchanged" (Kant, 1914, p. 462).

We do not derive the sense of human life from being a function for something else or someone else; Man must be the end in itself. (Kant, 1911, p. 429) This purpose limits all instrumental access. According to Kant, dignity is rooted in autonomy. As persons, we are creatures of freedom and reason.

"Reasonable nature", Kant writes, "is different than all else because it determines a purpose of its own" (Kant, 1911, p. 437) Thus, we are characterized in that we *can* behave morally. Naturally, in the course of our life, the radius of our freedom changes. It may differ in our old age from that of a young man who is still facing his life. The opportunities connected with freedom also vary with social status. A head of government or the Pope have other opportunities than students or cleaning staff. These examples show that it is not a matter of actually acting in freedom but that humans *can* be free. Dignity "includes not only the freedom to choose one's way of life self-reliantly. As members of the human family, we all have duties to ourselves as well as to others. In a self-determined life, there is freedom only in living together with others, and our freedom is therefore always limited by the freedom of the others. Therefore, the idea of dignity includes the duty to respect each other" (Kather, 2007, p. 8).

For Kant, "self-disembodiment", as he calls suicide, is not an expression of man's freedom. In his *Metaphysics of Morals*, we can read as follows:

> "To destroy the subject of morality in our own person is as much as removing the existence of morality itself from the world, although morality is an end in itself. Therefore to dispose of oneself as a mere means to an end means to degrade mankind in our person (*Homo noumenon*) to which man (*Homo phaenomenon*) had been entrusted for preservation" (Kant, 1914, p. 423).

[14] Human dignity is not a synonym for "life quality till the end". It does not grant a guarantee for a happy life: "The pragmatic reason for living is happiness. Does that mean I can take my life when I can't live in happiness? No! It is not necessary for me to live in happiness for as long as I live. But it is necessary that I live honourable for as long as I live" (Kant, 1990, p. 165).

According to Kant, the subject of freedom and autonomy is wiped out by precisely that act. In a deeper sense, it is a self-contradiction of human freedom (Cf. Kant, 1908, pp. 422 f.; Kant, 1911, pp. 421 f., 429; Kant, 1913, pp. 75 f.; Kant, 1990, pp. 161–167). Such an act contradicts the supreme duty to ourselves and cancels the condition of all duties. As far as reason is concerned, there can be no purpose in giving oneself up. That would undermine all ethics. The existence of reason must not be jeopardized or stamped out. As long as my maxims, by which my will is determined, could always become a universal law, self-disembodiment is contrary to that imperative.

According to Kant, the road to self-disembodiment is not an expression of autonomy, but exactly the opposite: heteronomy. There are many factors which influence a person in such an extreme life situation to think it would be better not to exist than to live and we can supplement Kant: A decision to commit suicide does not only affect this one person: Left behind are people at a loss who often have to suffer unbearably after such a step. People connected to persons willing to commit suicide have the obligation not to agree with them that their life makes no sense anymore and that being without them would be better for everyone. Instead they should be helped to rediscover their autonomy and to gain a new perspective by applying reason and by accepting support from fellow human beings.

In the footsteps of Kant, the answer to the question what it means to die in dignity should be; Dying in dignity is dying in the awareness that life is not a disposable commodity. Just as our own life is indispensable, so is the life of our fellow human beings.

References

AUGUSTINE (2007): *Vom Gottesstaat* (*De civitate Dei).* München: dtv.

BECKMANN, J. P. (1998): Patientenverfügungen: Autonomie und Selbstbestimmung vor dem Hintergrund eines im Wandel begriffenen Arzt-Patienten-Verhältnisses. In: *Zeitschrift für medizinische Ethik*, 44, pp. 143–156.

BORASIO, G. D. (2014): *Selbstbestimmt sterben. Was es bedeutet. Was uns daran hindert. Wie wir es erreichen können*. Munich: dtv.

BOZZARO, C. (2015a): Schmerz und Leiden als anthropologische Grundkonstanten und als normative Konzepte in der Medizin. In: G. Maio, C. Bozzaro & T. Eichinger (eds.): *Leid und Schmerz. Konzeptionelle Annäherungen und medizinethische Implikationen*. Freiburg & Munich: Alber, pp. 13–36.

BOZZARO, C. (2015b): Der Leidensbegriff im medizinischen Kontext: Ein Problemaufriss am Beispiel der tiefen palliativen Sedierung am Lebensende. In: *Ethik in der Medizin,* 27, pp. 93–106.

BRIEF VON JOHANNES PAUL II AN DIE ALTEN MENSCHEN (1999): [online] [Retrieved March 4, 2018] Available at: https://w2.vatican.va/content/john-paul-ii/de/letters/1999/documents/hf_jp-ii_let_01101999_elderly.html.

BROSCHE, W. (2014): Das Leben ist der Güter höchstes nicht. [online] [Retrieved March 4, 2018] Available at: http://www.theeuropean.de/wolfgang-brosche/9152-sterbehilfe-debatte-lustvoll-katholisch-verrecken.

CHAMBAERE, K., BILSEN, J., COHEN, J. et al. (2010): Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey. In: *Canadian Medical Association Journal*, 182(9), pp. 895–901.

CHARLESWORTH, M. (1997): *Leben und sterben lassen. Bioethik in der liberalen Gesellschaft*. Hamburg: Rotbuch Verlag.

DWORKIN, R., NAGEL, T., NOZICK, R., RAWLS, J., SCANLON, T. & THOMSON, J. J. (1997): *Philosopher's Letter.* [online] [Retrieved March 4, 2019] Available at: http://www.nybooks.com/articles/1997/03/27/assisted-suicide-the-philosophers-brief/

FUCHS, T. (1997a): Was heißt ‚töten'? In: *Ethik in der Medizin*, 9, pp. 78–90.
FUCHS, T. (1997b): Euthanasie und Suizidbeihilfe. Das Beispiel der Niederlande und die Ethik des Sterbens. In: R. Spaeman & T. Fuchs (eds.): *Töten oder sterben lassen?* Freiburg: Herder, pp. 31–107.
GRUNDSÄTZE DER BUNDESÄRZTEKAMMER ZUR ÄRZTLICHEN STERBEBEGLEITUNG (2011): In: *Deutsches Ärzteblatt*, 108(7), pp. 346–348. [online] [Retrieved September 22, 2019] Available at: http://www.bundesaerztekammer.de/fileadmin/user_upload/downloads/Sterbebegleitung_17022011.pdf
HATTLER, J. & KOECKE, J. C. (2020): *Biopolitische Neubestimmung des Menschen. Menschenwürde und personale Autonomie*. Wiesbaden: Springer VS.
HILLGRUBER, C. (2015): Die Bedeutung der staatlichen Schutzpflicht für das menschliche Leben und der Garantie der Menschenwürde für eine gesetzliche Regelung zur Suizidbeihilfe. In: S. T. Hoffmann & M. Knaup (eds.): *Was heißt: In Würde sterben? Wider die Normalisierung des Tötens*. Wiesbaden: Springer VS, pp. 115–140.
HIPPOCRATES: Der Eid (2007): In: J. Kollesch & D. Nickel (eds.): *Antike Heilkunst. Ausgewählte Texte aus den medizinischen Schriften der Griechen und Römer*. Stuttgart: Reclam, pp. 53–55.
HOERSTER, N. (1998): *Sterbehilfe im säkularen Staat*. Frankfurt a. M.: Suhrkamp.
HOERSTER, N. (2018): Zur Legitimität der Sterbehilfe, In: *Information Philosophie*, [online] [Retrieved September 22, 2019] Available at: http://www.information-philosophie.de/?a=1&t=2538&n=2&y=1&c=1
HOFFMANN, T. S. (2009): Töten auf Verlangen – eine Wohltat?. In: G. Kaster (ed.): *Sterben – an der oder durch die Hand des Menschen*, Münster: Dialog-Verlag, pp. 60–77.
HOFFMANN, T. S. (2015): Lasst die Finger davon. In: *FAZ*, Nov. 4, p. 9.
HOFFMANN, T. S. & KNAUP, M. (2015): *Was heißt: In Würde sterben? Wider die Normalisierung des Tötens*. Wiesbaden: Springer VS.
JOHN PAUL II ACADEMY FOR HUMAN LIFE AND THE FAMILY COMMENTS ON THE MEETING OF THE WORLD MEDICAL ASSOCIATION, EUROPEAN REGION, ON END-OF-LIFE QUESTIONS, HOSTED BY THE PONTIFICAL ACADEMY FOR LIFE (2017): [online] [Retrieved March 4, 2018] Available at: https://www.corrispondenzaromana.it/wp-content/uploads/2018/02/JAHLF-on-PAV-declaration.pdf
KANT, I. (1908): *Metaphysische Anfangsgründe der Tugendlehre, Akademieausgabe*, vol. VI, ed. Königlich Preußische Akademie der Wissenschaften. Berlin: Reimer.
KANT, I. (1911): *Grundlegung zur Metaphysik der Sitten*, *Akademieausgabe*, vol. IV, ed. Königlich Preußische Akademie der Wissenschaften. Berlin: Reimer.
KANT, I. (1913): *Kritik der praktischen Vernunft*, *Akademieausgabe*, vol. XIX, ed. Königlich Preußische Akademie der Wissenschaften. Berlin: Reimer.
KANT, I. (1914): *Die Metaphysik der Sitten*, *Akademieausgabe*, vol. VI, ed. Königlich Preußische Akademie der Wissenschaften. Berlin: Reimer.
KANT, I. (1990): *Eine Vorlesung über Ethik*. Frankfurt a. M.: Fischer.
KATHER, R. (2007): *Person. Die Begründung menschlicher Identität*. Darmstadt: WBG.
KNAUP, M. (2016): Der neue § 217 (StGB). In: *Imago Hominis*, 23(1), pp. 9–12.
KÜNG, H. (2014): *Glücklich sterben? Mit dem Gespräch mit Anne Will*. Munich & Zurich: Piper.
KURZ VOR DEM TOD (2018). [online] [Retrieved September 22, 2019] Available at: http://www.taz.de/!5487927/
MAIO, G. (2012): *Mittelpunkt Mensch: Ethik in der Medizin. Ein Lehrbuch. Mit einem Geleitwort von Wilhelm Vossenkuhl*. Stuttgart: Schattauer.

MAIO, G. (2014): *Medizin ohne Maß? Vom Diktat des Machbaren zu einer Ethik der Besonnenheit*. Stuttgart: Trias.
PÖLTNER, G. (2006): *Grundkurs Medizin-Ethik*. Vienna: Facultas.
RAU, J. (2001): Wird alles gut? – Für einen Fortschritt nach menschlichem Maß. In: S. Graumann (ed.): *Die Genkontroverse. Grundpositionen*. Freiburg, Basel & Vienna: Herder, pp. 14–29.
ROTHHAAR, M. (2015): Autonomie und Menschenwürde am Lebensende. Zur Klärung eines umstrittenen Begriffsfelds. In: S. T. Hoffmann & M. Knaup (eds.): *Was heißt: In Würde sterben? Wider die Normalisierung des Tötens*. Wiesbaden: Springer VS, pp. 101–114.
SANDEL, M. (2015): *Moral und Politik*. Berlin: Ullstein.
SCHOCKENHOFF, E. (2013): *Ethik des Lebens. Grundlagen und neue Herausforderungen*. Freiburg: Herder.
SCHWEIDLER, W. (2001): *Das Unantastbare. Beiträge zur Philosophie der Menschenrechte*. Münster: LIT.
SPAEMANN, R. (2002): *Grenzen. Zur ethischen Dimension des Handelns*. Stuttgart: Klett-Cotta.
SPAEMANN, R. (2013): Die Vernünftigkeit eines Tabus. In: R. Spaemann & B. Wannenwetsch (eds.): *Guter schneller Tod? Von der Kunst, menschenwürdig zu sterben*. Basel: Brunnen, pp. 9–40.
STERBEHILFE-STREIT IN BELGIEN (2017): [online] [Retrieved March 4, 2018] Available at: http://www.archivioradiovaticana.va/storico/2017/10/02/sterbehilfe-streit_in_belgien_vatikan_gibt_orden_letzte_cha/de-1340310
STERBEHILFE FÜR LEBENSMÜDE (2008): [online] [Retrieved March 4, 2018] Available at: http://www.nzz.ch/aktuell/startseite/sterbehilfe-lebensmuede--1.1215812
STRIET, M. (2015): *Gottes Schweigen. Auferweckungssehnsucht – und Skepsis*. Ostfildern: Grünewald.
THOMAS AQUINAS: *Summa Theologiae* II–II.
TODKRANKE AMERIKANERIN BRITTANY MAYNARD NIMMT SICH DAS LEBEN (2014): [online] [Retrieved March 4, 2018] Available at: https://www.welt.de/newsticker/dpa_nt/infoline_nt/brennpunkte_nt/article133924977/Todkranke-Amerikanerin-Brittany-Maynard-nimmt-sich-das-Leben.html
WIJKMARK, C.-H. (2001): *Der moderne Tod*. Berlin: Gemini Verlag.
WOLF, J. C. (2000): Sterben, Tod und Tötung. In: U. Wiesing (ed.): *Ethik in der Medizin. Ein Reader*. Stuttgart: Reclam, pp. 200–225.

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To live is to die: A virtue account of arguments for the right to die[1]

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Abstract
In recent years, debates about euthanasia and assisted suicide have increased to the point that now, many people defend the recognition of the right to die, the right for people to decide upon the end of their life. Consistently, advocates fight to legalise practices such as euthanasia to guarantee patients' possibility to die when they request it. In this paper, I review two of the strongest arguments invoked by proponents of physician-assisted suicide: the argument for compassion and the argument for dignity. The focus of this paper is to propose a review of these arguments through the lens of virtue ethics to inform the debate on physician-assisted suicide and question the relevance of such arguments for the legalisation of that right that would greatly ease the possibilities to end the life of a patient asking for it.

Keywords: compassion, dignity, right to die, virtue ethics, physician-assisted suicide

Introduction

Over the past years, debates about euthanasia and assisted suicide have increased to the point that now, many people defend the recognition of the "right to die," the right for people to decide upon the end of their life. Consistently, advocates fight to legalise practices such as euthanasia to guarantee patients' possibility to die when they request it. In this paper, I review two of the strongest arguments invoked by proponents of physician-assisted suicide: the argument for compassion and the argument for dignity. The focus of this paper is to propose a reading of these arguments through the lens of virtue ethics and see how they could inform the debate on physician-assisted death and the relevance of such arguments for the legalisation of that right that would greatly ease the possibilities to end the life of a patient asking for it.

In this article I do not make a differentiation between the two concepts of euthanasia and assisted suicide, following Younger and Kimsma (Younger & Kimsma, 2012, p. 32) who gather them under the name of physician-assisted death. They define euthanasia as "the unambiguous and intentional ending of a patient's life by a physician" and assisted suicide is when "a physician intentionally provides a patient with the medical means to end his or her life". These active forms of terminating somebody's life are the only ones I consider in this paper, consequently leaving out other possible alternatives such as stopping medical treatments. These active forms are the crux of the dilemma revolving around euthanasia as they imply "directly killing" a patient, as opposed to more passive forms, rather seen as "letting die".

I start by giving a review of two of the most common and powerful arguments advanced by the proponents of the right to die. They invoke the argument of dying with dignity and the argument for compassion to defend their proposal of the right to die, considering this right is consistent with respect for human dignity and that compassion is necessary to benefit people requesting to die. In the second part, I briefly introduce Aristotle's virtue ethics account and the telos of a state, which is to allow people to live a good life and be virtuous. I then examine these two arguments and their meaning in light of Aristotle's concepts to show that according to his demanding approach these arguments do not appear to be sufficient, and only some marginal and extreme cases would justify the possibility of having recourse to physician-assisted death.

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Argument for dignity[3]

In the debate about euthanasia and assisted suicide, the case of dignity is often invoked: it is one of the most powerful and most common arguments of the proponents of the right to die with dignity (Gentzler, 2003, p. 461). Yet, this argument is problematic. If it has provided a certain unifying normative vocabulary for the debate since people from different professions and different moral strands can refer to human dignity, the term covers nonetheless different meanings and if, to a certain extent, dying with dignity is understood as dying a good death (e.g. a painless death before losing all human capacities), the interpretations of the term are multiple (Gandsman & Burnier, 2014, p. 2). To make the point clearer, I would sketch out how dignity in its principal meaning is referred to in debates about assisted suicide.

Humans have placed special emphasis on dignity, going as far as to consider they were worthy of a dignity that no other species have. Since this dignity is thought to be the basis of their moral consideration, humans try to preserve it (Gandsman & Burnier, 2014, pp. 3–4). Even if the concept might be vague or cover different significations, anybody who takes human rights seriously should accept this powerful idea of human dignity (Dworkin, 1977, p. 98). Furthermore, with the development of bioethics during the twentieth century, international organizations have highlighted and put forward the importance of this concept. UNESCO's *Universal Declaration on Bioethics and Human Rights* (2005) describes humans as having a unique intrinsic value and therefore being worthy of dignity. It seems dignity is of paramount importance for humans, yet we have to clearly define it. That our dignity comes from our intrinsic values stems from Kant, and it is one possible approach of the concept advocates for the right to die have adopted. For Kant, humans have the capacity to act morally. This capacity entitles them to an intrinsic value: because humans have this capacity to act morally, they have dignity (Kant, 2012). As Kant's well-known categorical imperative formulates: "people are ends in themselves" and are not to be treated merely as means for other purposes. As ends in themselves, they shall be considered with utmost respect. Following his definition, suicide is morally impermissible since the one who destroys himself to escape an unbearable situation makes use of his person, reducing it to a mere means to an end. Kant's demanding view does not seem to allow any room to consider the possibility of physician-assisted death (Gentzler, 2003, p. 463). However, many authors have argued on this account about the possibility to commit suicide; arguing along Kant's line of thinking, that there are things worse than death, such as acting immorally. Even if suicide is a moral sin, some situations might require that a person puts an end to their life. Some have tried to prove it (Gentzler, 2003, pp. 464–465) but I will not discuss such views further as I only intend to present Kant's approach of dignity and not to discuss arguments and possibilities of physician-assisted death using his work.

If many retain the idea of dignity being linked to intrinsic value, Kant's view remains abstract and advocates for the right to die usually call for a more practical and contingent understanding of dignity (Gandsman & Burnier, 2014, p. 5). Dignity is then more subjective; it depends on personal views and how one perceives oneself. From this perspective, dignity is related in terms of suffering, autonomy, and dependency. It is important to understand, that from this perspective, it is not death that is a violation of dignity, but the process of dying. As Gandsman & Burnier (2014) write, this is the point where the body becomes the source of humiliation, torture, or degradation. People feel ashamed when they lose control and their body falls apart. For instance, if they soil themselves, or if their cognitive functions are damaged to the point they end up being unable to perform any action. As Ackerman emphasized it: "human dignity resides in the bladder and in the rectum" (Ackerman, 1998, p. 151). If the view may sound crude and trivial, many terminally ill patients experience it this way. If humans always depend

[3] Here again I make no distinction between euthanasia and assisted suicide, since in the studies about dignity it is not considered (Gandsman & Burnier, 2014).

in some ways on other beings, as an essential component of human life (Gentzler, 2003), when they must rely on others for their most basic needs, like showering or going to the toilet, this dependency is then perceived as demeaning. Loss of control and dependency are related but distinct: one can depend on somebody because they need help, of a housemaid for instance, but still have control over his or her life.

The emphasis here is on the possibility to have control over life and death: autonomy and self-determination to decide when they happen. Dignity is, in this context, a property we possess as long as we remain in control (Gentzler, 2003). This capacity should not be taken away from people: if someone requests physician-assisted death,[4] their will shall be executed. If not, this person would lose their dignity at the same time they loses the possibility to choose their death. Kant would have rejected suicide simply based on suffering; however, it is nowadays usually commonly agreed that there is no use to extend the life of somebody who experiences unbearable pain and who has no significant chances of recovery. When the centre of life becomes pain, a person can therefore, lose their dignity. Consequently, respecting this person's dignity might mean putting an end to their life (Velleman, 1999, pp. 617–619). From this second approach, losing dignity is due to one, or a combination of factors a person experiences: unbearable pain, loss of control, or increased dependency (Gentzler, 2003, pp. 466–471). Experiencing terrible pain, being unable to perform the simplest actions in life, or losing total control are, then, the main reasons grounding the argument for a right to die with dignity.

Another way to approach the concept of dignity still within the debate about the end of life was defined by Dworkin in his book *Life's dominion*. He defines human dignity as the moral right and responsibility to confront the fundamental questions about the value and meaning of our own lives for answering to our own convictions (Dworkin, 1993, p. 166). The ways we reflect on our lives and decide how to act accordingly defines some integrity. There is the integrity of our lives so everything fits in: there is a certain narrative unity in one's life. We envisage pursuing the achievement of a certain character of life through our acts during its course. This is how one can live with human dignity: by making sure of the integrity of their life. The same goes for death: to fits Dworkin's definition of dignity, it should follow the integrity of one's life. From his point of view, most humans protect the integrity of their life and will look for a way to die that will enhance it. Consequently, they shall be entitled to die as they see fit because that would be respecting their dignity.

The approaches of dignity I presented are of course not exhaustive. There are other ways to define dignity. For instance, some link dignity to a religious quality that makes humans special compared to other species because they were made in the image of God (Gandsman & Burnier, 2014). Nevertheless, the three views I presented are among the most prominent in the debate about physician-assisted death. If they differ on certain points, they start from the same premise: human life has an intrinsic value that should be revered and respected. No matter the definition, dignity remains an ultimate, mandatory, and non-negotiable value (Gandsman & Burnier, 2014).

Argument for compassion

Another aspect of granting people the right to die focuses on another value: compassion. The argument considers the good that can be done for the one who is dying: from empathy, the pity we feel for this person, we shall put them out of their misery and help them end their life if it is their wish. In this part, I want to come back to this argument and the virtue(s) advanced to

[4] Assuming of course this is a conscience autonomous choice, respecting the criteria established in the country where they reside.

defend the idea that assisted suicide and euthanasia are possible. Namely, it is compassion or pity expressed through the principle of beneficence.[5]

Introducing different accounts of dignity, I present various reasons that could lead to a loss of dignity: increased dependency, loss of control, and unbearable pain. They could also trigger a feeling of empathy and compassion for the close or distant entourage of the patient. This feeling is so strong that it could convince people that the best course of action for the patient is a physician-assisted death to relieve them.[6] Suffering is widely considered as being intrinsically bad (Sumner, 2011, p. 89) and the normative ethical theory of utilitarianism defines it as the main criterion to determine the morality of an act. From a utilitarian perspective, we shall increase the balance of pleasure over pain and therefore the moral course of action would be to relieve the person suffering. Also, it is important to mention that physician-assisted death is mostly considered for terminally ill patients (see for instance *The Oregon Death With Dignity Act*). Terminally-ill patients have no serious hope of recovery, therefore the pain they experience will lead to no good because it is the suffering they experience during the process of dying (Sumner, 2011, p. 89). From these assessments rises the argument for the well-being of the patient: it is in their interest to prevent them from suffering and help them to die. This is a utilitarian formulation of the argument as it aims at reaching the best outcome, it has the best consequences. However, it can also be formulated in deontological terms as a duty to not inflict unnecessary or avoidable harm (Sumner, 2011, p. 90).

Beauchamp and Childress have integrated such considerations in the four principles they defined, widely used as guidelines throughout the world in biomedical ethics (Beauchamp & Childress, 2013). One of these principles is the principle of beneficence, which goes along with the principle of non-maleficence. According to Beauchamp and Childress, morality requires that we contribute to people's welfare: we should not only prevent harm from happening to them, but also positively take steps to help them (Beauchamp & Childress, 2013, p. 202). The principle of beneficence, paired with the principle of autonomy, enables practitioners to express virtues of care and compassion offering by strong reasons to consider the possibilities of physician-assisted death (Beauchamp & Childress, 2013, p. 185). The feelings and concerns we have for others go beyond rules or principles because they express these virtues and excellence of character. For them, a virtue can be defined as a dispositional trait of character that is reliably present in a person and socially valuable. The moral virtue is not socially, but morally valuable (Beauchamp & Childress, 2013, p. 31). In the field of health care, they distinguish five virtues as being of paramount importance for professionals because they support and promote good practices in health care. Among these five virtues is compassion (Beauchamp & Childress, 2013, p. 33). As I mentioned already, this virtue is triggered by the view of suffering because it focuses on other people's pain and misery. I want to briefly add a clarification here. Usually pity and compassion are used indistinctively as synonyms. Yet, they are slightly different, and I believe that pity would be more accurate than compassion following Beauchamp's and Childress' definition. According to them, this virtue has affinities with mercy and is expressed in acts of beneficence that attempt to alleviate the suffering of another person (Beauchamp & Childress, 2013, p. 37). Pity can be defined as a feeling of affliction we have for the suffering of others and that drives us to relieve them from it, whereas compassion would rather be the

[5] Benevolence can also be considered to be one of the main virtues that could be reintroduced using an Aristotelian approach in the debate about assisted suicide (Zyl, 2000). I do not elaborate much in this paper about the virtue of benevolence, because in this perspective I take benevolence – when it specifically comes to assisted suicide- to be widely influenced by compassion: it provides the motive for being benevolent.

[6] I will leave aside loss of control and dependency. If they could trigger pity, I would need to talk more in detail about it since these two reasons/conditions also presuppose a loss of autonomy, which is fundamental to consider the possibility of assisted suicide (Sumner, 2011) (*The Oregon Death With Dignity Act*). Even in the case of suffering alone, the first thing to do in case of suicide (intervention) is to determine whether the person acts autonomously or not (Beauchamp & Childress, 2013, pp. 223–224;184).

feeling that would foster the sharing of this suffering. Etymologically, compassion means 'to suffer with'. Due to the common overlapping definitions of the two concepts that can be found in the literature, I use the two terms indistinctively as synonyms in this paper.

If at first glance the argument for compassion seems to focus on the good that can be done for the patient, it is also powerful because it embodies the expression of compassion, a virtue valuable to society and morality. However, even if the argument for compassion is powerful, the case of assisted death remains problematic. The fact the physician-assisted death aims at the welfare of the patient to relieve their suffering and is motivated by the virtue of compassion is not enough to make it permissible; certain additional conditions must be satisfied to justify it. Many authors have worked on this issue to provide such satisfactory conditions. Beauchamp and Childress distinguish nine different conditions such as an unacceptable suffering by the patient, or a voluntary request by the patient (Beauchamp & Childress, 2013, p. 184). In comparison Sumner lists only five criteria, although he also stresses the importance of unbearable pain and a careful assessment of the patient (Sumner, 2011, pp. 90–91).

Virtue ethics[7]

Although tracing back to Aristotle and Plato, virtue ethics remained marginal for centuries, to be revived in the 1950s by the British philosopher Anscombe when deontological and utilitarian arguments were unsatisfactory. It was first and foremost conceptualized in Aristotle's works. In *Nicomachean Ethics*, Aristotle defines what it is to live a good life by eudaimonia; happiness, better understood as human flourishing. It is the supreme end humans should pursue. To do so, humans must develop their virtues, moral character traits that will enable them to achieve this eudaimonia, because it is not merely a life of pleasures that will procure happiness in different ways to each human, but the ultimate end of the exercise of their virtues. Then, to be good, one must have been well-raised, to have developed good habits and live following them by behaving honestly (Aristotle, 2004b, I, 4). For being virtuous, one must practise developing one's character traits. Having a virtue means to be a certain person with a complex mind-set: mainly the acceptance of a certain range of considerations as a reason for action (Hursthouse, 2013). For Aristotle, possessing a virtue is a matter of degree; it is a decisional state, the middle of which is anchored in us. The middle between two vices; one of excess and the other of deficiency (Aristotle, 2004b, VI, 1). I think it is important to mention that being virtuous is a hard achievement, and as Athanassoulis (2000) mentions, the number of ways to fall short is many. For instance, a way to fall short would be due to a lack of moral or practical wisdom (*phronesis*). As I mentioned before, to be virtuous, one must make the best use of one's virtues and reason in one's life to achieve eudaimonia. And to do so, one must also have this knowledge or understanding that will enable one to do just that. Without this knowledge, one cannot be said to be truly virtuous. For instance, a child might be nice or honest because of his naivety and innocence but because he lacks *phronesis*, this knowledge, he cannot be virtuous in Aristotle's conception.

Now in light of this discussion, I shall briefly introduce the role of the state, the role of politics. According to Aristotle, the state exists for the sake of the good life and not merely life only (Aristotle, 2000, III, 9). It aims at cultivating the virtues of the citizens; that is the role of the state. Aristotle discusses different possible forms of government and the virtues of their citizens. He also discusses the possible differences of virtues between the good man and the citizen; in some states they are alike, in some they differ. However, in the perfect state, the virtues of the citizen and the virtues of the good man are the same (Aristotle, 2000, III, 4). In these conditions, the state then aims at developing the virtue of people to allow them, to become truly good. A variety of governments exist today. While it is beyond the scope of this article to

[7] I limit myself to the traditional view as defined by Aristotle.

argue for one over another and determine which form would be the most appropriate to realize the envisioned goal, beyond practical considerations, I take the stance that the telos of a state remains, in line with Aristotle to allow its people to be good humans and citizens, no matter which forms it may take. The good citizen is an important part because according to Aristotle, the political association would be nothing more than a mere alliance. But I focus here on the good man who shall pursue his telos and develop his virtues through good habits and practical wisdom to achieve eudaimonia. The state should therefore encourage people to do so and create a propitious environment where they would have the possibility to develop their virtues. It is with these considerations in mind that we shall approach and reflect on the topic of physician-assisted death and see whether or not it allows and encourages people to develop their virtues. With this teleological perspective in mind, I now discuss the two arguments for compassion and dignity and consider how they fit this conception.

Discussion

While discussing the concept of dignity, I highlighted its importance from different approaches. I have also explained that we often refer not only to dignity but to human dignity, in a way that we would have our very own special value. Compared to other living beings, we have dignity they do not, and if not superior, it implies nonetheless that we are different from plants and animals. But what sets us apart from these beings? According to Aristotle, the potential we have for cognitive and emotional capabilities sets us apart from them, it makes one human (Aristotle 2004a, II). Introducing virtue ethics, I presented the idea that the telos of human beings was to achieve eudaimonia by the exercise of their virtues. This is possible thanks to their capabilities: the cognitive and emotional capabilities that allow a human to live a good, distinctively human life are virtues (Gentzler, 2003). Hence, they are not valuable from an instrumental perspective; we do not merely use them to satisfy our basic needs, but to achieve a good life. From an Aristotelian perspective, this is how human dignity is possible. It comes from our unique capabilities and the use we make of them. It is thus possible to make a parallel between his understanding of dignity, and the second and third accounts I gave. To make use of these capacities, humans need certain levels of independence and control. To fulfil the purpose of achieving a good life they will have to make extensive use of these capabilities such as problem-solving, or certain control over feelings such as fear, or desire (Gentzler, 2003). Intuitively, such a virtuous account of human dignity would also seem to fit Dworkin's integrity of one's life, with the exception that the narrative unity in Aristotle's virtue ethics cannot be just any. It is clearly defined; it is eudaimonia. The same way Dworkin explained a death with dignity as one that fits the integrity of the person's life, a death with dignity according to Aristotle is consistent with a life lived with dignity. Nussbaum in her capability approach has developed a concept of dignity following Aristotle's lines. For her, this human dignity is inalienable and comes from humans' capacities for various actions and striving (Nussbaum, 2008, chapter 14). According to Nussbaum, respecting this human dignity means creating favourable conditions for development, which is consistent with the role of a state as I introduced it: to create a favourable environment allowing people to achieve a good life. It is the responsibility of the state and the society through its basic structure to ensure that conditions are reunited so it is possible for a human to live with dignity (Nussbaum, 2008, chapter 14).

Should a state enact a law in favour of the right to die to then allow the practice of physician-assisted death? For Aristotle, the law forbids suicide, and thus the one who commits it acts unjustly (Aristotle, 2004b, V, 11). Such person acts against right reason, she acts unjustly, not to herself, but to the state. Can the consideration and esteem we have for dignity turn the tables? Carefully considering the argument for dignity, a person may have the possibility to die when they cannot live their life with dignity anymore. Along the lines of virtue ethics we have discussed so far, it would entail that this person cannot make use of the capabilities allowing

them to achieve eudaimonia. People in a vegetative state for instance with no hope of recovery may fit such a description. Yet, this implies that we have already reached a stage where we examine cases of people finding themselves in extremely severe irremediable living conditions, and for whom considering the state's telos has no reason of being anymore.

But before reaching such an extent, and considering the possibility of physician-assisted death to give people the possibility to terminate their life, a state should rather consider the needs of its people at different stages in their life, and act in accordance to do everything so they could live with dignity before examining the possibility of a right to die. In other words, for people who might consider the option of terminating their lives, from a virtuous perspective, the most important question to ask normatively speaking, would not be whether granting these people such a possibility is right or wrong. The fundamental consideration would be whether or not there are any possibilities left for these people to live with dignity. For this point, the case of Jean-Dominique Bauby can serve as a brilliant illustration. Bauby was a very successful family man, and acclaimed journalist in his mid-forties. One day he had a stroke. After weeks in a coma, he woke up suffering from locked-in syndrome; while his cognitive capacities remained intact, he could only move his left eyelid; the rest of his body remained paralyzed. Life as he had known it was forever over. Yet, he did not give up and kept communicating with the people around him, by blinking, dictating his words, letter, after letter. Rather than seeking relief in death, Bauby told his story in a book he wrote by dint of hard work only using his left eyelid. Now, it would seem very odd to me, and quite obnoxious to consider that he has not lived in dignity, for he who has remained resilient and courageous facing such a desperate situation. Undoubtedly, I recognize the strength of will Bauby has shown is unique. He may very well be an exception, and not all patients in the same dire conditions may be able to respond the way he did, and such dramatic stories rightly compel us to question whether for Bauby, and patients in similar conditions, ending life could not be the best option. Some trains of thought may reach this conclusion. However, for virtue ethics, the state's telos is to allow us to live our life with dignity, even when everything seems lost, and to inspire us to walk in Bauby's footsteps. As Nussbaum said, the sheer fact of prolonging life is good and should be encouraged, and whichever our condition may be, we should seek to live in dignity above all. Only in cases where we have exhausted all possibilities and there is effectively no real possibility to live with dignity, the option of a death with dignity should be considered (Nussbaum, 2008, chapter 4).

Going further, the purpose of physicians and people working in healthcare is the safeguarding of life. All the more so referring to the original Hippocratic Oath. I believe this should be encouraged till to the point where achieving a life with dignity becomes truly impossible when life has nothing human anymore. Should this possibility be granted to everyone? In my opinion, the state should not enact a law in favour of physician-assisted death. As I intended to explain, physician-assisted suicide is a last resort measure that should be possible in some marginal cases. However, if it be possible and permissible, the state should not encourage its citizens, in any manner, to have recourse to ways of terminating their life through a law that would recognize one's possibility to take one's own life. From this analysis, the argument of dignity falls short of legitimising the right to die allowing people to decide upon their death.

Aristotle seems particularly relevant when discussing the second argument invoked by the proponents of the right to die. His definition of compassion fits our modern understanding of it. Aristotle sees compassion[8] as a feeling of pain caused by the sight of destructive or painful evil which befalls one who does not deserve it and which we might expect to befall us (Aristotle, 1991, II, 8). The description he makes of plights susceptible to spark compassion is also relevant

[8] Aristotle uses the term 'pity' in his work, but as I mentioned due to the overlapping uses of the terms in literature, I use pity and compassion as synonyms.

for our case. He evokes the most terrible evils of human life: death, bodily injuries, old age, afflictions, or diseases. They all are susceptible to stimulate pity. Considering the occurrences of these evils in the lives of physicians and healthcare personnel, it seems evident the importance of empathy and compassion considered as a virtue as Beauchamp and Childress developed it. It allows physicians to understand the way patients feel, and their state of mind to better benefit them, and serves as a driving force to relieve them. Yet, the question is whether Aristotle thought about compassion as a virtue or not and if it should be developed by the good man. The answer is not evident. Aristotle primarily sees pity as a feeling, yet he recognizes it is associated with good moral character (Aristotle, 1991, II, 1) and for this reason can be considered a virtue. I presented Aristotle's approach to virtue as a mean between two extremes: one of excess and the other of deficiency. Compassion despite being a virtue can also be a fault: someone's compassion can lead them to tell lies or act immorally. A compassionate person displays a virtuous character when they feels pity for the right reasons, the right people, and in the right ways, which would be to act appropriately in our case where we look at compassion and its practical implications. Defining pity, Aristotle presents the necessity of three judgments for the onlooker to form compassion: the judgment that the pain is serious and not trivial, the judgment that the pain is undeserved, and the judgment that a person may find himself in the same circumstances, going through the same pain as the person who is suffering. If for any reason, like cognitive impairment, one or more of these judgments is mistaken, it would result in unwarranted compassion. It follows that compassion is not necessarily a virtue, and needs further specification. Being compassionate for someone who has deserved the evils that have befallen them would be an excess of compassion and maybe not the expression of a truly virtuous character. There are cases of physicians who euthanized their patients invoking compassion, because they genuinely wanted to put them out their misery, thinking they did not have any chance of survival. Compassion can not only be the only criterion in such cases, and it must be carefully assessed, so it is beneficial and truly the expression of a virtuous character in line with regulations, at the risk of leading to harmful actions and disastrous consequences. It would be a long discussion to clarify which evils are deserved or not, to say that being compassionate is appropriate in certain defined cases of assisted death or not, and determine more precisely the validity of the argument. My purpose was to show that compassion is positively perceived and valued by society. It may be considered as a critical virtue healthcare personnel should foster, however, a thorough assessment of compassion in light of virtue ethics indicates that it is not as straightforward as it seems, and limitations of this understanding of the term appear.

Furthermore, the argument could somehow seem distorted, that, by, let's say, granting the right to die allow physicians to express a virtuous compassionate character and benefit patients, there would be no other possibility for physicians to do so. Yet, physicians can be compassionate and benefit their patients in other ways, by providing pain relief or mental support for instance. It does not entail that by not granting the right to die, the state prevents physicians from developing their virtuous character. As for Aristotle and virtue ethics, telos is the normative relevant criterion, neither the argument for compassion overrules the argument for dignity, nor does it prevent the achievement of the state's or physicians' purpose. Following the same logic, only in the most severe cases where a physician would have no other ways left to benefit the patient or to express its virtuous character, and within limits previously mentioned, would the argument for compassion be consistent with virtue ethics. But when such cases arise where physician-assisted death is requested, some practitioners should be ready to do it, out of compassion. Bear in mind that I, again, do not say that society should encourage it and that the argument is convincing enough to justify the recognition of the right to die: following the remark I made discussing dignity, if we do not encourage people to have recourse to physician-assisted death, we may want this option to be possible and remain exceptionally

permissible in some cases. In the eventuality of such cases, we need physicians who would be ready to do it. Here again, the role of the state would be to create this propitious environment where a virtuous character can express itself out of compassion and in the execution of physician-assisted death in cases that require it. This goes along with the careful assessment that the conditions are reunited and it is compassion as a virtue that is expressed.

Objections and conclusion

I would conclude this paper by addressing some possible objections to the points I have made. One possible objection to the first argument is the possibility to live a life without dignity. If there is a consensus on the value of living with dignity and everyone arguably pursues this goal, following the approaches I introduced, living a life with dignity is demanding. Some people may lack abilities or cognitive capacities making it thus impossible for them to achieve it. Crippled war veterans losing the functioning of their body, or people born with mental impairment such as autism may not be fit for it, especially if dignity is conceived in terms of functioning or capacities. Some might imply that the life of these people is therefore not worth living. I simply reject the idea that a life worth living requires dignity. It does not mean such lives are meaningless, or that these people cannot get some sense of pleasure or enjoyment, or they cannot live following principles. In the same spirit, one's dignity being violated does not warrant the termination of one's life.

Another possible objection concerns compassion and the requirements I formulated. They may appear too demanding and impractical; it seems unrealistic to ask practitioners to feel compassion only under certain circumstances. It is perfectly acceptable to feel compassionate; society values it and it can bring valuable information to reflections about assisted death. I simply highlight again, that in a practical approach, when it comes to a critical topic such as ending a person's life, understanding and framing compassion, not only as an emotion but as a virtue, as Aristotle defined, could be an effective safeguard against negative consequences that could arise from acts taken upon the willingness to be compassionate. Being compassionate is perfectly acceptable in any situation so to speak, but if one acts out of compassion, it should be for the right reasons, the right people, and in the right ways.

Starting from the consideration of two of the main arguments invoked by proponents of the right to die, I introduced virtue ethics as conceptualized by Aristotle to show that the telos of a state is not to encourage its citizens to engage in behaviours threatening their life. A state should rather work to enable its citizens to develop and exercise their virtues to live a life with dignity achieving eudaimonia. Only when there are no possibilities for a person to live a life with dignity, the possibility of physician-assisted death should be considered. I do not believe the arguments for dignity and compassion are strong enough to justify the enactment of the right to die and the subsequent laws allowing it. Nevertheless, I recognize that assisted death may in some cases be an appropriate solution and should be possible and permissible. The two arguments would still stand by fulfilling the demanding conditions in these cases, allowing, then, the possibility of this last resort option to end a person's life. In these marginal cases, where the arguments of compassion and dignity would be consistent with virtue ethics as presented, they are not sufficient to justify the recognition of the right to die.

References

ACKERMAN, F. (1998): Assisted suicide, terminal illness, severe disability, and the double standard. In: M. P. Battin, R. Rhodes & A. Silvers (eds.): *Physician-assisted suicide: Expanding the debate.* New York: Routledge, pp. 149–162.

ARISTOTLE (1991): *The art of rhetoric.* London: Penguin Classics.

ARISTOTLE (2000): *Politics.* London: Penguin.

ARISTOTLE (2004a): *De Anima (On the Soul)*. London: Penguin.

ARISTOTLE (2004b): *The Nicomachean ethics.* London: Penguin Classics.
ATHANASSOULIS, N. (2000): A Response to Harman: Virtue ethics and character traits. In: *Proceedings of the Aristotelian Society*, 100(1), pp. 215–221.
AUTHORITY, O. H. (n.d.). *The Oregon Death With Dignity Act – Statute.* [online] [Retrieved February 5, 2020] Available at: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ors.aspx.
BEAUCHAMP, T. & CHILDRESS, J. (2013): *Principles of biomedical ethics.* New York: Oxford University Press.
DWORKIN, R. (1977): *Taking rights seriously.* Cambridge: Harvard University Press.
DWORKIN, R. (1993): *Life's dominion.* New York: Knopf.
GANDSMAN, A. & BURNIER, D. (2014): "Can't you at least die with a little dignity?" The Right to Die. In: *Bioéthique Online*, 3(8), [online] [Retrieved February 5, 2020] Available at: https://papyrus.bib.umontreal.ca/xmlui/handle/1866/10945
GENTZLER, J. (2003): What is a death with dignity? In: *Journal of Medicine and Philosophy*, 28(4), pp. 461–487.
HURSTHOUSE, R. (2013): *Virtue ethics*. [online] [Retrieved February 5, 2020] Available at: http://plato.stanford.edu/archives/fall2013/entries/ethics-virtue/
KANT, I. (2012): *Groundwork of the metaphysics of morals.* Cambridge: Cambridge University Press.
NUSSBAUM, M. (2008): Human dignity and political entitlements. In: A. Schulman (ed.): *Human dignity and bioethics*: *Essays commissioned by President's Council on Bioethics*. Washington: President's Council on Bioethics, pp. 351–380.
SUMNER, L. W. (2011): *Assisted death: A study in ethics & law.* Oxford: Oxford University Press.
VELLEMAN, J. (1999): A right to self-termination? In: *Ethics*, 109(3), pp. 606–628.
YOUNGER, S. & KIMSMA, G. (2012): *Physician-assisted death in perspective.* Cambridge: Cambridge University Press.
ZYL, L. v. (2000): *Death and compassion: A virtue-based approach to euthanasia.* Farnham: Ashgate.

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The limits of libertarianism in debates over euthanasia and the application of moral fictionalism in bioethics[1]

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Abstract
This text focuses on selected basic arguments of libertarianism that could be found in certain debates on the moral issues of euthanasia and the application of moral fictionalism in bioethics. Firstly, I devote my article to the criticism of libertarian arguments (as one of the dominant discourses related to the debate over euthanasia) in a wider perspective of moral philosophy. The article is based on an approach that understands morality as a kind of social practice and the primary goal is to grasp the key theoretical concepts which are included in the mechanism for identifying and assessing our moral intuitions. This text is primarily an analysis of selected arguments of current normative theories of libertarianism on two levels: first it examines the idea of self-ownership in connection with certain debates over euthanasia, while the latter part of the article concerns an analysis of the critique of libertarian arguments and a comparison of the alternative arguments of moral fictionalism. The last part of this text, focusing on moral fictionalism and its general application in bioethics, is the core of the article.

Keywords: bioethics, euthanasia, liberalism, libertarianism, moral fictionalism, self-ownership

Introduction

Public debates on euthanasia have featured many difficult moral dilemmas. Some people offer as a universal solution to act according to the simple slogan "My body, my choice!" It's not only the slogan of some public demonstrations but this point of view belongs to the philosophical approach of libertarianism and partly also liberalism. It's a version of the well-known libertarian concept/principle of self-ownership. Not only for this reason do I think that libertarianism is one version of current pre-theoretical moral beliefs. I also suppose that normative theories can partly influence our moral practices. For these reasons it is necessary to analyse this point of view and connected opinions.[3]

Firstly, in this article, I would like to focus on selected basic arguments of current normative theories of libertarianism on two levels: first of all I would examine the idea of self-ownership in connection with some debates on moral issues of euthanasia, while in the second part of my text, I shall focus on an analysis of the criticism of libertarian arguments, mainly the concept of self-ownership as one of the dominant discourses related to the debate on euthanasia. In some cases, I shall compare selected alternative arguments, but I don't want to defend certain current normative theories, e.g. evaluating euthanasia cases from perspective utilitarianism or Kantianism. The core of this article is the last part that concerns the application of moral fictionalism in bioethics. It is for me a general alternative approach to the issues of bioethics.

As for methodology, my approach is based on a wider perspective of moral philosophy. My analysis is based on an approach that understands morality as a kind of social practice.

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[3] I view morality, as many thinkers do, as a kind of social practice, rather as an expression of theory. But moral theorizing is, according to this view, a part of moral practice. "It is a way of trying to ensure that the moralizing of ourselves and others is defensible [...] Moral theories, the abstract conceptions that we study in moral philosophy, are derivative of moral theorizing [...] We use these abstract structures for various purposes: to grade and categorize agents, acts, and outcomes; to relate to various religious beliefs and cultural outlooks; to evaluate, analyse, extend, and so on" (Jamieson, 1993, pp. 479–480).

However, on the level of metaethics, I agree with the opinion that statements of moral philosophy about justice and other themes of morality are not empirically verifiable or falsifiable.

The primary, general goal of my analysis is to grasp the key theoretical concepts which are included in the mechanism for identifying and assessing our moral intuitions. Specifically, it means identifying the discrepancies in the concept of self-ownership and to test the concept of self-ownership and to use moral fictionalism as an alternative approach. I believe that the interpretation provided by libertarian philosophers is not very persuasive or suitable for debates about issues of euthanasia and general issues of bioethics.

Libertarianism, self-ownership, and euthanasia

The viewpoints that combine to make up libertarianism include many different opinions, however the concept of self-ownership is one of the main ideas (see Cohen, 1995). I apply the term libertarianism essentially as a rights-based ethical philosophy and I mean that the concept of self-ownership is probably used more by right-wing libertarians. But I don't make differences among various groups of libertarian thought in this presentation, e.g. left-wing or right-wing political libertarianism, since the motto or slogan "My body, my choice!" is used by many left- and right-wing representatives of libertarianism (see, e.g., Fabre, 2006). And it is necessary to add again that it is also used by some liberals.

A basic kind of the libertarian argument has the following form:

> "1. Every moral agent is a self-owner. 2. To be a self-owner implies very weighty rights over one's own body, as well as (under the right circumstances) weighty rights to acquire, hold, and transfer property at one's will. 3. For the modern nation-state to produce (most) regulation, paternalistic laws, public goods, and social insurance, it has to violate these rights. 4. Therefore, the modern nation-state is to that extent unjust" (Brennan & van der Vossen, 2018, p. 200).

One of the founders of liberalism and an inspiration of libertarianism, John Locke, already assumed and claimed that the right to life is connected with the individual's ownership of his own body or life (see Locke, 1988). From this perspective, self-ownership is a core point, the basis of full rights of control. It means the right to determine the use of oneself, decisions may not be taken against a person without his/her consent against his/her will. More precisely, we can think of self-ownership as being made up of two variables: on the one hand, self-ownership offers protections against unwanted incursions on one's person; on the other hand, self-ownership offers the freedom to use one's person (Brennan & van der Vossen, 2018, p. 208). It offers a principled objection to clearly objectionable forms of paternalism or legal moralism (Brennan & van der Vossen, 2018, p. 200). This view is based on the general liberal thesis that each person has the right to live their own life as they see fit, consistent with the same rights for others.

These views and opinions are also possible to find in debates about various medical issues. Most liberals agree that people at least have rights to make medical decisions about their bodies. For example, Jessica Flanigan defends a broadly libertarian approach to medicine and mainly argues against medical paternalism (Flanigan, 2017; Flanigan, 2018). Her main idea is that people's bodily rights extend beyond the mere right to refuse medical treatment and also include the right to choose and access medical treatment (Flanigan, 2018, p. 405).

This libertarian tradition of the opinion that we do own ourselves is also the foundation for some arguments in defense of the right to assisted suicide or a voluntary, non-compulsory kind of euthanasia. If a willing partner can be found, euthanasia is possible. This is not only a philosophical defense. Some liberal political philosophers claim that the right to autonomy must also be a constitutional right, if we want a guarantee of personal autonomy. In the case of

euthanasia, people should be free to choose for themselves whether they wish to ask for the ending their life.

The liberal and libertarian statement of the right to die was established by Ronald Dworkin, Robert Nozick, Judith Thomson, John Rawls, T. M. Scanlon, and Thomas Nagel in 1997 for two Supreme Court cases that addressed whether patients had the constitutional right to die. In their text named 'The Philosophers' Brief', these thinkers argued that a person's interest in making end-of-life decisions is "[...] a central part of the more general right to make 'intimate and personal choices' for himself that a failure to protect that particular interest would undermine the general right altogether" (Dworkin et al., 1997).[4]

The limits of libertarianism

What are the problematic aspects contained in the slogan 'My body, my choice!' as a mirror of the concept of self-ownership? If we use the concept of self-ownership as an opinion of absolute ownership, this concept is highly controversial. For example, full self-ownership may permit voluntary enslavement because people have the right to control their own utilization. That's that they also have the right to transfer their rights over their persons to others, for example through sale or gift. However, some libertarians deny that these kinds of transfers are possible, e.g. it's morally impossible, because such transfers undermine our autonomy (Grunebaum, 1987).

The concept of self-ownership, statements like "My body, my choice!" or "I am the owner of my own body", are essentially metaphorical. The metaphorical character of this concept is maybe misleading or confusing. What is usually owned is something other than oneself as an embodied individual. The owner does not distinguish from what is owned in this case. But this is not such an essential objection as other more important objections.

Some libertarians use the self-ownership hypothesis as not based on an opinion of absolute ownership and reject full self-ownership. According to this view, we own different things in different ways, that is why rights that constitute ownership varies from thing owned to thing owned, and also the strength of these rights varies (Brennan & van der Vossen, 2018, p. 208). As pointed out by some libertarians: "[...] disputes between libertarians and left liberals are not really about whether individuals are self-owners but rather about which conception of self-ownership is the correct one" (Brennan & van der Vossen, 2018, p. 200). In the debate between liberals and libertarians, the debate is over which liberties are basic and non-conventional. In the state of nature we cannot evaluate the justice of purported liberal rights. On face value, this argumentation works equally well against liberalism as it does against libertarianism. It is a very important point used when raising objections against this type of rights-based argumentation.

Weakened conceptions of self-ownership have a complicated structure. If self-ownership has multiple dimensions that can be weakened in light of competing considerations, it loses some of its theoretical appeal and then it is complicated to use it as a foundational principle. Libertarianism is also weakened in cases that deal with under-age persons. As a solution, it is proposed to make under-age children the responsibility of their parents, but this view means that the under-aged child is not a fully-fledged person. The same problem also comes up in the

[4] See also: "'The philosophers' brief' answers these questions in two steps. First, it defines a very general moral and constitutional principle – that every competent person has the right to make momentous personal decisions which invoke fundamental religious or philosophical convictions about life's value for himself. Second, it recognizes that people may make such momentous decisions impulsively or out of emotional depression, when their action does not reflect their enduring convictions; and it therefore allows that in some circumstances a state has the constitutional power to override that right in order to protect citizens from mistaken but irrevocable acts of selfdestruction. States may be allowed to prevent assisted suicide by people who – it is plausible to think – would later be grateful if they were prevented from dying" (Dworkin et al., 1997).

case of incompetent individuals. A solution is that someone close to the incompetent patient should make decisions for that patient. There are, for example, dangers of conflicts of interests between the decisions of a patient and family members or others surrogates.

The slogan 'My body, my choice!' and the concept of self-ownership is connected to the idea that a person is differentiated from other people as an individual agent. This idea doesn't indicate the social level of an individual life. But the decision to die by euthanasia affects other people. In the case of assisted suicide, the patient needs someone who practices euthanasia. There is also the need of a health system. This system needs institutionalized rules for the practice of legal euthanasia. And it is not possible, without the social consensus and the forced solidarity of those who refuse to join the consensus even if assisted suicide is legal only on a purely private basis, because such transactions would have to enjoy state protection like any other market transaction. The decision for one particular euthanasia is the decision of one particular person. But the possibility of legal, institutionalized assisted suicide is the decision of the whole society.[5]

I think that if we deny the concept of self-ownership, we can also question the form of the libertarian and liberal concept of autonomy. As already mentioned, liberal and libertarian political philosophers claim that there is the right for autonomy that should be the constitutional right to assisted suicide. They say: if we should guarantee some other rights in the name of autonomy so that the people can be free to choose for themselves, should it be the freedom to ask for the assistance of a physician in ending their life.

According to the contemporary philosopher Michael Sandel (Sandel, 2010), we need to engage with the moral ideas underlying our political debates, and I add, including the issues of euthanasia. In the case of euthanasia the question arises: would a constitutional law in the name of autonomy, guaranteeing the right to physician-assisted suicide, be neutral among competing conceptions of the good life? His answer is that autonomy-based right to assisted suicide would change the law in favour of one of the notions of the good life. Because not all moral views think of life or of a good life as a product of a human creation, as human beings or as the possession of the person who lives it (see also Sandel, 2015).

The conception of the good life according to a person's autonomy as a basis to defend a right to assisted suicide may not even be acceptable for many liberal philosophers who defend the concept of autonomy. For example, current Kantian philosophers also defend the right to assisted suicide because it guarantees our personal dignity (see Hill, 1991; Dworkin, 1993). But Immanuel Kant rejected the idea that we have the right to suicide, it's at odds with autonomy (Kant, 1964, p. 398). According to Kant's perspective, one's own life isn't one's own, it's not a possession, because moral law commands respect for humanity.[6]

It does not follow from these notions that libertarians are wrong to defend a terminally ill patient's right to choose assisted suicide under certain conditions. But the debate over assisted suicide and the debate about the liberal and libertarian form of autonomy isn't really neutral among competing conceptions of the good life, or of the best way to live.

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[5] In this paragraph, I was inspired by the philosopher M. Škabraha's reflection on assisted reproduction (Škabraha, 2016).

[6] Sandel also comments on this point of view in this way: "His [Kant] point is that only the motive of duty – doing something because it's right, not because it's useful or pleasing or convenient – confers moral worth on an action. He illustrates this point with the example of suicide. Most people go on living because they love life, not because they have a duty to do so. Kant offers a case where the motive of duty comes into view. He imagines a hopeless, miserable person so filled with despair that he has no desire to go on living. If such a person summons the will to preserve his life, not from inclination but from duty, then his action has moral worth. Kant does not maintain that only miserable people can fulfill the duty to preserve their lives. It is possible to love life and still preserve it for the right reason – namely, that one has a duty to do so. The desire to go on living doesn't undermine the moral worth of preserving one's life, provided the person recognizes the duty to preserve his or her own life, and does so with this reason in mind" (Sandel, 2010, pp. 113–114).

To claim certain rights means to make certain claims on society. But in order to create the conditions for fulfilling those demands, society must reciprocally place certain claims on us as individuals. The concrete degree of fulfillment of rights and obligations is connected with social debate, disputes, conventions and laws. It is important know that rights are neither natural nor universal.[7]

We attribute rights to each other in response to the experience that we as a society (or humanity) experience. Maximizing personal freedom, compatible with the same degree of freedom for others, is a principle that, according to our historical experience, helps to create a better society, with better decision-making processes. Human rights are a tool to build such a society. But these tools are useless if we understand rights as a kind of individual property and not as something that is rooted in reciprocity and thus in the ability to empathize with others and to understand their desire for the best life possible.[8]

Moral fictionalism and its application in bioethics

Bioethics is applied ethics that focuses on specific moral issues such as euthanasia. In my opinion, the above mentioned limits of libertarianism in the debate on euthanasia show certain general errors in thinking about normative judgments. Therefore, it is also necessary to remove these errors from the general debate on bioethical issues. In this section, firstly, I focus on how to discuss ethics, moral norms and values. Secondly, I try to show how this approach could be applied in the field of bioethics.

The issues of morality and moral judgment are dealt with the philosophical discipline of metaethics. "For among its central questions are the questions whether any moral claims are true, and whether it is rational to commit oneself to acting morally" (Copp, 2006, p. 6).[9] David Hume was among the first significant modern critics of our natural understanding of morality from metaethical positions. He believes that when we use normative term 'ought to' in our moral judgements, we have to explain and also express some new relation or affirmation that has arisen from using this term. It is necessary to observe and explain it.[10] According to my

[7] I would like to refer to some basic notes made by the historian and philosopher Y. N. Harari. In his popular TED speech titled *What explains the rise of humans?* Harari says: "Take a human being, cut him open, look inside, you will find the heart, the kidneys, neurons, hormones, DNA, but you won't find any rights. The only place you find rights are in the stories that we have invented and spread around over the last few centuries. They may be very positive stories, very good stories, but they're still just fictional stories that we've invented" (Harari, 2015). Basically, this is a popular version of moral theories of cognitivist realism or cognitivist anti-realism. It is also my point of view.

[8] Other types of arguments dedicated to the problems with 'Assisted suicide: The philosophers' brief' made F. M. Kamm (Kamm, 2013, pp. 42–52). She presents these counterarguments: "(i) that intending patients' deaths against their wishes does not alone make not-aiding impermissible, and (ii) that whether in the presence or absence of intending patients' deaths against their wishes, killing can be impermissible while letting die is not impermissible" (Kamm, 2013, p. 44).

[9] In more detail: "In meta-ehics we are concerned not with questions which are the province of normative ethics like 'Should I give to famine relief?', or 'Should I return the wallet I found in the street?', but rather with questions *about* questions like these. What does the 'should' in such question mean? Does it signal that these questions are about some matter of facts? If so, then how do we justify giving one answer rather than another? In other words, what sort of facts are moral facts? In what sense is a moral argument simply a species of rational argument? And if the 'should' does not signal that moral questions are about a matter of fact then, again, how do we justify giving one answer rather than another to such questions? In other words, what is its point of function? What is the standard against which a good moral argument is to be measured?" (Smith, 1994, p. 2).

[10] "In every system of morality, which I have hitherto met with, I have always remark'd, that the author proceeds for some time in the ordinary way of reasoning, and establishes the being of a God, or makes observations concerning human affairs; when of a sudden I am surpriz'd to find, that instead of the usual copulations of propositions, is, and is not, I meet with no proposition that is not connected with an ought, or an ought not. This change is imperceptible; but is, however, of the last consequence. For as this ought, or ought not, expresses some new relation or affirmation, 'tis necessary that it shou'd be observ'd and explain'd; and at the same time that a reason shou'd be given, for what seems altogether inconceivable, how this new relation can be a deduction from

counter-arguments mentioned above, I believe that libertarianism does not meet the demands of Hume's critique.

Due to the scope of my article, I cannot focus on other tests of normative ethics, such as Moore's Open Question Argument,[11] in general (not only against libertarianism), therefore I will try to propose an alternative approach in a straightforward manner. First, one thing needs to be taken into account. The findings of evolutionary biology, psychology and ethics show that morality is a somewhat natural feature of human nature, but that does not mean that our moral judgements reflect objective reality or the realm of objective moral facts (see Haidt, 2012). As Richard Joyce, whose concept of morality I will discuss further, writes, the current research of human morality implies only that moral judgements operate to something more resembling encouraging successful social behavior (Joyce, 2006).[12]

In my opinion, so-called fictionalism is best resisted in debates about norms and beliefs in metaethics and ethics, because its goal is not to produce truths about reality.[13] Fictionalism is intended as a theory with certain advantages, which it can offer without being true. That means we do not have to seek confirmation of our belief in the (universal) truthfulness of our morality – which in turn leads to errors (as in the analyzed case of libertarianism) –, because we are able to refute it with reason. But that does not necessarily mean a rejection of morality. A representative of fictionalism, M. E. Kalderon (2005), proposes accepting moral statements as if they were true (full acceptance) or temporary (tentative acceptance). The starting point of Joyce's moral fictionalism – Joyce being another author of this approach – is Mackie's 'Theory of Error'. Mackie claims that: "If there were objective values, then they would be entities or qualities or relations of a very strange sort, utterly different from anything else in the universe. Correspondingly, if we were aware of them, it would have to be by some special faculty of moral perception or intuition, utterly different from our ordinary ways of knowing everything else" (Mackie, 1977, p. 38). But Mackie argued that there are no moral facts and that all basic moral claims are false.[14] According this theory moral facts do not exist, but with a connection with fictionalism we can see that fiction also evokes real emotions in us, which can motivate action, and for this reason fictions are also practical for our moral acts. Currently, this idea is being developed by Joyce. I will now concentrate especially on Joyce's concept of fictionalism in his book *The myth of morality* (Joyce, 2003).

Joyce holds the hypothesis that morality is an enhancement of reproductive fitness and the role of morality is to act as a kind of 'internalized authority' against the temptations of short-term profit (Joyce, 2003, pp. 206–213).[15] According to Joyce a different kind of advantage of moral thinking is that: (i) morality provides a strong foundation for 'moralistic aggression' towards variable defectors; (ii) moral framework "[…] may also provide something of a shared experience of value which binds a community together"; or (iii) morality is "[…] a familiar and widespread way of understanding our relations to each other, and therefore to abolish it

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others, which are entirely different from it. But as authors do not commonly use this precaution, I shall presume to recommend it to the reader; and am perswaded, that this small attention wou'd subvert all the vulgar systems of morality, and let us see, that the distinction of vice and virtue is not founded merely on the relations of objects, nor is perceiv'd by reason" (Hume, 2007, p. 302).

[11] See Moore's book *Principia Ethica* (1993).

[12] The cognitivist anti-realism of Joyce also stands the test of Moore's Open Question Argument.

[13] Apart from fictionalism, another approach that rejects the traditional notions of morality, is e.g. amoralism (see Mark, 2013).

[14] "Mackie held that the moral properties, if there were any, would be intrinsically normative. *Rightness* would have "to-bedoneness" built into it. He thought that such a property would be 'queer', and unlike 'anything else in the universe'. He therefore concluded that there are no such properties (Copp, 2006, p. 9).

[15] Joyce argues: "[...] the instrumental value of moral beliefs lies in their combating of weakness of will, their blocking of the temporary revaluing of outcomes that is characteristic of short-sighted rationalizations, their silencing of certain kinds of calculation" (Joyce, 2003, p. 215).

entirely may bring anxiety and confusion" (Joyce, 2003, p. 228). And for this reason the moral fictions – and rules derived from them – may be practical instruments for our society and for our lives. And how can such statements and this philosophical position be useful for debates over issues of bioethics? Joyce in his book presents an example of the ethics committee of a hospital trying to work out the optimal and ethical means of allocating funds (Joyce, 2003, pp. 219–220). He writes:

> "Personally, I don't find it at all implausible to claim that combating the temptations of short-term profit is important even there. But even if that were not so it may still be useful to each individual if she thinks in moral terms since this will support and encourage her tendency of doing so in personal 'temptation situations' […] Suppose that members of the hospital ethics committee are moral fictionalists […] An important point to stress is that even if this were true, it would not follow that the deliberations of the committee are uncritical" (Joyce, 2003, p. 219).

The use of fictionalism brings several advantages over commonly accepted morality. I believe that the most important advantage is that it can make ethical decisions (in this specific situation decisions of the commission) without being bound by any particular morality. "The whole point of the moral fictive stance is that it is a strategy for staving off inevitable human fallibilities in instrumental deliberation" (Joyce, 2003, p. 223). Joyce also adds that the community may continue to require those who break agreements to suffer from 'moralistic aggression', or that those who do not sufficiently express such condemnation of opponents are themselves rejected. However, the motivation for such moral behavior in the case of moral fictionalism is different than in the case of common normative ethics.

The adoption of the above-mentioned and presented theories such as Hume's critique of normative thinking, Mackie's theory of error, or Joyce's theory of moral fictionalism, leads to the conviction that the moral character of man exists but there are no moral imperatives as separate moral facts. In my opinion, that is the reason why we need to take a position of pluralism when considering moral dilemmas or judgements. What does it mean to take a position of pluralism? Morality can be understood from several different basic perspectives. From the perspective of universalism, relativism, nihilism, or pluralism. From the perspective of universalism exist (in our debates on ethical issues) universally valid normative moral norms. From the position of relativism, it is claimed that morality is always relative, either because it is subjective or because it is culturally conditioned. According to the theories of nihilism, there is neither general truth nor general morality. However, pluralism means that we recognize the existence of moral systems (even only as social constructs) and measure and select their advantages and disadvantages. Pluralism is an approach to measure of values. We apply selected concepts in a social or personal value system, etc. The perspective of pluralism is thus interconnected both with the above mentioned fictionalism and with the evolutionary concept of morality as a mechanism of adaptation.[16] Compared to that, universal ethical theories (such as libertarianism, kantianism, utilitarianism, but also strongly advocated liberalism) are controversial precisely because of their universalism, which can create a dogmatic position put forward as a universal truth.

I think that we need a critique of a particular attempt to derive normative conclusions form universalistic ethics in debates over issues of bioethics. This critique is presented in moral fictionalism. Applying this perspective to the debate about euthanasia means that we are looking for solutions that meet the criteria of 'usefulness', pragmatism, etc. This approach can

[16] It is also possible to define certain meta-ethical pluralism. Joyce points out how both moral naturalism and moral scepticism may be permissible positions: that certain forms of moral naturalism may be maintained, but the moral error theory may also be maintained (Joyce, 2006, pp. 89–105).

also be called pragmatic empiricism.[17] This kind of objective secular ethics satisfying the criteria of usefulness or pragmatism is e.g. a concept of Harm:

> "[...] a system of 'everyday morality' which is founded on the concept of Harm, and which treats conduct as immoral primarily when it causes unjustifiable harm to others. This form of ethics does not presuppose any controversial theory of value, and it constitutes the viewpoint from which the author defends physician-assisted suicide. A doctor who helps a patient die – or who causes the patient's death on his own request – does not cause that individual harm if he/she has only a period of life filled with pain left" (Hříbek, 2010, p. 749).

An important element of this article is to show moral fictionalism and its applications in bioethics. The arguments for moral fictionalism are used in opposition to libertarian arguments often found in the debate on the issue of euthanasia. The most important advantage of moral fictionalism is that it can make ethical decisions without being bound by any particular morality except scientific discoveries. On the other hand, the approach of moral fictionalism can have some weakness. Adopted fictionalism can be too abstract without a stable point for moral judgment and lead to wide pluralism. In this case, this ethics itself may become a source of decision paralysis. For this reason, moral fictionalism could be defined throughout some restrictive rules, regulating and limiting mechanisms, which are introduced to avoid overfilling the moral system. In this context, in debates on euthanazia, it is possible to use the above-mentioned principles of compassion, protection and respect, or the concept of Harm. But also these concepts may be problematic, because they also have the significant disadvantage of ambiguity and variability. Therefore, the ethical approach of fictionalism needs another debate about its definiton, rules, regulating and limiting mechanisms.

Conclusion

We all take it for granted that we have a body. However, there is no subjectivity without intersubjectivity. It is the formation of the most individual – the personality and his/her inner life – that is most and most delicately dependent on reciprocal relationships with others. Does the body have to belong to someone? Is it not that I belong to my body at least to the same extent? The possessive pronoun in slogan "My body, my choice!" maybe isn't a practical idea for our debates on euthanasia, because in this slogan a person uses an idea of essentialism which is very controversial. It is necessary to view humanity and personality as something that is ascribed to the individual and what the individual further creates (and, in turn, affects the ideas of others, which in turn affect him/ her). None of us have our identity, personality, body, or even mind in our hands. 'Self-ownership' is an illusion. And it is necessary to say that it is a historical concept arising from liberalism and the so-called WEIRD morality: Western, Educated, Industrialized, Rich, Democratic systems of values (see Haidt, 2012). It's not a universally valid idea. Of course, if it is the act of decision itself, it must be taken on by the individual. However, if it is a decision-making process, it can be the decision of a number of additional votes or the whole society. I advocate moral fictionalism as an alternative approach

[17] Secular objectivistic moral theory is applied, e.g., in J. Rachels' *The end of life: Euthanasia and morality* (Rachels, 1986); or D. M. Hester provides this sort of moral approach in his book *End-of-life care and pragmatic decision making*, a philosophical framework based on a radically empirical attitude toward life and death: "As patients move through the dying process, our care for and about them must keep them in mind – not cookie-cutter care, but sensitive to their life stories and to those of their families and the communities of which they are a part. Taking seriously a radically empirical approach to patient care that encompasses patient experiences as integral to medical decision making, and helping to provide the space and tools for development of the final chapters in the lives of dying patients, is a morally significant act that we must continually take seriously, vigilant in our attempts to create some manner in which a peaceful death can prevail" (Hester, 2010, p. 161).

to pragmatic empiricism, but it is still true that: "[…] so long as we live in a world of imperfect rationality and epistemological fallibility, morality has a place" (Joyce, 2003, p. 230). Applying this perspective to the debate on euthanasia and the issues of bioethics means that we are looking for solutions that meet the criteria of 'usefulness', pragmatism, etc.

I hope that I have pointed out some important arguments why it is better to substitute the concept of self-ownership although the limits of libertarianism arguments don't implicate that euthanasia is inherently morally wrong. The concept based on the notion of our body as property contains a number of issues. In the perspective I have presented, which is admittedly more complicated and less easily pictured than the metaphor of ownership, persons are what they are because of their relationships with one another. And this must be a foundational principle for our debates on euthanasia. I believe that better principles are compassion, protection and respect, or the concept of Harm.

References

BRENNAN, J. & VOSSEN, B. van der (2018): The myths of the self-ownership thesis. In: J. Brennan, B. van der Vossen & D. Schmidtz (eds.): *The Routledge handbook of libertarianism*. New York: Routledge, pp. 199–211.

COHEN, G. A. (1995): *Self-ownership, freedom, and equality*. New York: Oxford University Press.

COPP, D. (ed.) (2006): *The oxford handbook of ethical theory*. Oxford: Oxford University Press.

DWORKIN, R. (1993): *Life's dominion. An argument about abortion, euthanasia, and individual freedom*. New York: Alfred A. Knopf.

DWORKIN, R., NAGEL, T., NOZICK, R., RAWLS, J., SCANLON, T. & THOMSON, J. (1997): *Assisted suicide: The philosophers' brief, New York Review of Books 44* (March 27, 1997). [online] [Retrieved January 6, 2020] Available at: https://cyber.harvard.edu/bridge/Philosophy/philbrf.htm

FABRE, C. (2006): *Whose body is it anyway? Justice and the integrity of the person*. Oxford: Clarendon Press.

FLANIGAN, J. (2017): *Pharmaceutical freedom*. Oxford: Oxford University Press.

FLANIGAN, J. (2018): *A libertarian approach to medicine*. In: J. Brennan, B. van der Vossen & D. Schmidtz (eds.): *The Routledge handbook of libertarianism*. New York: Routledge, pp. 405–416.

GRUNEBAUM, J. (1987): *Private ownership*. New York: Routledge & Kegan Paul.

HARARI, Y. N. (2015): What explains the rise of humans? In: *TED Ideas worth spreading* [online] [Retrieved January 13, 2020]. Available at: https://www.ted.com/talks/yuval_noah_harari_what_explains_the_rise_of_humans

HESTER, D. M. (2010): *End-of-life care and pragmatic decision making*: *A bioethical perspective.* Cambridge: Cambridge University Press.

HŘÍBEK, T. (2010): Za etiku bez teologie. K článku Marka Váchy o eutanazii. [For ethics without theology: On Marek Vácha's article on euthanasia]. In: *Filosofický časopis*, 58(5), pp. 729–749.

HAIDT, J. (2012): *The righteous mind: Why good people are divided*. New York: Pantheon Books.

HILL, T. E. (1991): *Autonomy and self-respect*. Cambridge: Cambridge University Press.

HUME, D. A. (2007): *Treatise of human nature*. Oxford: Clarendon Press.

JAMIESON, D. (1993): Method and moral theory. In: P. Singer (ed.): *A companion to ethics*. Oxford: Wilie-Blackwell, pp. 476–487.

JOYCE, R. (2003): *The myth of morality*. Cambridge: Cambridge University Press.

JOYCE, R. (2006): *The evolution of morality*. Cambridge: MIT Press.

KALDERON, M. E. (2005): *Moral fictionalism*. Oxford: Clarendon Press.
KAMM, F. M. (2013): *Bioethical prescriptions: To create, end, choose, and improve lives*. Oxford: Oxford University Press.
KANT, I. (1964): *Groundwork for the metaphysics of morals*, trans. H. J. Paton, New York: Harper Torchbooks.
LOCKE, J. (1988): *Two treatises of government*. Cambridge: Cambridge University Press.
MACKIE, J. L. (1977): *Ethics. Inventing right and wrong*. London: Penguin Books.
MARKS, J. (2013): *Ethics without morals*: *In defense of amorality*. New York: Routledge.
MOORE, G. E. (1993): *Principia Ethica*. Cambridge: Cambridge University Press.
RACHELS, J. (1986): *The end of life: Euthanasia and morality*. Oxford & New York: Oxford University Press.
SANDEL, M. (2010): *Justice: What's the right thing to do?* New York: Farrar, Strauss and Giroux.
SANDEL, M. (2015): *Physician-assisted suicide*. [online] [Retrieved January 13, 2020]. Avaliable at: https://www.youtube.com/watch?v=NRMRpqBSKNw
SMITH, M. (1994): *The moral problem*. Oxford: Blackwell.
ŠKABRAHA, M. (2016): Naše těla, naše volba [Our bodies, our choice]. In: *Deník Referendum*, October 16, 2016 [online] [Retrieved January 6, 2020] Available at: http://denikreferendum.cz/clanek/tisk/23925-nase-tela-nase-volba

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The Liverpool Care Pathway for the dying patient: Euthanasia through the back door, or the sign of poor death education?[1]

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Abstract
The Liverpool Care Pathway for the Dying Patient (LCP) was an integrated care pathway for patients in the final days or hours of life, developed at the Royal Liverpool University Hospital in conjunction with the Marie Curie Palliative Care Institute, Liverpool. The LCP became increasingly the normative style of care for patients in the terminal stage across NHS England from the 1990s onwards. Following significant questions raised in Parliament, by the media and other stakeholders, an independent review panel was established under Baroness Neuberger in 2013 to investigate the LCP. The findings of the panel were published as *More Care Less Pathway: a Review of the Liverpool Care Pathway* identifying significant failings in the delivery of the LCP thus leading to it being phased out some six months later. Rather than being euthanasia through the backdoor, many of the criticisms of the LCP and its poor implementation are indicative of poor communication, limited knowledge of the dying process and a paucity of death education.

Keywords: The Liverpool Care Pathway, communication, culture shift & death education

Introduction

During the 1990s there was a concerted effort to develop Integrated Care Pathways across the National Health Service in the United Kingdom, this American market-based model of healthcare was created in the 1980s to be of benefit to patients by focusing upon the work of multi-disciplinary teams providing the best standard of care and to be more cost effective for insurance companies. The Liverpool Care Pathway for Adults in the Last Days and Hours of Life (the LCP) was developed using this model, through applying the principles of hospice style care to this pathway approach; it became the normative style of care for terminally ill patients for over a decade in parts of the United Kingdom. Following significant questions raised in Parliament, a campaign by the media and other stakeholders, with the particular charge that the LCP was euthanasia through the back door, the British Government established an independent review panel in 2013 to investigate the claims being made against the LCP. The panel's findings: *More Care, Less Pathway: A Review of the Liverpool Care Pathway* identified significant failings in the delivery of the LCP (Neuberger et al*.,* 2013), but that the LCP itself was a good tool for the provision of care, the panel recommended that the LCP be phased out over the following six to twelve months. The key finding of the *Review* was that the LCP had been implemented poorly, primarily due to a lack of poor communication with relatives who often had a limited knowledge of the dying process. Consideration of the failures of the LCP cannot be confined to the academic and medical world alone, rather the perceived failings of the LCP are indicative of the problems in discussing death and dying in wider society and that death education might alleviate such problems in the future.

[1] The paper was presented at the international conference *End of Life and Euthanasia – Intersection of Issues and Questions* held in Prague (Czech Republic) on 4–5 November 2019.

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The Liverpool Care Pathway

The LCP was developed at the Royal Liverpool University Hospital in conjunction with the Marie Curie Palliative Care Institute in the early 1990s (Kinder & Ellershaw, 2003, p. 11). Much of the earliest work in developing the LCP was to help patients with cancer, but the scope was widened for all patients in the terminal phase. The key aim of the LCP was to provide the best hospice style care for the terminally ill, be they in a hospice, an acute hospital, a care home or living in the community. Integral to the LCP was the training of healthcare staff across an organisation to provide qualitative Palliative Care, without having to involve the limited resources of Palliative Care specialists on a case by case basis (Kinder & Ellershaw, 2003, p. 11). Only those who had been diagnosed as dying could be placed on the LCP (Kinder & Ellershaw, 2003, p. 11), namely that they were in the active dying phase with "the body shutting down and the person … letting go" (Neuberger et al., 2013, p. 14). The approach was goal-orientated, and the specific goals were to be achieved over three phases. The first two phases of the LCP focus upon the physical, spiritual, psychological and emotional care of the patient, and include communicating with the patient, family and General Practitioner. The first phase of the LCP involved thoroughly assessing the patient's condition, including common symptoms in the dying phase, such as: inability to swallow, nausea, vomiting, constipation, confusion, agitation, restlessness, distress, urinary tract problems, need of a catheter, respiratory tract problems or pain (Kinder & Ellershaw, 2003, p. 19). Having made such an assessment, the healthcare team decide whether non-essential medication and inappropriate interventions such as blood tests, antibiotics, I.V. fluids, should be discontinued and whether to increase or introduce medication for pain relief or to ease symptoms, such as those stated above (Kinder & Ellershaw, 2003, p. 19). The initial assessment included addressing issues such as cardio-pulmonary resuscitation, religious and spiritual support, communicating with the family and others with matters such as who is to be informed when the patient dies, and that the LCP and its use be explained and discussed with the family (Kinder & Ellershaw, 2003 p. 20).

Once these initial goals had been achieved, the second phase begins, with assessing the patient's condition on regular four hourly intervals including levels of pain and symptom management (Kinder & Ellershaw, 2003, p. 19) and addressing any needs such as increasing the use of opioids. The second phase also involved meeting the psychological and emotional needs of the patient and his or her carers (Kinder & Ellershaw, 2003, p. 19). This second phase continues until the patient dies, no matter how long that may be, unless the patient is deemed fit to be taken off the LCP. The third phase of the LCP occurs after the patient has died and includes following local hospital protocols, as well as focusing upon the needs of grieving relatives (Kinder & Ellershaw, 2003, pp. 26–27).

The LCP was endorsed by the UK Government and implemented across National Health Service England (Department of Health, End of Life Care Strategy, 2008, pp. 66-67), and subsequently National Health Service Scotland and Health and Social Care Northern Ireland; the Welsh Government together with the National Health Service Wales developed the *All Wales End of Life Care Pathway for the Dying Patient*, based on the LCP (Welsh Assembly Government, 2006, 30). The LCP became normative for patients in the terminal stage across the United Kingdom; in 2013: "130,000 of the 450,000 patients who die in hospital care every year die while being cared for on the pathway" (*Hansard*, 2013, Vol. 556). The LCP was also in use in more than 20 different countries, with pilot schemes taking place in Argentina, Italy, India, The Netherlands; some of which incorporated the LCP into their healthcare settings (McCartney, 2012, p. 345; Cauldwell & Stone, 2015, pp. 94–98; Zinner, 2013a, pp. 30–31; Zinner, 2013b, pp. 27–28; Veerbeek, 2008; Smeding, Bolger & Ellershaw, 2011, pp. 190–205). A significant voice that heralded the introduction of this approach to care was that of Dame

Cicely Saunders, founder of St Christopher's Hospice in London, and pioneer of modern hospice care (Ellershaw & Wilkinson, pp. v–vi). With such positive endorsements for the focus on patient-centred care, based upon the well proven practice of hospice care in which the sick person with all his/her needs being met, what could possibly have gone so wrong as to lead to Parliamentarians, the press, and grieving family and friends to question as to whether the LCP was euthanasia through the back door, particularly its use in the acute hospital setting, where most people die (Public Health England, 2018).

Euthanasia through the back door the media campaign

The first to raise concerns over the LCP was a medical doctor, Gillian Craig, who in 2008 looked particularly at the issue of hydration and sedation on the LCP (Craig, 2008, pp. 155–160). Others followed suit in questioning the precision of diagnosing death (Millard et al., 2009), Dr Hargreaves noted that: "some patients were being 'wrongly' put on the pathway, which created a 'self-fulfilling prophecy' that they would die" (Devlin, 2009). Diagnosing death, removing clinically assisted nutrition and hydration, and heavily sedating patients, led to what some have described as terminal sedation: "the deliberate lowering of a patient's level of consciousness in the last stages of life … the practice usually involves continuous intravenous infusions of sedatives, but no hydration or nutrition" (Wyatt, 2015, p. 169). Yet neither heavy sedation nor withdrawing clinically assisted nutrition and hydration were goals to be achieved or even discussed in LCP documents (Kinder & Ellershaw, 2003, pp. 18–25). From this there followed a series of stories in the media from distressed relatives who had witnessed the death of close relatives on the LCP: "Sentenced to death on the NHS" (Devlin, 2009), "My diary of mum's awful death on the Liverpool Care Pathway: Nurse's heart-rending account of how doctors decided to put her mother on 'pathway to death'" (Rawstorne, 2012), "It was murder, says son of woman 'starved to death' on Liverpool Care Pathway as he calls for police inquiry" (Smith, 2013). Social media became a forum in which the LCP came to be described as "the death pathway". Concerns were raised in Westminster (Davies, 2013), leading to the Minister of State for Care Services appointing an independent panel to review the use and experience of the LCP (Neuberger et al., 2013, p. 13).

This independent panel met between February and June 2013 and examined 483 submissions from members of the public, most of whom had experience of the LCP as relatives or carers, 91 from health and care professionals, and 36 professional bodies and other organisations, as well as visiting hospitals and meeting with a variety of stakeholders (Neuberger et al., 2013, p. 57). The results of this panel were published as *More Care Less Pathway, a Review of the Liverpool Care Pathway* and identified significant failings in the delivery of the LCP leading, as a result of its recommendations, to the LCP being phased out six months later (Neuberger et al., 2013, p. 57). The Panel was clear that the LCP was a well-intentioned approach at providing the best of care for those in the terminal phase. The main criticisms and subsequent suggestions for the future of end of life care in the terminal stage related to poor implementation and poor communication, and included 44 recommendations (Neuberger et al*.,* 2013, pp. 52–59). As well as receiving negative feedback, the Panel also received positive input from families whose relatives had been placed on the LCP that found no place in the press (Neuberger et al., 2013, pp. 14, 23). In light of the publication of the Review, members of the medical profession expressed their own support for the LCP, including those who stated that they would wish, in the case of their own terminal illness, to be placed on the LCP (Chinthapalli, 2013a; Chinthapalli, 2013b; Chinthapalli, 2013c).

The LCP had become such a toxic issue, that, whilst the recommendations could have been implemented, this was not deemed to be feasible owing to the public outcry and the attention in the press (Neuberger et al., p. 17), "the pathway had become a brand, 'and now the brand is damaged beyond fixing'" (Hawkes, 2013). The Panel, whilst taking into consideration the

claims by some relatives that their lost loved ones had been euthanised, did not examine the issue of euthanasia, rather they addressed the specific issues regarding the use of opioids and clinically assisted nutrition and hydration in the terminal stage, misunderstandings and misconceptions and the lack of good communication on the part of health care workers (Neuberger et al., 2013, p. 29—30). It is worth noting that no cases regarding the use of the LCP ever came to court.

In 2014 the LCP was phased out in accordance with the recommendation of the Review, yet "the decision to phase out the LCP was made on the basis of little more than an accumulation of anecdotal evidence" and not based on clinical research" (Sleeman, 2013). There is a still a common belief, found in social media,[3] that this was but a whitewashing and rebranding exercise and that the LCP is still in use, but under a new name. In Wales *The All Wales Care Pathway for the Last Days of Life*, based upon the LCP, was reviewed and the recommendation of *More Care, Less Pathway*, as well as those of the *National Institute for Health and Care Excellence Guidelines* were put in place (Seymour & Clark, 2018, p. 12; NICE, 2015). Despite the rapid phasing out of the LCP in NHS England, NHS Scotland, and the HSC in Northern Ireland, there are those such as Professor Pullicino, one of the most ardent critics of the LCP, who stated that the LCP had changed the culture of care for the terminally ill, and that despite having being phased out, that same culture and the same problems persist (Pullicino, 2015). The charge that the NHS is engaged in covert involuntary euthanasia is still present in social media, despite there being no evidence to back up such claims. The LCP has had a profound effect upon end of life care in NHS England, "many health professionals are frustrated at the loss of the LCP, and some fear that that care of the dying may be set back years" (Regnard, 2014). This concern cannot ignore the wider cultural difficulties that exist concerning the questions surrounding death and dying among the general populace and the limited knowledge of this process that ordinary people have, that may in turn have led to the strong reactions against the LCP and the new personalised end of life care plans that were developed to replace the LCP.

Limited knowledge of the dying process and the development of death education initiatives

Death and the dying are subjects that are not frequently discussed, they have become taboo subjects; invariably, the few times in life in which death is encountered is when a loved one dies (IPSOS-Mori, 2010, pp. 3, 20–21) and for many, as a result of increasing life spans, death has become a rare event which is first encountered in adulthood. This is a fairly recent phenomenon, in the past: "funerals were a community affair. Washing the body, laying it out, would all have been done by family members and friends" (Battersby, 2012). Death was once something that affected everybody in a local community and there was an awareness the procedures for caring for a dying person and what would have happened when the end finally came. Part of the reason for death having become such an unfamiliar process over the last century is that it was outsourced to the medical profession and funeral directors (Span, 2013). In the medical setting the language around death and dying uses specialised vocabulary, which is alien and unfamiliar to those not engaged or employed within the field of healthcare. When confronted with news of terminal illness and death, many people are bewildered by what can feel like an information overload, especially when trying to come to terms with the news of a terminal illness (IPSOS-Mori, 2010, p. 3). Being told that a relative was going to be placed on

[3] There are a number of Facebook Groups and Twitter accounts that perpetuate these theories and ideas, with names such as: The Liverpool Care Pathway Protest Group, LCP Awareness UK, Liverpool Care or Death Pathway, Help Put a Stop to Liverpool Care Pathway, Liverpool Care Pathway Say No, Petition against the Liverpool Care Pathway, Stop using the Liverpool Care Pathway without Consent now and there are also Blogs such as: http://liverpool-care-pathway-a-national-sc.blogspot.com

the LCP raised the question as to what a Pathway is and what this has to do with Liverpool. As well as the misconceptions that abound concerning Do Not Resuscitate Orders, the use of pain relief, and the withdrawal of ordinary medical treatment. Often the intricate and vital information that those living with a terminal illness receive, as well as their family and friends, is only given once the diagnosis is made. Kübler-Ross, Kessler, Nolan, Rumbold, Weismann identify in their various approaches that patients will often be in a state of denial at this stage, (Kübler-Ross & Kessler, 2005, p. 7; Nolan, 2012, p. 24), these patients and their families are often not in a position to appreciate the information that is given to them. In the case of the LCP this situation was not helped by the lack of communication from healthcare workers when it came to placing patients on the LCP (Neuberger et al., 2013, p. 49). In its conclusions the Review identified that the problems surrounding the LCP were indicative of the current cultural climate in which death is no longer part of life, but rather has become a taboo which receives scant attention. The Review states clearly that: "While the Government cannot itself change the way the nation thinks about death and dying, the professional bodies can play their part by taking a lead among their members" (Neuberger et al., 2013, p. 49). As such the onus is placed upon medical staff who are invited to be "prepared to talk openly and honestly about dying, death and bereavement, accepting these as a normal part of life" (Neuberger et al., 2013, p. 49). Whilst medical staff, and professional bodies can play a part, the conversations have to begin before people are diagnosed as having a terminal illness.

In the context of the LCP, whilst informal death education initiatives may not have prevented the public outcry, they may have lessened its ferocity. *More Care, Less Pathway* in its concluding comments noted: "The Review panel strongly supports the work of organisations that promote public awareness of dying, death and bereavement," (Neuberger et al., 2012, p. 49). There are contemporary initiatives such as Death Cafés, the Death over Dinner movement, and others that could meet this need (Hebb, 2018). There is a marked increase in the number of books dealing with the subjects of death, dying and palliative care, authors such as Kathryn Mannix and Atul Gawande, who bring their varied experiences and knowledge of palliative care, encounters with patients and their own personal stories who through their writings bring that knowledge to the wider public (Mannix, 2017; Gawande, 2015). The objective of these initiatives is: "to increase awareness of death with a view to helping people make the most of their (finite) lives" (What is Death Café?' https://deathcafe.com/what/). The question is whether death education can reach all sections of society? Barnard notes that these initiatives are "extremely young", and that there is a lack of scientific research demonstrating their utility; they are however at least steps in the right direction for creating the necessary 'cultural shift' (Barnard, 2016, pp. 237–238). If these initiatives enable conversations to begin, and barriers to be broken down so that everybody has an awareness and understanding of terminal illnesses, end of life care, palliative care and death itself, patients, together with their relatives and friends, will be able to fulfil the vision that Cicely Saunders worked for with healthcare staff supporting patients and relatives at the end of life: "You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die" (Tributes to Dame Cicely Saunders).

Conclusion

Cicely Saunders' vision for care at the end of life underpins the principles, methodology and practice of what has become hospice care and in turn palliative care and a significant part of the vision of the authors of the LCP. With the increase in longevity and of those living with cancer, life-limiting conditions and comorbidities, the need for good qualitative end of life care will only increase. Taking Saunders' principles on board, the LCP proved to be, at least in theory, an excellent way to achieve the best care for those in the terminal phase. Among the LCP's flaws was the overly optimistic move from palliative care as a specialism to it becoming

a generic form of care that anybody could learn to deliver. Indicative of this flaw was the lack of good communication, including communicating with the terminally ill and their relatives. From what has been learnt from the LCP there needs to be a more open, more transparent and more honest approach to the issue of what happens when we are dying, and what happens when we die, and that this should not be left until the last days of life. The experience of the LCP, and the campaign against it, highlight the worst-case scenario of poor communication, one which was never counterbalanced with information on what the LCP was, nor its benefits. The greatest lesson of the LCP seems to be that there is a need for better communication on the part of healthcare staff and healthcare agencies and organisations such as the NHS, but also the need for wider conversations and a shift in culture surrounding the issue of death and dying.

This cultural change is necessary for those working in healthcare, those who are sick, and importantly for those engaged in caring for their sick relatives and friends; of equal importance is the wider societal shift in which a greater awareness of the dying process and death itself are better understood by everybody. When all is said and done, this is an issue that will eventually affect each of us. As has been seen there are various death education initiatives that have developed recently, as well as a new genre of literature, both in print and online, dealing with the many questions that people may pose and upon which they may wish to reflect. One of the significant challenges is to heighten the awareness of these initiatives and to include them as an intrinsic part of community-based health education, as well as for these issues to be discussed in the compulsory sector, namely in primary and secondary education. Changing the culture from one in which death is treated as a taboo to being a subject that is discussed freely is an enormous task, and yet there are opportunities in which the subject of death, dying and end of life care can be gently introduced to the general public as has been demonstrated in the new initiatives that are becoming a burgeoning industry.

References

BARNARD, D. (2016): On our difficulties speaking to and about the dying. In: S. J. Younger & R. M. Arnold (eds.): *The Oxford handbook of ethics at the end of life.* Oxford: Oxford University Press, pp. 227–241.

BATTERSBY, M. (2012): The Death Café Movement: tea and Mortality. In: *The Independent*, [online] [Retrieved September 19, 2019] https://www.independent.co.uk/life-style/health-and-families/features/the-death-cafe-movement-tea-and-mortality-8082399.html

CAULDWELL, K. & STONE, P. (2015): The changing nature of end of life Care. In: *Indian Journal of Medical and Paediatric Oncology: Official Journal of Indian Society of Medical & Paediatric Oncology*, 36(2), pp. 94–98. [online] [Retrieved May 5, 2019] Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4477384/

CHINTHAPALLI, K. (2013a): The birth and death of the Liverpool Care Pathway. In: *BMJ,* 347:f4669. [online] [Retrieved October 1, 2019] Available at: https://doi.org/10.1136/bmj.f4669

CHINTHAPALLI, K. (2013b): Nine out of 10 palliative care experts would choose Liverpool care pathway for themselves. In: *BMJ,* 346:f1303. [online] [Retrieved October 1, 2019] Available at: https://doi.org/10.1136/bmj.f1303

CHINTHAPALLI, K. (2013c): The Liverpool care pathway: What do specialists think? In: *BMJ*, 346:f1184 [online] [Retrieved October 01, 2019] Available at: https://doi.org/10.1136/bmj.f1184

CRAIG, G. (2008): Palliative care in overdrive: Patients in danger. In: *American Journal of Hospice and Palliative Medicine*®, 25(2), pp. 155–160. [online] [Retrieved September 29, 2019] Available at: https://doi.org/10.1177/1049909107312596

DAVIES, M. P. G. (2013): quoted in: The House of Commons Debate on the Liverpool Care Pathway 08 January 2013. In: *Hansard*, Volume 556 [online] [Retrieved September 30, 2019]

Available at: https://hansard.parliament.uk/Commons/2013-01-08/debates/13010824000001/LiverpoolCarePathway
DEPARTMENT OF HEALTH (2008): *End of life care strategy*, [online] [Retrieved September 27, 2019] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf
DEVLIN, K. (2009): Sentenced to death on the NHS. In: *The Telegraph* [online] [Retrieved September 25, 2019] Available at: https://www.telegraph.co.uk/news/health/news/6127514/Sentenced-to-death-on-the-NHS.html
ELLERSHAW, J. & WILKINSON, S. (2003): *Care of the dying: A pathway to excellence.* Oxford: Oxford University Press.
ELLERSHAW, J. & WILKINSON, S. (2011): *Care of the dying: A pathway to excellence*, 2nd ed. Oxford: Oxford University Press.
GAWANDE, A. (2015): *Being mortal*. London: Profile Books.
HAWKES, N. (2013): Liverpool care pathway is scrapped after review finds it was not well used. In: *BMJ*, 347:f4568 [online] [Retrieved October 01, 2019] Available at: https://doi.org/10.1136/bmj.f4568
HEBB, M. (2018): *Let's talk about death (over dinner).* New York, USA: Da Capo Publishing.
IPSOS-MORI (2010): *Attitudes towards death and dying in the East of England - Qualitative Report* [online] [Retrieved October 01, 2019] Available at: https://www.ipsos.com/sites/default/files/migrations/en-uk/files/Assets/Docs/Publications/attitudes-towards-dying-2011-qualitative-report.pdf
KINDER, C. & ELLERSHAW, J. (2003): How to use the Liverpool Care Pathway for the dying patient. In: J. Ellershaw & S. Wilkinson (eds.): *Care of the dying: A pathway to excellence.* Oxford: Oxford University Press, pp. 11–41.
KÜBLER-ROSS, E. & KESSLER, D. (2005): *On Grief and Grieving*. London: Simon & Schuster.
LEADERSHIP ALLIANCE FOR THE CARE OF DYING PEOPLE (2013): *One chance to get it right*. [online] [Retrieved September 29, 2019] Available at: https://wales.pallcare.info/files/One_chance_to_get_it_right.pdf
MCCARTNEY, M. (2012): The assault on the Liverpool Care Pathway. In: *BMJ*, 345:e7316. [online] [Retrieved October 1, 2019] Available at: https://doi.org/10.1136/bmj.e7316
MANNIX, K. (2017): *With the end in mind*. London: Collins.
MILLARD, P. H., COLE, A., HARGREAVES, P., HILL, D., NEGUS, E. & DOWAGER LADY SALISBURY (2009): Dying patients. In: *The Telegraph.* [online] [Retrieved September 29, 2019] Available at: https://www.telegraph.co.uk/comment/letters/6133157/Dying-patients.html
NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE (NICE) (2015) *Care of dying adults in the last days of life*. [online] [Retrieved September 22, 2019] Available at: https://www.wales.pallcare.info/files/NICE%20Care%20of%20dying%20adults%20in%20the%20last%20days%20of%20life%20NG31.pdf
NEUBERGER, J., GUTHRIE, C., AARONOVITCH, D., HAMEED, K., BONSER, T., HARRIES, R., CHARLESWORTH-SMITH, D., JACKSON, E., COX, D. & WALLE, S. (2013): *More Care Less Pathway, a Review of the Liverpool Care Pathway*. [online] [Retrieved September 29, 2019] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf
NOLAN, S. (2012): *Spiritual care at the end of life: The Chaplain as a 'Hopeful Presence.*' London: Jessica Kingsley Publishers.
PUBLIC HEALTH ENGLAND (2018): *Statistical commentary: End of life care profiles.* [online] [Retrieved September 30, 2019] Available at: https://www.gov.uk/government/

publications/end-of-life-care-profiles-february-2018-update/statistical-commentary-end-of-life-care-profiles-february-2018-update
PULLICINO, P. (2015): The new end-of-life guidelines are lethal. In: *The Telegraph*. [online] [Retrieved September 27, 2019] Available at: https://www.telegraph.co.uk/news/nhs/11779394/The-new-end-of-life-guidelines-are-lethal.html
RAWSTORNE, T. (2012): My diary of mum's awful death on the Liverpool Care Pathway: Nurse's heart-rending account of how doctors decided to put her mother on 'pathway to death. In: *The Mail on Sunday*. [online] [Retrieved September 25, 2019] Available at: https://www.dailymail.co.uk/news/article-2220409/My-diary-mums-awful-death-Liverpool-Care-Pathway-Nurses-heart-rending-account-doctors-decided-mother-pathway-death.html
REGNARD, C. (2014): Blaming care pathway 'like blaming Highway Code.' [online] [Retrieved October 3, 2019] Available at: https://www.bbc.co.uk/news/health-25757322
SEYMOUR, J. & CLARK, D. (2018): The Liverpool Care Pathway for the Dying Patient: a critical analysis of its rise, demise and legacy in England [version 1; peer review: 2 approved]. *Wellcome Open Res*, 3(15) [online] [Retrieved September 22, 2019] Available at: https://doaj.org/article/4ca295abe8ed47f99678492500f3dcde
SLEEMAN, K. (2013): The Liverpool care pathway: A cautionary tale. In: *BMJ,* 347:f4779 [online] [Retrieved October 1, 2019] Available at: https://doi.org/10.1136/bmj.f4779
SMEDING, R., BOLGER, M. & ELLERSHAW, J. (2011): International development of the Liverpool Care of the Dying Patient. In: J. Ellershaw & S. Wilkinson (eds.): *Care of the Dying: A Pathway to Excellence*, 2nd ed. Oxford: Oxford University Press, pp. 190–205.
SMITH, J. (2013): It was murder, says son of woman 'starved to death' on Liverpool Care Pathway as he calls for police inquiry. In: *The Daily Mail*. [online] [Retrieved September 25, 2019] Available at: https://www.dailymail.co.uk/news/article-2513136/It-murder-says-son-woman-starved-death-Liverpool-Care-Pathway-calls-police-inquiry.html
SPAN, P. (2013): Death Be Not Decaffeinated: Over Cup, Groups Face Taboo. In: *The New York Times*. [online] [Retrieved September 09, 2019] Available at: https://newoldage.blogs.nytimes.com/2013/06/16/death-be-not-decaffeinated-over-cup-groups-face-taboo/?_php=true&_type=blogs&_r=0
TRIBUTES TO DAME CICELY SAUNDERS [online] [Retrieved September 25, 2019] Available at: https://www.stchristophers.org.uk/about/damecicelysaunders/tributes
WELSH ASSEMBLY GOVERNMENT (2006): *Welsh Health Circular* (WHC 2006 30). [online] [Retrieved September 29, 2019] Available at: http://www.wales.nhs.uk/documents/WHC_2006_030-English.pdf
WHAT IS DEATH CAFÉ? [online] [Retrieved September 19, 2019] Available at: https://deathcafe.com/what/
VEERBEEK, L. (2008): *Care and quality of life in the dying phase: The contribution of the Liverpool Care Pathway for the dying patient*. Rotterdam: Erasmus University. [online] [Retrieved January 16, 2019] Available at: http://hdl.handle.net/1765/13429
WYATT, J. (2015): *Right to die*. Nottingham: Inter-Varsity Press.
ZINNER, M. (2013a): *Der "Liverpool Care Pathway"*. Norderstedt: Grin Verlag.
ZINNER, M. (2013b): *Sterbenbegleitung im kontext des Liverpool Care Pathway*. Hamburg: Diplomica Verlag.

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Inappropriate hemodialysis treatment and palliative care

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Abstract

The paper discusses inappropriate (futile) treatment by analyzing the casuistics of palliative patients in the terminal stage of illness who are hospitalized at the Department of Internal Medicine and Geriatrics of the Faculty hospital with policlinic (FNsP). Our research applies the principles of palliative care in the context of bioethics. The existing clinical conditions of healthcare in Slovakia are characteristic of making a taboo of the issues of inappropriate treatment of palliative patients. Inductive-deductive and normative clinical bioethics methods of palliative care and ethical strategy are applied for defining issues found in inappropriate hemodialysis treatment. An algorithm of hemodialysis treatment requires the definition of those lege artis criteria which, in the context of a patient's autonomy and his/her decision, precondition the avoidance of the situation in which hemodialysis treatment is inappropriate (futile). Futile treatment in a terminal condition is ethically inappropriate medical treatment that extends the suffering of patients and their relatives. Its definition is determined by the relevant legislation and the methods of bioethics. An active palliative strategy is aimed at managing the process of incurable diseases in the patient's bio-psycho-socio-spiritual continuity in the process of special bioethics. The global bioethical objective of general bioethics for palliative care is based on the paradigm of social harmony and solidarity in the context of an authentic modus of the patient's existence as a constitutive principle for the phenomenon of the patient's being to finite being (death).

Keywords: hemodialysis treatment, futile treatment, bioethics, individualized prognostic strategy, palliative care

Introduction

The prevalence of chronic kidney diseases has been growing. Half of all dialyzed patients in Australia are older than 65 years, and 26% of patients are older than 75 years (Grace, Hurst & McDonald, 2012). The fastest growing group of dialyzed patients in Great Britain are above 65 years (U. S. Renal Data System, 2014); in the Czech Republic, patients of the age above 60 years represent 70% of all dialyzed patients (Rychlík & Lopot, 2017). The initiation of dialysis treatment of senior citizens is frequently connected with worsened functional condition and quality of life. An important role is played by comorbidities and frailty syndrome in the elderly. Age is not the only relevant factor. Dialyzed patients above 75 years of age are a fairly heterogenous group in which the survival period depends on the higher number of comorbidities, primarily IHD (ischemic heart disease) and unplanned dialysis initiation (Murtagh et al., 2007). The main symptoms are chronic pain, fatigue, cognitive deficiency and depression. These symptoms are present in as many as half of the patients (Hedayati et al., 2009). The data from abroad, covering the period from 1995 to 2010, indicate an increased mortality from 25.6% to 42.4% in patients above 65 years of age after the completion of dialysis as a result of the patients' end-of-life decision. (U.S. Renal Data System, 2011). The standard treatment of frail and high-risk patients who suffer from CKD (chronic kidney disease) affects their life values and can result in inappropriate treatment. Palliative/supportive care personalizes the treatment and correlates with the patient's values and life objectives. Integration of supportive care in standard CKF patient treatment is an indispensable condition forshowing respect for the human dignity and rights of patients. Abstracted 'classical' ethical principles do not favour the solution of specific fates of individual patients, especially in critical situations and at the end of one's life. In these cases situational ethics is applied. This kind of

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situation requires the methods of applied ethics - the bioethics in order to implement desired ethical procedures because the classical ethical postulates are too strict in these situations.

Objectives

This paper discusses casuistics of three patients undergoing chronic dialysis treatment in order to manifest the necessity to define the critical condition and the terminal condition in a patient, and the possibility of intensive palliative treatment of dialyzed patients. Furthermore, the paper discusses issues regarding inappropriate hemodialysis treatment of terminal condition patients.

Casuistics 1
81-year-old patient, hospitalized for 34 days in 2018

Pre-disease period

The basic diagnosis identified chronic stage 5 K/DOQI (Kidney Disease Outcomes Quality Initiative – clinical guidelines) kidney failure, i.e., the terminal stage. The patient was included in a chronic hemodialysis program in 1999, HD was administered three times a week. The other chronic diagnoses included: chronic heart failure, function group NYHA IV (*New York Heart Association)* – terminal stage aggravated by repeated pulmonary edema. Chronic lung and bronchial obstruction disease accompanied with high pulmonary artery pressure. Organic delusional disorder (similar to schizophrenia).
Clinical frailty index (evaluated by testing daily activities, mental endurance, physical performance and nutrition): patient in the terminal stage, i.e., in the terminal frailty stage.

Hospitalization

The patient was hospitalized due to dyspnoea and fever. Hemodialysis treatment continued during the hospitalization, and was applied three times a week. The condition was diagnozed as sepsis. A targeted seven-day ATB treatment and complete supportive treatment resulted in a temporary improvement in clinical and laboratory results. The patient suffered from progressive signs of heart weakness. The following days brought progressive inflammation, the clinical picture showed strong pain, and the patient suffered from acute psychiatric syndrome with disorientation.

- 15^{th} day of hospitalization: consultations with an HD specialist (nephrologist) who decided to withdraw dialysis and evaluated the patient's condition as a pre-terminal condition due to instable blood circulation and low blood pressure. Since blood pressure increased the next day, the HD specialist recommended to resume hemodialysis and apply it three times a week.
- 27^{th} day of hospitalization: the condition worsened due to a blood clot in the right cardiac atrium, and poor performance of the left cardiac atrium with signs of heart failure (heavy dyspnoea and body edema).
- 34^{th} day of hospitalization: based on the patient's own desires and the desires of her relatives, the patient was released for home care in the condition of high-level inflammation, progressive kidney failure, aggravated malnutrition, and persisting pains and dyspnoea in the clinical picture.
- During hospitalization, HD was applied 13 times.
- The patient's relatives insisted on hemodialysis throughout the hospitalization period.
- The patient, exhibiting a serious disorder of cognitive functions and developing disorientation, was not able to communicate on her treatment and continued hemodialysis.
- The nephrologist recommended continuing hemodialysis treatment twice a week.

Four days after release from hospital, the patient was hospitalized again based on the decision of the nephrologist due to terminal condition diagnosis based on progressive kidney failure refractory to treatment. HD was withdrawn due to low blood pressure and cardiac failure. Ten hours after hospitalization, the patient suffered from a quantitative consciousness disorder and died.

Conclusion: Terminal condition of disease
Patient in a terminal condition (kidneys, heart, lungs)
Frailty index for elders – terminal frailty stage
High degree of deterioration in the elderly: high degree of cachexia, chronic immobilization syndrome, decubitus
Catheter sepsis, hypercoagulation condition
Progressive chronic kidney disease CKD st.5 K/DOQI, refractory to treatment, anuric stage
Ischemic heart disease, chronic heart failure, function group NYHA IV, LV EF 20%, thrombosis in the right-sided cardiac atrium.
Chronic obstructive bronchopulmonary disease, serious pulmonary hypertension
Vascular dementia, organic affective delusional disorder (similar to schizophrenia).

Casuistics 2
79-year-old patient, hospitalized for 14 days in 2018

Pre-disease period
The basic diagnosis of the patient was chronic, terminal stage 5 K/DOQI, kidney disease (CKD), - due to diabetes mellitus. He was included in a chronic hemodialysis program in 2015, three times a week. The other chronic diagnoses included the condition after repeated bloodstream infections with applied dialysis catheter. Diet-controlled type II diabetes mellitus developed after a myocardial infarction in 2005. Permanent pacemaker implantation. Recurring heavy inflammation of the gastrointestinal tract. A high degree of cachexia. Chronic immobilization syndrome.
Clinical frailty index: terminal frailty stage.

Hospitalization
The patient was hospitalized due to ingestion failure, fever, cough and apathy. Due to pneumonia, the patient was administered antibiotic treatment and complete supportive treatment. The clinical condition of the patient during hospitalization showed low blood pressure, unstable blood circulation, permanent apathy and chronic immobilization.
Hemodialysis was applied as follows:

- 3rd day of hospitalization: hemodialysis and intravenous catecholamine application (a drug used to increase blood pressure) due to low blood pressure.
- 7th day of hospitalization: due to the overall condition, a nephrologist recommended reducing the frequency of hemodialysis to twice a week.
- 10th day of hospitalization: serious hypotension (blood pressure at 84/45mmHg); hemodialysis applied only partially, without ultrafiltration; after 70 minutes, the patient himself asked to cease hemodialysis due to pains and lower limb coldness.
- 13th day of hospitalization: Owing to kidney failure (CKD st. 5 K/DOQI), refractory chronic heart failure and septic condition, the nephrologist diagnosed a 'pre-terminal' stage. Based on consultations with other doctors, the hemodialysis program was withdrawn.
- 14th day of hospitalization: the patient died.

The patient's relatives were hesitant about withdrawal from hemodialysis during the hospitalization period. They agreed to withdraw from it one day before the patient's death. The patient suffered from mid-severe cognitive function disorder. As a result, he was not able to communicate on his treatment and hemodialysis continuation.

Conclusion: Terminal condition
Patient in a terminal condition.
Frailty index for elders – terminal frailty stage
Terminal deterioration in the elderly - chronic immobilization syndrome, decubitus, severe cachexia, chronic non-tumoral pain
Left-sided pneumonia (bronchopneumonia syndrome)
Hypocoagulation condition
Chronic kidney inflammation (chronic tubulointerstitial nephritis) and diabetic nephropathy, chronic kidney disease (CKD st.5 K/DOQI) refractory to treatment, anuric stage, secondary mid-severe anemia
ICHS 1 – coronary artery disease, condition after anteroseptal MI (2005), TKS primoimplantation due to the dysfunction of the sinoatrial (SA) node, chronic refractory heart failure with EF 30- % f.c. NYHA IV, chronic cardiorenal syndrome
Diet-controlled type II diabetes mellitus
Recurring pancolitis

Casuistics 3
82-year-old patient, hospitalized for 7 days in 2017

Pre-disease period
The basic diagnosis of the patient was chronic kidney failure (CKD st. 5 K/DOQI), anuria, failing kidneys due to diabetes mellitus and atherosclerotic renal artery disease; included in a chronic HD program in 2015, three times a week. Other chronic diagnoses include: condition after repeated catheter sepsis (2015, 2017); chronic heart failure, function group NYHA III based on ischemic heart disease and mid-severe heart-valve disease; diet-controlled type II diabetes mellitus , stage of organ complications; anemia of mid-severe degree of chronic diseases; condition after small bowel resection due to ileus (2014), short bowel syndrome; condition after rectum amputation due to carcinoma (2001); condition after RAT (radiotherapy) with colostomy.
Clinical frailty index: terminal frailty stage.

Hospitalization
The patient was hospitalized due to overwatering, hypotension, dyspnoea, aqueous feces into colostomy, approx. 3000ml/day, multiple hematomas on the patient's body, 3rd degree decubitus in the lumbar region.
From the beginning of the patient's hospitalization, her blood pressure was low, and blood circulation failed, intravenous medication and solution administration became difficult. Due to advanced kidney disease (CKD st. 5 K/DOQI), ischemic heart disease, function group NYHA IV, left-sided hydrothorax, ascites, respiratory failure with hypercapnia, and hypotension (TK 60/40 mmHg) which did not respond to catecholamine support, the patient's condition was evaluated as terminal; we withdrew from invasive therapeutic puncture of the left-sided fluidothorax and from ascites puncture.

- The patient was provided with a peripheral venous access catheter on her neck at the Clinic of Anesthesiology and Intensive Care (CAIM) for administration of liquids and

medication; furthermore, we administered ATB therapy, catecholamine (dopamine) by means of an injectomat, oxygenotherapy and analgetics.

- 2nd day of hospitalization: the patient underwent nephrological examination. Due to the clinical condition and severe hypotension, the nephrologist decided on "withdrawing from dialysis treatment. If blood pressure does not exceed 110mmHg we recommend continuing with maximum conservative management of the patient."
- 4th day of hospitalization: Based on the insistence of the patient's relative the patient on catecholamine support was administered dialysis. During the whole three-hour hemodialysis, the patient was administered catecholamine (dopamine) by means of an injectomat; voluminous ultrafiltration was not possible, the patient was sleepy (somnolent), complained of pain, and suffered from heavy breathing.
- 6th day of hospitalization: HD for two hours; unstable blood circulation; interrupted dialysis; her clinical condition was evaluated by the nephrologist "as preterminal due to the presence of refractory kidney failure (CKD st.5 K/DOQI), progressive chronic heart failure, function group NYHA IV, acute global respiration insufficiency, cachexia, and hypocoagulation condition" Dialysis treatment was not indicated.

The patient, with catecholamine support, was transferred from the HD workplace back to the ward; progressive delirium, continuous catecholamine support, other treatment reduced, emphasis on suppression of pain; the patient died on the 7th day of hospitalization. The patient's relatives strictly insisted on hemodialysis during the whole period of hospitalization, and personally accompanied the patient to the HD workplace.

Conclusion: Terminal condition
Patient n. the terminal stage of disease (kidneys, heart)
Frailty index for elders – terminal frailty stage
Terminal decline of the elderly –chronic immobilization syndrome, decubitus, severe cachexia, chronic non-tumoral pain
Diabetic nephropathy and vascular nephrosclerosis, chronic kidney disease (CKD st.5 K/DOQI), anuric stage, condition after recurrent catheter sepsis (2015, 2017)
ICHS and mid-severe heart-valve disease, refractory chronic heart failure, function group NYHA IV, left-sided fluidothorax, ascites
Chronic cardiorenal syndrome
Diet-controlled type 2 diabetes mellitus, in the stage of organ complications, anemia of mid-severe degree of chronic diseases
Condition after small bowel resection due to ileus (2014), short bowel syndrome
Condition after rectum amputation due to carcinoma (r.2001), condition after RAT with colostomy

Discussion

Meaningful and, therefore, appropriate treatment is related to a disease, disability or symptom. It is not related to a therapeutic objective. It is evaluated by a physician with the relevant education.

The definition of futile treatment is affected by value judgements and, therefore, it depends on a specific approach. The significance of a discussion on futile treatment stems from the fact that it refers to the limits of medicine beyond which medicine is powerless. This kind of discussion conceives of death as an inherent part of human life. The effort to achieve medical effects may be perceived by a patient as unsuccessful and futile; it may be perceived as treatment that does not result in saving the patient's life, in maintaining his health or quality of life. This kind of treatment does not respond to the patient's interests because it causes unnecessary suffering. From the point of view of medical ethics, the concept of futile treatment

may be interpreted as a return to paternalism. A more profound analysis of futile treatment can take the form of the quantitative, qualitative and physiological forms of futility.

Quantitative futility expresses the measure of probability of a positive change in the patient's condition as a result of treatment. Treatment with low probability of success, mostly under 10%, is considered futile. A physician relies on his own experiences, shared experiences, and published data. There have been attempts to employ modelling programs for scoring disease development. These programs have limited applicability to futility prognoses.

Qualitative futile treatment fails to achieve its goals, or it is not compatible with them, and does not improve the patient's life quality. Qualitative futile treatment, for example, maintains a permanent condition of unconsciousness, or results in complete dependence of the patient on intensive medical care. Futile treatment thus has adverse and undesired consequences for the patient.

Physiological futility refers to a situation in which the patient's physiological systems resist any available medical intervention that could reverse the patient's condition. Unlike the former two cases, physiological futile treatment can be decided exclusively by a physician as an expert capable of recognizing the capacity of the treatment to fulfil physiological objectives.

The decision to consider any medical treatment as futile means that it is not commenced, extended, or it is stopped. The treatment then pursues a different objective and employs a different procedure. Treatment which increases the patient's discomfort, suffering and pain contradicts both ethical principles of medicine: nonmaleficence and beneficence. From the ethical point of view, medicine does not have to provide futile treatment. The temporary improvement of a physiological function or of its partial parameters without any improvement in the overall course of the disease, and without the possibility of saving the patient's life cannot be considered a favourable effect of the specific medical treatment.

The fundamental objective of medical treatment is to support and protect human health. Its second objective pursues the patient's benefits. This clinical objective implies the treatment of a man as a whole that affects the patient's personal objectives and long-term benefits, life plan, everything that is perceived as a significant part of the quality of life. A physician himself cannot use the quantitative futility method for making a decision on the meaningfulness of a particular degree of probability of the treatment's success or failure. This would contradict another principle of medical ethics – respect for the patient's autonomy. The qualitative futility method does not enable a physician to estimate the meaningful degree of the patient's personal objectives.

Any evaluation of futile treatment should be based on the relation to life, life as the highest value, life as the fundamental human right. Recognition of the natural life finitude is of principled importance. Some other human rights are also significant in this context, mainly the patient's right to self-determination and human dignity. This right also pertains to the patient's opinion, which must be taken into consideration. It primarily bears on informed consent and the instituting of a previously expressed desire, unless the patient is not able to express his informed consent at the time of decision-making. The physician's ethical and legal duty is to inform the patient. The right to self-determination entitles the patient to accept or reject the proposed medical treatment by way of informed consent on the basis of his attitude to the proposed treatment and by evaluating its futility. The physician is obliged to respect the patient's wish as much as possible. By implication, the patient can reject treatment even if the physician believes in its success, or he can require such treatment which, in the physician's view, has minimum chances to be successful.

The casuistics discussed in this paper illustrate the meaningless treatment of chronic diseases in the stage of terminal condition and aggravated syndromology. The permanence of the patient's adverse clinical condition with progression fulfills the criteria of qualitatively futile treatment. The perspective of physiological futility made us conclude on the treatment's

meaninglessness and futility due to the terminal stage of geriatric frailty. While the instituting of informed consent could not be employed due to the patients' cognitive incompetence, we consider respect for human dignity a category that enables us to stop the patient's suffering (dysthanasia) and to observe the bioethical principles of nonmaleficence and beneficence.

The basic dilemma of hospitalizing a palliative, i.e., chronically dialyzed, patient concerns our ability to distinguish between a potentially reversible critical condition and the terminal condition. The lege artis procedure in patients in a critical condition is intensive care aimed at the maintenance and improvement of the impaired organs and functions; the lege artis procedure in patients in terminal condition is active palliative care (Sláma, 2010).

Two of the presented casuistics report on initiation of the treatment of an acute critical condition – sepsis and bronchopneumonia in chronically dialyzed patients, and subsequent redefinition of the patients' condition in the course of their hospitalization as a terminal condition. One casuistics reports on a terminal condition of the patient from the very beginning of hospitalization. Hemodialysis was administered to all three patients until their death.

The transition from acute treatment to palliative care must be lege artis evaluated and documented. From the point of view of bioethics, it means decision-making in ethical uncertainty. Traditional philosophical and medical ethics does not have any reliable instruments for decision-making in uncertainty. The whole ethical reflection, its structure and methodology are based on the reflection of certainty rather than uncertainty (Kuře, 2015).

The decision-making strategy for ethical uncertainty offers three options according to which doctors proceed in decision-making situations of medical uncertainty (Rhoden, 1986):

1. Waiting for certainty
2. Statistical prognostic strategy
3. Personalized prognostic strategy

There are three basic types of therapy according to the extent of treatment:

a) Standard therapy (complete treatment) – a therapy lege artis which makes use of all currently available means of intensive care medicine, theoretical knowledge and clinical experiences.

b) Withholding therapy –therapy without extending the currently used diagnostic and treatment procedures for a patient.

c) Withdrawing therapy (basic therapy) –therapy which proceeds according to the decisions on the restriction or withdrawal from the current treatment. It proceeds according to a scheme of restricted discomfort in the stage of dying (Kuře, 2012).

In our casuistics, the Hemodialysis Centre specialists evaluated the clinical situation of chronically hemodialyzed patients on the basis of the 'technical' hemodialysis potential rather than by evaluating the overall condition of the patients. From the point of view of palliative care in the terminal condition, the application of hemodialytic treatment until the death of the patient in the above-mentioned casuistics is an inappropriate treatment. These cases illustrate patients in the terminal stage when the communication with their relatives about withdrawal from dialysis can be considered as delayed. The patients themselves were not competent to express their standpoint on the withdrawal from an inappropriate form of treatment.

The relevant procedures in the Slovak Republic are specified in the document "Recommended procedure for the transition from intensive care to palliative treatment of and care for adult patients who are unable of decision-making at the terminal disease stage." This document resulted from a consensus between the Slovak Society for Anesthesiology and Intensive Medicine (SSAIM) and the Palliative medicine section of the Slovak Medical Society. It was approved by the SSAIM on 20 May, 2014. While it is not a legally binding document, it meets the condition of lege artis procedure in withdrawal from dialysis treatment in severely ill patients. In cases when the withdrawal from therapy by decision of a doctor complies with the lege artis procedure, but the patient or their legal representative insists on this type of health care (e.g., hemodialysis), the health-care provider should appeal to a court and continue the

treatment until the court makes the decision even if the health-care provider considers the treatment to be futile (Firment, 2015). Clinical practice in the Slovak Republic does not experience court appeals in standard clinical procedures for this type of situation (no such case has occurred in the case-law of the Slovak Republic). The existing legal situation makes medical doctors opt for continuation of inappropriate (hemodialysis) treatment because if the patient or his relatives do not agree with the doctor's decision the doctor risks potential legislative sanctions (in the case of an indicated withdrawal from futile dialysis).

In the case of the patients of the first and the third casuistics, the relatives insisted on hemodialysis treatment in spite of the fact that the patient's condition was evaluated as terminal. A way out of this situation may be an evaluation by a commission (for example, by the ethical commission of a hospital). A professional presupposition for such a procedure is lege artis a definition of the terminal condition of the hemodialyzed patient. Communication about the termination of the hemodialysis treatment with the patient and his/her relatives in the stage of chronic hemodialysis appears to be a taboo subject in the Slovak Republic.

The definition of the terminal stage of an oncological patient specifies the following characteristics: a disseminated or a locally advanced oncological disease or its complications; all possibilities of oncological treatment are exhausted in the situation of irreversible failure of one or more organ systems. A definition of the terminal condition requires a comprehensive evaluation of the clinical condition; a doctor must be sure that the disease imminently endangers the *life* of a terminally ill *patient* (Sláma, 2013).

It follows from the application of the 'oncological' definition of the terminal condition that the terminal condition could have been identified in all three casuistics of the patients undergoing chronic HD treatment. Hemodialysis failed due to chronic kidney disease in the terminal stage. Moreover, it was accompanied with hemodynamic instability and refractory chronic heart failure. The clinical frailty index confirmed the terminal frailty stage.

In selecting a personalized prognostic strategy in the critical or palliative situation of a hemodialyzed patient, clinical bioethics systematically evaluates all professional and ethical arguments as well as the patient's condition, and makes a decision on the next procedure in the process of communication with the patient and his/her relatives.

In the case of medical monitoring of patients with chronic kidney disease, communication between the doctor and the patient should start in time, months before the intended dialysis, in stage 4 of CKD (Moss, 2001; Brown, Murtagh & Murphy, 2011). The planning should be implemented with respect to the patient's autonomy and their right for dignity.

Withdrawal from or withholding of dialysis is ethically and clinically acceptable if it is preceded by a joint patient-doctor decision in the process of clinical bioethics. Time-trial dialysis is a possible solution if the patient hesitates whether or not dialysis should be started. It can extend over a specified time period of dialysis (4–6 weeks) (Moss, 2001).

Integration of early palliative care can prolong the life of high-risk patients with progressive CKD. The objective of palliative care consists of improving the comfort of patients near the end of their life. Possible measures include reduced pharmacotherapy, relieved dietary restrictions, modification of the dialysis schedule, changed transportation to a dialysis workplace, changed frequency of dialysis per week, changed vascular access, etc. Continuous communication with a patient and the patient's family is a must.

The frailty syndrome, functional condition, cognitive dysfunction, depression and the risk of fall are aggravated with the progression of CKD, and predict mortality, hospitalization, subsequent care, and femoral shaft fracture. Any prognosis is rather demanding because, in comparison to oncological patients, we miss clear milestones in the trajectory of chronic kidney disease (Couchoud et al., 2016).

Dialysis centres should develop procedures that specify the time and the method of communication of withdrawal from or withholding of dialysis. The length of life after

withdrawal from dialysis depends on residual kidney function and the patient's overall condition. All the care should concentrate on the comfort and the management of symptoms; those diagnostic and therapeutic steps which do not contribute to the comfort should be withdrawn, including blood tests (Szonowská, 2018).

Any decision on withdrawal from or withholding of dialysis is preconditioned by the process of clinical bioethics. The score itself is merely an auxiliary tool for evaluating the risk and for facilitating communication with the patient on medical treatment. The decision of withdrawal from dialysis should result from an ethical process of communication between a nephrologist and a patient. Clinical recommendations of American nephrologists (Renal Physicians Association: "Shared Decision Making in the Appropriate Initiation of and Withdrawal from Dialysis" (Moss, 2001) includes ten areas pertaining to the initiation or termination of dialysis. Nephrologists who make use of these recommendations more frequently prefer withdrawal from and withholding of dialysis and time-trial dialysis, and more frequently send their patients to hospices (Holley, 2007). The RPA ethical process covers the following areas: the relation which facilitates joint decision-making, identification of high-risk patients, providing information to patients, estimating and advising patients on the prognosis, planning future care, including its formalities, deciding on dialysis withdrawal/withholding, considering the termination of dialysis in patients who do not benefit from it, time-trial dialysis, conflict-situation regulations, effective palliative care, continuous communication (Brown, Murtagh & Murphy, 2012).

Palliative care for incurable patients in the terminal stage, with life expectancy of several weeks, rarely months, is provided in a specific clinical and ethical context. Medical procedures which do not contribute to the patient's comfort but prolong the patient's life (e.g., antibiotics, parenteral hydration and nutrition, hemodialysis, artificial pulmonary ventilation) in fact mostly prolong the process of dying and worsen the suffering of the patient and his family. Their application/withdrawal must be decided on individually.

If a medical procedure does not guarantee a positive effect on the patient's health or if saving the patient's life implies a high risk of complications, pain, discomfort and suffering which outweigh the actual clinical contribution of the selected procedure the treatment is not in favour and in the patient's best interest, and therefore it can be labeled as futile or inappropriate treatment. Dysthanasia is the condition of severe patient's suffering related to treatment; the chances for recovery are minimal (Sláma, 2010).

Clinical bioethics suggests an integrated ethical program as a comprehensive approach to addressing ethical issues in clinical practice in patients with advanced CKD. The program is based on a four-level method. Level 1 represents medical indications. Level 2 monitors the patient's preferences. Level 3 evaluates the quality of life of the patient, and level 4 evaluates contextual characteristics of the patient (Jonsen, Siegler & Winslade, 2010).

The suffering at the end of life is total, and is related to the loss of control of the situation and one's own integrity, to the awareness of no future, dependence, loss of dignity, fear of loneliness, of the unknown, of death. These areas pertain to the patient's personality values, and philosophical 'beliefs' (Czech Society for Palliative Medicine, 2013).

A theoretical bioethical model combines methods of general bioethics and bioethical expertise by making use of professional instructions for disease management in the patient's bio-psycho-socio-spiritual and existential dimensions. The theoretical bioethical model developed for palliative care within general bioethics encompasses situation ethics and nursing ethics, ethics of responsibility and phenomenological philosophy. The preferred principles include human dignity, autonomy and solidarity. The process of clinical bioethics should include a personalized prognostic strategy and clinical pragmatism in accordance with the guidelines for supportive/palliative care. The main objective of palliative strategy is the management of an incurable disease in the bio-psycho-socio-spiritual and existential dimension

of the patient. In the global bioethical objective, the paradigm of solidarity and social harmony can be related to the authentic mode of existence as a constitutive phenomenon of the being-to-finitude (death). The existential movement philosophy refers to the corporality and temporality of existence in this world. Man is corporeal from the nature of his being, the relation to the world is established by the experienced corporality rather than by acts of thought. Three movements of human existence include the movement of anchoring, the movement of self-prolongation, and the movement of self-gaining which results in self-comprehension. An individual can change his relationship to the universe through awareness of his finitude, which makes him authentic. By means of intersubjectivity, he presents himself to others through interpolation, he masters his finitude and overcomes it (Patočka, 1999).

Conclusion

The instituting of a prior wish is the decisive medical-legal criterion which enables patients to exercise their right to self-determination and to apply the principle of external autonomy. However, it is de facto unattainable in the clinical practice of the Slovak Republic. The Slovak community and health-care should accept active palliative care. This is conditioned by enacting a corresponding legislation and professional procedures for the Slovak Republic, making use of bioethical methods and models. Futile hemodialysis treatment in the terminal condition of a palliative patient is an inappropriate procedure from the ethical point of view, because it prolongs the suffering of patients and their relatives. The palliative strategy is aimed at managing the incurable disease process in the patient's bio-psycho-socio-spiritual continuity. The global bioethical objective for palliative care is based on the paradigm of social harmony and solidarity related to an authentic mode of the patient's existence as a constitutive mode for the phenomenon of his being-to-finitude (death).

References

BROWN, E., MURTAGH, F. & MURPHY, E. (2012): Communication with patients and families. In: E. Brown, F. Murtagh & E. Murphy (eds.): *Kidney Disease: From advanced disease to bereavement*, 2nd ed. Oxford: Oxford University Press, pp. 199–224.

COUCHOUD, C., HEMMELGARN, B., KOTANKO, P., GERMAIN, M. J., MORANNE, O. & DAVISON, S. N. (2016): Supportive care: time to change our prognostic tools and their use in CKD. In: *Clinical Journal of the American Society of Nephrology*, 11, pp. 1892–1901.

Czech Society for Palliative Medicine (2013): *Standardy paliativní péče 2013* [*Palliative care standards 2013*].[online] [Retrieved December 15, 2019] Available at: https://www.paliativnimedicina.cz/paliativni-pece-v-cr-v-roce-2013/

FIRMENT, P. (2015): Terminálna fáza ľudského života a poskytovanie zdravotnej starostlivosti z pohľadu práva [The terminal phase of human life and the provision of healthcare from the perspective of law]. In: *Anestéziológia a intenzívna medicína (SOLEN)*, 4(2), pp. 75–77.

GRACE, B., HURST, K. & MCDONALD, S. (2012): *ANZDATA 35thAnnual Report 2012. Australia and New Zealand Dialysis and Transplant Registry*.

HEDAYATI, S. S., MINHAJUDDIN, A. T., TOTO, R. D., MORRIS, D. W. & RUSH, A. J. (2009): Prevalence of major depressive episode in CKD. In: *American Journal of Kidney Diseases*, 54, pp. 424–432.

HOLLEY, J. L. (2007): Palliative care in end-stage renal disease: Illness trajectories, communication and hospice use. In: *Advances in Chronic Kidney Disease*, 14(4), pp. 402–408.

JONSEN, A. R., SIEGLER, M. & WINSLADE, W. J. (2010): *Clinical ethics. A practical approach to ethical decisions in clinical medicine*, 7th ed. New York: McGraw-Hill Medical.

KUŘE, J. (2012): *Kapitoly z lékařské etiky* [*Chapters from medical ethics*]. Brno: Masarykova univerzita.

KUŘE, J. (2015): Rozhodování o péči o novorozence na hranicích viability [Deciding on the care of newborns on the borders of viability]. In: *Časopis zdravotnického práva a bioetiky*, 5(1), pp. 63–85.
MOSS, A. H. (2001): Shared decision-making in dialysis: The new RPA/ASN guideline on appropriate initiation and withdrawal of treatment. In: *American Journal of Kidney Diseases*, 37, pp. 1081–1091.
MURTAGH, F. E., BURNS, A., MORANNE, O., MORTON, R. L. & NAICKER, S. (2016): Supportive care: Comprehensive conservative care in end-stage-kidney disease. In: *Clinical Journal of the American Society of Nephrology*, 11, pp. 1909–1914.
MURTAGH, F. E., MARSH, J. E., DONOHOE, P., EKBAL, N. J., SHEERIN, N. S. & HARRIS, F. E. (2007): Dialysis or not? A comparative survival study of patients over 75 years with chronic kidney disease stage 5. In: *Nephrology Dialysis Transplantation*, 22, pp. 1955–1962.
PATOČKA, J. (1999): *Péče o duši II. Sebrané spisy* [*Care for the Soul, vol. II: Collected Works*]. Praha: Oikoymenh.
RHODEN, N. K. (1986): Treating Baby Doe: The ethics of uncertainty. In: *The Hastings Center Report,* 16(4), pp. 34–42.
RYCHLÍK, I. & LOPOT, F. (2017): *Statistická ročenka dialyzační léčby v ČR za rok 2016* [*Statistical Yearbook of Dialysis Treatment in the Czech Republic in 2016*]. Česká nefrologická společnost. [online] [Retrieved December 15, 2019] Available at: http://www.nefrol.cz/odbornici/dialyzacni-statistika
SLÁMA, O. (2010): Co je postup lege artis u pacientů v terminálním stavu? Aktuality v onkologii [What is the lege artis procedure in terminal stage patients? Oncology news]. In: *Klinická onkologie*, 23(3), pp. 182–183.
SLÁMA, O. (2013): Co je postup lege artis u pacientů v terminálním stavu? [What is the lege artis procedure in terminal stage patients?]. In: R. Ptáček, P. Bartůněk & J. Mach et al. (eds.): *Lege artis v medicine* [*Lege artis in medicine*]. Praha: Grada Publishing, pp. 125–130.
SZONOWSKÁ, B. (2018): Paliativní péče v nefrologii [Palliative care in nephrology]. In: *Časopis lékařů českých*, 157(1), pp. 25–29.
U. S. RENAL DATA SYSTEM (2011): Incidence, prevalence, patient characteristics and treatment modalities. In: *USRDS 2011 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States.* Bethesda: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases.
U. S. RENAL DATA SYSTEM (2014): Incidence, prevalence, patient characteristics and treatment modalities. In: *USRDS 2014 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States.* Bethesda: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases.

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Current issues in aesthetics and beyond: Revisiting lookism[1]

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Abstract
Lookism is a term used to describe discrimination based on the physical appearance of a person. We suppose that the social impact of lookism is a philosophical issue, because, from this perspective, attractive people have an advantage over others. The first line of our argumentation involves the issue of lookism as a global ethical and aesthetical phenomenon. A person's attractiveness has a significant impact on the social and public status of this individual. The common view in society is that it is good to be more attractive and healthier. This concept generates several ethical questions about human aesthetical identity, health, authenticity, and integrity in society. It seems that this unequal treatment causes discrimination, diminishes self-confidence, and lowers the chance of a job or social enforcement for many human beings. Currently, aesthetic improvements are being made through plastic surgery. There is no place on the human body that we cannot improve with plastic surgery or aesthetic medicine. We should not forget that it may result in the problem of elitism, in dividing people into primary and secondary categories. The second line of our argumentation involves a particular case of lookism: Melanie Gaydos. A woman that is considered to be a model with a unique look.

Keywords: aesthetic authenticity, discrimination, health, lookism, social identity, unique look

Introduction

In this paper, we will follow two primary lines of argumentation. The first is concerned with what lookism is. The second is concerned with the question why it is a global aesthetic phenomenon. In any case, lookism is a relatively new term used to describe an old phenomenon: discrimination based on a person's physical appearance. We suppose that the social and cultural impacts of lookism represent a serious philosophical issue because, according to this concept, attractive people have an advantage over others. Therefore, it is highly probable that the phenomenon we call lookism may cause discrimination against those who are not considered sufficiently attractive by society. Many different theoretical questions arise from this assumption. For example: What are the criteria for measuring beauty? Should human beauty be normalized? Is there a single idea of beauty throughout time? Is it acceptable to perceive the human body as a fashion brand?

The term "lookism" was first used during the 1970s, within the "fat acceptance movement". It was used by The Washington Post newspaper in 1978, which declared that the term was coined by obese people (Fat pride, 1978). Those people created the term to refer to discrimination based on appearance. For instance, William Safire argues that lookism is one of the most penetrating – yet denied – prejudices based on appearance (Safire, 2004, p. 189). Compared to the 20th-century perception of lookism, formed as a critical response to discrimination, 21st-century lookism seems more heterogeneous. In this paper, we will analyze the current form of lookism. There are two fundamental issues in understanding contemporary lookism. The first one is the perception of lookism as aesthetics of corporeality. In this understanding, there are several serious issues that

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needed to be analyzed, such as the extent and form of enhancements and adjustments, or economic discrimination in modern society. The second issue lies in the authenticity and integrity of a human being with a unique appearance.

Modern plastic surgery offers a variety of "improvements" of the human body. We argue that all parts of human body can be modified through plastic surgery. However, the dominant position of plastic surgery in society may lead to several issues, for instance, elitism, segregation of people based on body improvements. Usually, lookism is not even regarded as other discriminatory practices (cultural or sexual discrimination). In this paper, we argue that lookism is now globally widespread and is affecting various aspects of human life, for example, job opportunities, social relations, partner selection.

Lookism and the workplace; contemporary or long-term effects?

Physical attractiveness is associated with positive gratification (feelings) such as pleasure, delight, and enjoyment. On the other hand, unattractiveness is related to negative feelings such as frustration, loss of self-esteem, and disgust. People also judge others based on their appearance, and this judgment can affect the treatment of others. The research paper "What is beautiful, healthy, more intelligent is good" demonstrates that people who are physically attractive benefit from their better appearance. Such a person can have an advantage when choosing a job because they are seen as a healthier, stronger, and smarter person. For instance, sales assistants are often expected to be physically attractive to promote a particular brand image. Some companies regard attractiveness as a necessity for their candidates (Cavico et al., 2012, p. 792). A specific appearance and style, as we will demonstrate in the article, produces many ethical issues because it leads to various discriminatory practices. For instance, companies might only favour young, slim or beautiful applicants and discriminate against those who do not meet the requirements.

Attractiveness should be understood as a global concern because the long-lasting impacts of lookism are present in all societies. Most cultures prefer youth, physical attractiveness, and health over other qualities. Zahra Ghodrati and Toktam Namayendeh Joorabchi argue that we consciously and even unconsciously try to match established criteria of beauty and overall appearance because we want social acceptance from others (Ghodrati & Joorabchi, 2016, p. 86). The norms and standards of human beauty are constantly changing with every generation and culture. Currently, the understanding of these standards and norms is influenced by globalization. The idea of beauty is a crucial standard in every culture but this factor is plastic and changes.

International companies and the fashion industry contribute to the way people judge beauty and appearance in the current culture. The extent to which an individual is exposed to a local or international environment defines to what extent he/she is inclined to the cultural values or globally defines norms (Ghodrati & Joorabchi, 2016, p. 86). These differentiations create a new type of discrimination based on the appearance and general looks of an individual (Ghordrati & Joorabchi, 2016, p. 86).

Fashion companies currently follow the trend of hiring attractive people from different cultures and countries. The discrimination factor is entirely centred on the beauty of the individual. Knowledge and professionalism are regarded as secondary qualities.

Height as one of the issues of lookism

Physically attractive people benefit from these stereotypical beliefs and use this type of discrimination to get an advantage over others. More attractive people have more friends, better

social skills, better jobs, and more opportunities in general. These people even have a higher chance of reproduction because they have a more active sex life.

Attractive appearance is also tied to the height of the individual. For instance, women with a height of 170 cm or more are preferred in many career positions. This pattern originates from the world of modelling and is associated with hidden discrimination. For men, the consequences of height are not as significant as for women, but they also suffer from similar discrimination if the men are deemed too short. There are important issues that arise from our argumentation about what society deems as "too short". What is the appropriate height for men? Do men lose social status if they are too short? Are shorter men discriminated in society?

The American philosopher Michael Sandel argues that it is necessary to consider four examples of possible bioengineering of the near future: muscle enhancement, memory enhancement, height enhancement, and sex selection (Sandel, 2007, p. 10). In each case, what began as an attempt to treat a disease (some form of medical therapy) is now moving towards genetic enhancement because, currently, the enhancements are presented as a means to eliminate disorders (Sandel, 2007, p. 10). Sandel suggests that to fix the problem of height, we should use growth hormones. Growth hormones as therapy are currently used routinely, and it is this type of generalization that allows these new types of improvements. However, the problem of height is not solely tied to growth hormone solutions. The issue of height is more complex than it seems.

Michael Sandel continues his argument and claims that paediatricians and medical doctors already struggle with the ethics of enhancement when confronted by parents who want to make their children taller (Sandel, 2007, p. 16). Since the 1980s, human growth hormone has been approved for children with a hormone deficiency that makes them much shorter than average. The treatment can alter the height also of healthy children, so there is a possibility of misuse. Some parents of healthy children who are unhappy with their child's stature, primarily boys, ask for hormone therapy (Sandel, 2007, pp. 16–17). Sandel's arguments prove that the problem of low growth is more frequent for boys than for girls. The issue of height produces many forms of discrimination, for instance, social (social isolation, lack of relationships, partner selection) or economic (job opportunities).

Sandel claims that some critics want to use human growth hormone for cosmetic endocrinology (Sandel, 2007, pp. 17–18). If we agreed with these critics, we could create a space for consumerism in medicine. Consumerism in medicine can be seen in plastic surgery and corrective medicine as these enable people to transform the aesthetics of their bodies according to individual preferences. Sandel adds to his argumentation; health insurance is unlikely to cover it, and the treatments are expensive. Injections are administered up to six times a week, for two to five years, at an annual cost all for a potential height gain of two or three inches (5,08 cm or 7,62 cm). Some people oppose height enhancement because it is collectively self-defeating, as some become taller, and others become shorter, relative to the norm (Sandel, 2007, p. 18).

What is this norm? Is it some current or long-term standard? Is it possible to normalize a human body? Can we tolerate the practices that lead to discrimination? For instance, if we agree with Nick Bostrom and Rebecca Roach about the normality of the human body, we automatically discriminate against those who do not meet these given criteria (Bostrom & Roache, 2008, pp. 120–121). In the future, if we accept some criteria for normality, we should be prepared to address various discriminations and prejudices in job opportunities, education, social activities, or partner selection.

It seems that the major issue is the prejudicial sort of aestheticism that creates a glorification of a specific type of human body; the victims of the current trends are short men and very tall women (Tietje & Cresap, 2005, pp. 32–33). There are other instances when we discriminate against people who are considered to be different, for instance, people from different cultures, religions, or sexuality. These types of discrimination share one aspect; they cannot accept diversity and different perceptions.

Economic impacts of lookism

Lookism is not only a philosophical and aesthetical issue but also has broader economic consequences because people are willing to invest money in various human body enhancements. Therefore, we argue that economic arguments play a major role in the future of lookism.

There are many economic arguments that we must consider in our analysis of lookism. For example, the difference in income can create discrimination between people who can afford improvements and those who cannot. People also undergo various surgeries and enhancements to increase productivity in the workplace. The number of resources spent on physical aesthetic improvements suggests that people want to improve themselves to be more economically attractive. For instance, people who work in tourism or catering are improving their bodies to be more appealing to customers. The fashion industry is a unique category in this regard because applicants are primarily selected based on their appearance. However, this does not diminish the fact that there is discrimination even within this category. Some examples of these criteria from the fashion industry are bodyweight limits, suppression of bodily characteristics, or height limits. Currently, there is a lack of emphasis on female hips and breasts, which were a symbol of fertility and attractiveness.

In our analysis, we face an additional issue and that is the constantly changing preferences in the proportional and reproductive features of the body. For instance, there is a connection between aesthetics, hygiene, and health. Lenderová et al. demonstrate this fact in the book *The body between medicine and discipline: The beautiful female body, the clean female body, and the growing of beauty with the perspective of medicine in a cross-sectional historical context to the present* (Lenderová et. al., 2014, pp. 168–185). We can observe in the historical context that the effort to look good has a long-lasting effect on the current perception of health and beauty. These two are closely related because they are often understood as synonyms.

New data shows that Americans spent more than $ 2 billion on silicone gel for breast implants and injectables in 2018 (New data shows, 2019). In Europe, the silicone breast implant market was valued at $ 578 million in 2018 (Europe breast implant market, 2019). Countries with the highest number of surgical and nonsurgical cosmetic procedures in 2018 are the USA, Brasil, Mexico, German, India, Italy, South Korea, and Argentina. Statistics demonstrate that the countries with the highest number of surgical and nonsurgical cosmetic procedures in 2018 are: USA – the number of procedures 2.8 mil., Brasil – 1.4 mil., and Mexico – 0.52 million (New statistic reveal, 2018). We conclude that the USA is the country with the most use of plastic surgery and nonsurgical cosmetic procedures. In the year 2018, they reported 4.36 million cosmetic procedures: 1.49 million surgical and 2.87 million nonsurgical (Elflein, 2019).

Physical attractiveness is often associated with a health condition. For instance, a person who is deemed attractive can have healthy self-esteem because others compliment their appearance. We argue that attractiveness impacts on the quality of our health. The issue is that currently many

men are struggling with the effects of heightism, weightism, and this negatively impacts their on mental health (Adomaitis et al., 2017, p. 86). We have to conclude that our society seems to be fixated too much on body image.

How does lookism impact on employment? We argue that many philosophical and ethical issues arise from the impacts of lookism on employment. Many of these issues are tied to social pressure, for instance, segregating people into different categories based on their appearance. The idea of beauty and health is linked to the economic conditions of the individual because people that have better jobs and are paid more can afford to invest more in their improvements (exercising, cosmetic surgeries, or healthier diet). This economic segregation leads to discrimination because those who cannot afford enhancements have lower self-esteem and negative self-image.

We argue that employers appear to discriminate in favour of more attractive people; this means that less attractive people are discriminated against in job opportunities. Experts perceive these consequences of lookism to be the next frontier in the struggle against discrimination in employment (Warhurst et al., 2012, p. 132). The physical appearance of a person heavily influences services. Services continue to increase as an employment choice and physical appearance is becoming more significant than before so the issue of lookism is likely to become more prominent (Warhurst et al., 2006, p. 74).

Lookism creates several ethical dilemmas about human beings, for example, issues with social identity, health, authenticity, integrity, and self-presentation. Furthermore, unequal treatment (discrimination) has a negative impact not only on our self-esteem but also on overall integrity, authenticity, and tolerance in society. We argue that lookism increases social pressure on individuals because they have to undergo beautification to be accepted as valuable members of society.

Some experts claim that many of these enhancing procedures are ethically dubious. For instance, Harris and Chan argue that we can call these examples ethically dubious: breast or penis augmentation, skin whitening, or the taking of anabolic steroids to increase muscle mass (Harris & Chan, 2007, p. 1). We are not discussing severe modifications of human bodies; these are more akin to the aesthetic or fashion enhancements according to the personal inclinations of individuals such as long hair, eye colour, or physique (Harris & Chan, 2007, pp. 1–2). We argue that enhancement is something that benefits the individual if it does not impact upon their health. The impacts of these improvements are often highly problematic to determine because they manifest themselves after a longer period.

As a result of this analysis, some experts would argue that there is nothing morally wrong with human enhancement. We already accept and actively encourage the use of various enhancing practices in our everyday activities (Harris & Chan, 2007, pp. 1–2). For instance, supplements to improve health such as cures, antibiotics, vaccination to increase immunity, vaccination against serious and fatal diseases belong to this category of accepted practices. We can also argue that prosthetic limbs, reading glasses, or hearing aids are a method of enhancement. Harris and Chan ask an important question. We could argue that some of these constitute medical treatment rather than enhancement, but is this a meaningful question; it is difficult to see the difference between improving reduced function to a normal level and improving it to super-normal (Harris & Chan, 2007, pp. 1–2). The concept of what we think of as normal has changed across time (Harris & Chan, 2007, pp. 1–2). Harris and Chan add that it is through altered environmental and genetic factors.

The trend in human corporeality is changing, as the very nature of trends is rather plastic and malleable. The fashion of the body reflects many subtle deviations, reassessments, and evolutions. Aesthetic enhancements can reach beyond our predispositions, but only if the attractiveness of a person is maintained or does not negatively impact upon their health. However, clashes may occur between enhancing the body and impacts on the health. Eva Carpigo claims that it is necessary to focus on the viewpoint of beauty practitioners who agree in considering aesthetic enhancements as their cathartic objectives to remove inner uneasiness and suffering. Consequently, aesthetic treatments should be recognized as practices of well-being since they aim to enhance the user's psychological and social life (Carpigo, 2016, pp. 1–3).

Anton Leist argues in his paper What Makes Bodies Beautiful that we are on the threshold of a new era in which biological science has an increasing power to design the human body. To this date, medicine has always been geared towards illness. Traditionally, its task has been to alleviate physical suffering caused by disease or to prevent suffering in the first place. Medicine in the future will probably be oriented towards design (Leist, 2003, p. 187). Leist's argument points to a distinct type of consumerism in medicine – plastic surgery. The tendency to achieve the ideal of beauty (reshaping of the human body) is present in plastic medicine and corrective surgeries. The current conception of beauty is motivated by the prevailing trends of aesthetic body treatments. The classic example of this is rhinoplasty because the nose is a dominant feature of the face. According to Leist, the task of design will be to create a body according to particular ideals. These are primarily health and vitality because they are the most important. The first harbingers of this shift are already visible in the fields of sports, medicine, cosmetic surgery, and different types of geriatric medicine (Leist, 2003, pp. 187–188).

Can medicine be only about aesthetics? This question reflects the growing superimposition of beauty and health. In the next part of our analysis, we will examine this idea on the example of Melanie Gaydos.

Special Case: Melanie Gaydos

In the past, models were tall, skinny, and were mostly white. They were beautiful and stunning, but they did not reflect the diversity of the human race. We argue that current trends are changing and the fashion world is developing towards more diverse models. Therefore, outdated ideas are being replaced by fashion models with a unique appearance.

Melanie Gaydos is one of the leading faces of this contemporary trend. She is a 28-year-old model in the USA and has a rare genetic disorder called ectodermal dysplasia. This disorder prevents her teeth, skin, muscles, cartilage, and bones from fully developing. Gaydos has scratched eyes as a result of her eyelashes growing so she is partially blind. In the case of Melanie Gaydos, corrective surgery or standard plastic surgery would help, for instance, save her eyes. However, these procedures often considered a global ethical dilemma.

Melanie Gaydos perceives her body as a fashion brand because it is an original and unique presentation of her identity. There are two lines of reasoning about her perception of the body. In the first one, we must consider the complete acceptance of her body authenticity. Everyone has the right to self-expression and the opportunity to work and create art or fashion. We must recognize that everyone can express ideas about their identity and determine who they are. The ability to determine our lives leads to a fulfilled and happy life.

The second line is the opposition and criticism that is composed of a series of questions. Is it ethically acceptable to put physical appearance above health? Is Gaydos's fashion brand more than healthy eyesight? Is self-expression and authenticity of more importance than a healthy body? Is medical opinion less important than the expression of art or fashion?

Melanie Gaydos has already answered these questions for herself. For instance, she claims that eye-saving surgery is not an option because her appearance is the decision to self-express. An ethical dilemma arises in this decision because she primarily perceives her body as a fashion brand. Many critics would argue that an individual should not favour appearance over health. We believe that Gaydos accepts the health risks of her decisions because she believes that the expression of individual choice is a basic right of every human being. It is an expression of authenticity for an individual. However, the health risks can be grave and the consequences irreversible. Therefore, we have to be very careful in favouring appearance over health.

Melanie Gaydos is a unique case in the fashion industry because health disadvantages are used as a subject of aesthetic body appeal. There are other models with physical disabilities, but the case of Melanie Gaydos is significant because she used her disability as a fashion brand. She turned a disadvantage into an advantage in the world of fashion.

However, we must conclude that there are ethical issues in enhancements (improvements) of the body. For example, individual decision can often be influenced by social pressure. Some critics may argue that decisions made under social pressure are not a display of free will. Ultimately, an individual's demonstration of authenticity is not authentic because discriminatory practices of contemporary society influence it. Sophie Mitra argues that there is a difference between disabled models that ignore prevention and are unlikely to be conducive to the human development of all; they do not cover many people with temporary difficulties or late-life onsets who may not self-identify as having a disability and are not connected to disabled people's organizations. They also ignore the potential well-being enhancements that health care and prevention may bring about (Mitra, 2018, p. 158). Mitra's argumentation can be used for the case of Melanie Gaydos because she wants to maintain physical integrity at the expense of reduced health. She is aware of her health handicap, but her modelling career has a higher value than health.

Conclusion

To summarize our first thematic line, we argue that it is possible to find a specific justification of lookism in the field of services and businesses, where an attractive appearance is a condition. More than others, fashion trends and current aesthetic ideals heavily determine this justification. Our culture also influences our understanding of beauty and how we perceive the human body. We conclude that, under different circumstances, the ideal of beauty often changes. The contemporary understanding of appearance and beauty seems to be more flexible and plastic than in previous times. Fashion trends also begin to include more diversity and accept a wider variety of models.

In the second thematic line, we have analyzed ethical issues and the consequences of preferring appearance over health. Concretely, we have examined the issue of discrimination arising from lookism. People who are enhanced could have an advantage over others, because, as we have demonstrated, some sectors in society prefer individuals with improved appearance. Of course, social and cultural influences heavily impact upon the contemporary understanding of beauty. The current ideal of beauty is much wider and more diverse than it was in the past, and in the future, most probably, it will expand even more.

We argue that current trends are becoming more individualized. This development signifies that, in the world of fashion, individuality and authenticity are two of the accepted factors. Models are now being created through various medical procedures, and therefore, they can adjust the ideal and develop this concept of beauty further. We argue that some people believe that the personal idea of beauty is more significant than their health. Melanie Gaydos is an example of a model that was able to use her disability and health problems as a fashion brand. In her case, however, she is not a victim of lookism, because she was using her disadvantage as an advantage. Here, a question arises: Is it possible to perceive disability as a fashion brand?

It seems that we must perceive this issue from an aesthetic perspective, because it belongs to the fashion world. If we use an ethical perspective, we should be obliged to prefer the health of a person above the individual idea of beauty. Yet the width and plasticity of fashion trends impact upon the ideal of body beauty and concurrently corrects it and Alexis Shotwell reminds us that we do not want to harp too much on philosophy; the "well-being beauty brand"; it is a little as though the writing of their marketing copy is writing directly for us (Shotwell, 2016, p. 3).

We conclude that in this situation, the ideal path would be to fully accept individuality and authenticity with an emphasis on maintaining or improving health. Enhancement could be acceptable only if it helps to maintain or increase the quality of life and the health of a person. We can assume that utilitarianism can also be useful with respect to the concept of lookism. More good for more people, and in this case, the good can be taken to be synonymous with beauty. There are countries, such as Brazil, that has this type of open approach to human aesthetic improvements. They call it the "right to beauty" and the state participates in the financing plastic and aesthetic surgeries. It increases the availability of those procedures to the general population. However, the people have to undergo certain medical checks first. They believe that prevention and treatment are more effective. Of course, only a healthy person can undergo aesthetic enhancement.

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References

ADOMAITIS, A. D., RASKIN, R. & SAIKI, D. (2017): *Appearance discrimination: Lookism and the cost to the American woman*. In: *The Seneca Falls Dialogues Journal*, 2(1/6), pp. 73–92.

BOSTROM, N. & ROACHE, R. (2008): *Ethical issues in human enhancement.* In: *New Waves in Applied Ethics*, pp. 120–152. Available at: www.nickbostrom.com.

CARPIGO, E. (2016): *Beauty at the service of humanity. A Review on the therapeutic value of aesthetic treatments*. [online] [Retrieved December 30, 2019] Available at: https://halshs.archives-ouvertes.fr/halshs-01512281 *This text is issued from a speech done in the 4th global meeting: Beauty, exploring the critical issue.*

CAVICO, F. J., MUFFLER, S. C. & MUJTABA, B. G. (2012): Appearance discrimination, "Lookism" And "Lookphobia" in the workplace. In: *The Journal of Applied Business Research,* 28(5), pp. 791–802.

ELFLEIN, J. (2019): Countries with the highest number of surgical and nonsurgical cosmetic procedures in 2018. [online] [Retrieved December 30, 2019] Available at: https://www.statista.com/statistics/293391/surgical-and-nonsurgical-cosmetic-procedures-by-country/.
EUROPE BREAST IMPLANT MARKET SIZE BY PRODUCT (SALINE, SILICONE), BY SHAPE (ROUND, ANATOMICAL), BY APPLICATION (BREAST AUGMENTATION, BREAST RECONSTRUCTION), BY IMPLANT TEXTURE (SMOOTH, TEXTURED), BY END-USE (HOSPITALS, CLINICS), INDUSTRY ANALYSIS REPORT, REGIONAL OUTLOOK (U.S., CANADA), ESTIMATED TO EXCEED USD 1.1 BILLION BY 2025 (2019): [online] [Retrieved December 30, 2019] Available at: https://www.graphicalresearch.com/industry-insights/1194/europe-breast-implants-market.
FAT PRIDE (1978): [online] [Retrieved December 30, 2019] Available at: https://www.washingtonpost.com/archive/lifestyle/magazine/1978/05/14/fat-pride/782c4d14-4c75-424b-aff0-ae62cc8dd8fa/.
GHODRATI, Z. & JOORABCHI, T. N. (2016): Does age, gender, education affect lookism with mediation effect of culture? In: *Journal of Globalization Studies*, 7(2), pp. 86–101.
HARRIS, J. & CHAN, S. (2007): In support of human enhancement. In: *Studies in Ethics, Law, and Technology – Questions of human enhancement.* 1(1), Article 10, pp. 1–3. Available at: http://www.bepress.com/selt/vol1/iss1/art10 DOI: 10.2202/1941-6008.1007.
LENDEROVÁ, M., TINKOVÁ, D. & HANULÍK, V. (2014): *Tělo mezi medicínou a disciplínou*. *Proměny lékařského obrazu a ideálu lidského těla a tělesnosti v dlouhém 19. století* [*Body between medicine and discipline: Changes of doctor's views and ideals of human body and carnality in the long 19th century*]. Praha: Lidové noviny.
LEIST, A. (2003): *What makes bodies beautiful*. In: *Journal of Medicine and Philosophy*, 28(2), pp. 187–219.
MITRA, S. (2018): *Disability, health and human development*. New York: Palgrave Pivot/ Springer Nature.
NEW DATA SHOWS THAT AMERICANS SPENT MORE THAN $2 BILLION ON SILICONE GEL BREAST IMPLANTS AND INJECTABLES IN 2018 (2019): [online] [Retrieved December 30, 2019] Available at: https://www.surgery.org/media/news-releases/new-data-shows-that-americans-spent-more-than-2-billion-on-silicone-gel-breast-implants-and-injectables-in-2.
NEW STATISTICS REVEAL THE SHAPE OF PLASTIC SURGERY (2018): [online] [Retrieved December 30, 2019] Available at: https://www.plasticsurgery.org/news/press-releases/new-statistics-reveal-the-shape-of-plastic-surgery.
SAFIRE, W. (2004): *The right word in the right place at the right time*. New York: Simon & Schuster.
SANDEL, M. J. (2007): *The case against perfection: ethics in the age of genetic engineering*. Cambridge, MA: Belknap Press of Harvard University Press.
SHOTWELL, A. (2016): *Against purity. Living ethically in compromised*. Minneapolis & London: University of Minnesota Press.
TIETJE, L. & CRESAP, S. (2005): *Is lookism unjust? The ethics of aesthetics and public policy implications*. In: *Journal of Libertarian Studies*, 19(2), pp. 31–50.
WARHURST, C., BROEK, D., HALL, R. & NICKSON, D. (2006): *Lookism: The new frontier of employment discrimination?* In: *Journal of Industrial Relations*, 51(1), pp. 131–136.

WARHURST, C., BROEK, D., HALL, R. & NICKSON, D. (2012): *Great expectations: gender, looks, and lookism at work*. In: *International Journal of Work Organisation and Emotion*, 5(1), pp. 72–90.

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The ethical dimension of erotic self-education and development ethics[1]

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Abstract
The ethical dimension of sexual education can referred to morality, religion and the ethos of life. Morality and religion exert pressure on certain behavior patterns. "Ethical eroticism" in relation to the theory of Development ethics implies a positive integration of sexuality with the ethos of life. "Ethical eroticism" in this area is not identical to sexual morality. Sexual morality is an external element as comprehended by a person, while "ethical eroticism" based on the ethos of life expresses a person's moral subjectivity. In the principles of development ethics, the emphasis is shifted to individual development, which is the reason for propounding the postulate of erotic self-education.

Keywords: morality, sexual education, ethical eroticism, Development ethics

Introduction

The aim of the article is to reveal the ethical dimension of sexual education. The first subchapter will present moral aspects of sexuality, or rather, the interest in sex taken by "morality". The second subchapter will suggest selected ethical views on sexuality that had or still have some impact on sexual education. The last subchapter refers to the theory of Development ethics; Development ethics is "a theory which aims to show the normative dimension of human development with basic assumptions built on the theses of moral existence of the man and ethical personality" (Grzybek, 2010, p. 120). Based on this proposition, an attempt will be made to define ethical eroticism as a proposition for sexual self-education.

Sex and morality

It is worth asking the key question: why is "morality" interested in sex? What are the reasons for such an interest? Are they natural? Or, is it rather the result of a desire to effectively control faithful people (in terms of religion), subjected citizens (when it comes to some historical restrictions) in order to influence their civic behaviour and attitudes, to control business so that the customer chooses proper products?

To illustrate this issue, a few interesting statements will be provided. Quite significant in this respect is Peter Singer's view:

> "So the first thing to say about ethics is that it is not a set of prohibitions particularly concerned with sex. Even in the era of AIDS, sex raises no unique moral issues at all. Decisions about sex may involve considerations of honesty, concern for others, prudence, and so on, but there is nothing special about sex in this respect, for the same could be said of decisions about driving a car" (Singer, 1999, p. 2).

The conviction that ethics should not deal with the sexual sphere has a double meaning. The first one concerns morality, that is, one should not unnecessarily moralize sexual life and burden it with prohibitions. The second meaning concerns the way of understanding ethical reflection

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and the role of ethics in a person's life. If the role typical of the theory of Development ethics is accepted, then it is shaping our ethical standards - the sexual sphere then requires certain integration with the ethos of life (Grzybek, 2014, pp. 71–84). Thus, the morality present in the form of social pressure can be considered undesirable, and ethics will then be understood as life wisdom necessary for the sexual sphere (Grzybek, 2016, p. 18). Here, one can agree with Osho's view that:

> "There is no future of any morality concerning sex. In fact, the very combination of sex and morality has poisoned the whole past of morality. Morality became so sex-oriented that it lost all other dimensions which are far more important. Sex should not be so much of a concern for moral thinking" (Osho, 2003, p. 131).

Morality, seen as a force exerting pressure to behave in a certain way, may be considered as a restriction of freedom, while in the sexual sphere there has been and continues to be a tendency to enslave another. Michel Foucault puts it this way:

> "The notion of repressed sex is not, therefore, only a theoretical matter. The affirmation of a sexuality that has never been more rigorously subjugated than during the age of the hypocritical, bustling, and the responsible bourgeoisie is coupled with the grandiloquence of a discourse purporting to reveal the truth about sex, modify its economy within reality, subvert the law that governs it, and change its future. The statement of oppression and the form of the sermon refer back to one another; they are mutually reinforcing. To say that sex is not repressed, or rather that the relationship between sex and power is not characterized by repression, is to risk falling into a sterile paradox. It not only runs counter to a well-accepted argument, it goes against the whole economy and all the discursive "interests" that underlie this argument" (Foucault, 1978, p. 8).

Although some oppressive approach to the sexual sphere seems to be historically determined, there is still a discussion going on and the gender struggle continues (Fromm, 1999).

Not only did Peter Singer draw attention to excessive interest in sexuality shown by religion, but Osho also emphasized the following: "All the religions are against sex because that is the only way to make you miserable. That is the only way to make you feel guilty. That is the only way to reduce you to being sinners" (Osho, 2003, p. 133). Perhaps the source of motivation of the oppressive approach to the sexual sphere is to make people unhappy so that to make them easier to be ruled. Zygmunt Bauman calls this approach the management of anxiety (Bauman, 2006; Bauman, 2010, pp. 56–57).

It is worth pointing out, however, that normalizing the sexual sphere is natural if the view of Georges Bataille is accepted:

> "From the human perspective, the place of sex life is undoubtedly defined by prohibition. It is never absolutely free; the ban keeps it always within the limits set by the custom. Of course, it would be barren to resist this, against prohibition; it is not "human" to say that only freedom is compatible "with nature". Man is fundamentally different from nature, can even be viewed in strong opposition to it, and cancelling the prohibition would mean only one issue – the so-called "animality" from which people evolved (of which they are aware) and which can no longer be longed for" (Bataille, 2008, p. 22).

Since normalizing the sexual sphere seems natural, the question should be posed about the relation not only of morality to the sexual sphere, but also to ethical thought.

The above-mentioned author in his work "History of eroticism" accepts as the starting principle that sexuality will be considered "only in concrete, coherent 'wholeness' in which the erotic and intellectual world complement each other and occupy equal positions" (Bataille, 2008, p. 22). Thus, we have sexuality subjected to morality, eroticism escaping intellectual understanding, although the thought triggers eroticism, and then eroticism triggers back the thought, as well as ethics and life ethos which should enclose sexuality.

An important problem also affecting sexuality is the awareness of sin, evil. Michel Foucault points out the right of asking the question:

> "why sex was associated with sin for such a long time-although it would remain to be discovered how this association was formed, and one would have to be careful not to state in a summary and hasty fashion that sex was "condemned" - but we must also ask why we burden ourselves today with so much guilt for having once made sex a sin. What paths have brought us to the point where we are "at fault" concerning our sex? And how have we come to be a civilization so peculiar as to tell itself that, through an abuse of power which has not ended, it has long "sinned" against sex? How does one account for the displacement which, while claiming to free us from the sinful nature of sex, taxes us with a great historical wrong which consists precisely in imagining that nature to be blameworthy and in drawing disastrous consequences from that belief" (Foucault, 1978, p. 9).

Is it possible to talk about freeing oneself from the awareness of sin in the sexual sphere? Aren't many people made to visit a psychotherapist for this reason? Maybe it is time to take heed in Osho's statements: "The future will know a different vision of sex. It will be more fun, more joy, more friendship; more a play than a serious affair as it has been in the past. It has destroyed people's lives, has burdened them so much - unnecessarily! It has created so much jealousy, possessiveness, domination, nagging, quarreling, fighting, condemnation - for no reason at all" (Osho, 2003, p. 132). It seems that due to human well-meaning, associating guilt with sexuality leads to a lack of comfort in life.

Miroslav Plzák draws attention to the problem of the moralization of the sexual sphere and the glorification of continence:

> "The general public, for example, refuses to accept the view that in just sporadic cases the subject is erotically stimulated throughout life only by one partner. Recognition of this sad fact would lead to the breakdown of the monogamous marriage model if there were no morality glorifying virtue and chastity. Most people maintain the view that women have to guard chastity rather than develop sexual and erotic techniques. The contradiction between the moral principle and the tendency of sex drive is solved in favor of the moral principle because, otherwise, it would require the necessity to re-evaluate the assumptions laying the background of today's marriage and family" (Plzák, 1973, pp. 21–22).

Does the adoption of a certain model of conjugal relationships not lead to moral double standards? According to Miroslav Plzák, "The presented contradiction is, however, the cause of harmful social phenomena, such as sexual infidelity and prostitution on the one hand, and neurosis - on the other. Society reconciles this contradiction by the existence of double-faced morality - official (formal), putting the principle of virtue in the first place and unofficial (but tolerated), allowing promiscuity" (Plzák, 1973, p. 22). Such double-faced morality not only undermines healthy emotional relations between partners but also does not allow erotic development and integration of the sexual sphere with the life ethos (Plzák, 1973, p. 22).

Ethical thought as related to the moralizing of sexuality has been divided among ethicists. One of the classifications worth mentioning was presented by Tadeusz Ślipko. He distinguishes

absolutist ethics- to which he includes the ethics of natural law and personalistic ethics- from relativistic ethics, where he attributes humanistic orientation (secular and Christian orientation) and naturalistic orientation (including secular and Christian orientation). The author reduces the fundamental dividing line of anti-permissive, objective and absolute Christian ethics, from the relativistic, permissive liberal ethics (Ślipko, 2012, pp. 67–68, Ślipko, 2005, p. 284).

Ethics, sexuality, norms, religion

While the previous subchapter was aimed at considering the tension between morality and sex in the context of ethical thought, this subchapter's task is to show, through the writings of selected authors, the normative indications extrapolated from these texts on educational principles as seen through the sphere of sexuality. It should be noted that some views will be based on our comments. Such educational intervention is justified in so far as it is dictated by the necessity of a brief expression of thought.

Referring to social forces that moralized sex in antiquity, continuing to influence the modern era, it is worth pointing to the emergence of Christianity and its manner of drawing ethics from other ideologies. Apart from the religious aspects and oppressiveness resulting from Gnosticism, Stoic thought played an important role in this development. Uta Ranke-Heinemann emphasized, among other things, the significance of the Stoic school: "That increasingly rigorous assessment of sexual activity and the tendency to reduce it within the first two centuries after Christ was the result of the influences of the Stoics, the largest philosophical school of that time, from about 300 BC to around 250 after Christ. The word "stoic" to this day means an attitude of indifference and dispassion" (Ranke-Heinemann, 2015, p. 17). It was the Stoics who, not only for antiquity, introduced undervaluation of the sexual sphere and physical relations between a man and a woman: "The suspicion aroused in the Stoics concerning striving for sensual enjoyment led, on the one hand, to admitting that sexual activity within marriage was of higher value than disordered life of the sexes; on the other hand, it led to neglecting marriage as being too far from the ideal of total abandonment of lust and passion" (Ranke-Heinemann, 2015, p. 17). Marriage as a joyful sexual relationship was crossed out at the beginning of the emergence of Christianity, which was not only burdened with Gnosticism, but also with the views of the Stoics: "[The] [M]arriage act remained connected with the concept of lust; it was impossible to be integrated; it was stigmatized with distrust concerning all the bodily pursuits aimed at experiencing pleasure. The idea that it should only be an act of procreation, that in any other case it should be related to a negative evaluation with the slogan "lust", not for example "love", left a particular mark on Christianity" (Ranke-Heinemann, 2015, p. 19). Quite heavy in its consequences was the conviction of Sextus who influenced Christian thought: "Who is a too passionate (ardentior = hotter) a lover of his wife is an adulterer (...) Thomas Aquinas, second after Augustine as a pillar of sexual morality, repeated the above- mentioned idea: marriage is aimed at producing offspring, and therefore anyone who loves his wife too passionately, violates the well-being of marriage and can be called an adulterer" (Ranke-Heinemann, 2015, pp. 68–69). Concerning this view, it is worth mentioning the original thought expressed by Thomas Aquinas:

> "… because pleasure in a good action is good, and in an evil action, evil; wherefore, as the marriage act is not evil in itself, neither will it be always a mortal sin to seek pleasure therein. Consequently the right answer to this question is that if pleasure be sought in such a way as to exclude the honesty of marriage, so that, to wit, it is not as a wife but as a woman that a man treats his wife, and that he is ready to use her in the same way if she were not his wife, it is a mortal sin; wherefore such a man is said to be too ardent a lover of his wife, because his ardour carries him away from the goods of marriage. If, however, he seek pleasure within the bounds of marriage, so that it would

> not be sought in another than his wife, it is a venial sin" (Thomas Aquinas, 2006, Supplement to the Third Part, q. 49, a. 6).

The separation of marriage from the possibility of joyful sex is an important influence on the formation of Christian sexual morality.

This problem is clearly evident in the views and attitudes expressed by Augustine of Hippo: "For Augustine, hostility to pleasure was even more important than the procreative goal of every marital act. (...) For Augustine, virginity ranked morally higher than marriage, and again any marriage without sexual relations was placed higher than marriage maintaining such relations. Giving up sexual life together, the spouses achieved a higher degree of moral development" (Ranke-Heinemann, 2015, p. 104). Sexuality in Christian, as well as Catholic thought, has been subjected to moral prohibitions for many centuries. To this day, there is a view that claims the procreative purpose to be the basis of the sexual relationship of spouses: "To put it simply, this position can be expressed employing a formula that is the reverse of the hedonistic-utilitarian view. The point is not to deny the presence and significant role of pleasure experienced in the structure of sexuality or to disregard it. However, the decisive factor shaping the proper reality of sexuality and defining the hierarchy of the importance of its constituent elements in sexuality is the procreative purpose. The deepest sense of sexuality is expressed in it. Sexuality directly and in the first place is directed towards creating and promoting life. In comparison with the procreative purpose, pleasure is considered as a secondary factor and is subordinated by its fundamental orientation, which constitutes its proper content and essence. Since the procreative purpose of sexuality deals with the objective perfection of human life, its position can be described as a perfectionistic, ethical, but not psychological" (Ślipko, 2012, p. 195).

Although Karol Wojtyła re-evaluated the sexuality of a person in Christian thought, he did not change the fundamental focus on the procreative purpose: "It cannot be presumed that sex drive, which has its purpose within man, the purpose that is determined, independent of will and self-determination of man, is something below the person and below love. The purpose of that drive is the existence of the species "*Homo sapiens*, its extension, *procreatio*; and the love of persons, of a man and a woman, is formed within this finality, in its bedrock, as it were; it is formed as if out of this material, which is provided by the drive" (Wojtyła, 2013, p. 36). Therefore, the sexual aspect of love between a woman and a man must be found in the drive to prolong the life of the species.

Dietrich von Hildebrand, on the other hand, recognizes marriage as the most suitable kind of interpersonal relationship capable of manifesting love: "Among all earthly communities, the "I-You" community gains the clearest shape in conjugal love, in which the beloved person is the object of thinking, feeling, thirst, longing and hope. In the order of created goods, the other person becomes the focal point of life. Someone who is filled with such love not only lives with another person but also lives for another person" (Hildebrand, 2017, p. 23). Karol Wojtyła also appreciates love as the most perfect human relation that receives its unique shape in spousal love:

> "Spousal love is something other and something more than all the forms of love analysed so far, both from the perspective of the individual subject, from the perspective of the person who loves, and from the perspective of the inter-personal connection created by love. When spousal love enters in this inter-personal relation, then something other than friendship arises, namely the reciprocal self-giving of persons" (Wojtyła, 2013, pp. 78–79).

There is no denying that, for ethical thought, religious morality remains the reference point concerning sexuality, especially the views of the Catholic Church. In the Catechism of the

Catholic Church, the procreative purpose determines the key, the essence of sexual relations. Love seems to be just an additive aiming to emphasize such purpose: "Fertility is a gift, the purpose of marriage because conjugal love by its nature tends to be fertile. The child does not come from the outside as added to the mutual love of the spouses; but emerges in the very center of this mutual gift of which it is the fruit and fulfillment. Therefore, the Church, "advocating for life", teaches that "every marriage act should remain open to the transmission of human life". Such teaching, repeatedly conducted by the Educational Office of the Church, has its basis in an unbreakable relationship established by God between the dual meaning of a marriage act: a unifying and procreational meaning. Such a relationship cannot be arbitrarily broken by a man" (Katechizm, 1994, p. 534, No. 2366).

The reasons for the polemics concerning setting specific rules for sexual relations in marriage seem to be provided by the Bible. Saint Paul in "The Letter to the Corinthians" entitles the spouses themselves with the opportunity to specify sexual relations and define their purpose: "As for the matters you have written about, it is good for a man not to connect with a woman. However, because of the danger of immorality, let everyone man have a wife and every woman have a husband. Let the husband give the duty to his wife, likewise the wife to her husband. Let not wife dispose of her own body, but her husband; neither does the husband possess his own body, but his wife only. Do not avoid one another, unless for a while, by mutual consent, so that to devote yourself to prayer; then you will come back to each other, for the sake of not being tempted by Satan due to the lack of temperance" (Pismo, 1990, p. 1290, 1 Cor 7: 1-6). Disposal of the body of a spouse can be considered as the principle of an exclusive relationship, without the possibility of interference by a third person or religion. The socialization of sexuality, even marital, can undermine the right to express one's eroticism. However, this problem will be addressed in the section on sexual self-education.

Ethical eroticism and erotic self-education

Before presenting the idea of a possible contemporary pattern of erotic self-education based on the view of "ethical eroticism", it is worth citing some significant opinions held in the past.

Jean Jacques Rousseau, in spite of his modern views on education, created quite a patriarchal image of sexual education. His work "Emil, or Education" addresses the development, the preparation of a woman – the wife intended for Emil. The author indicates first of all that "Sophy" is to be compliant. Compliance can be acknowledged as the basic characteristic feature that defines the relationship between Emil and Sophy. A woman is destined to give birth to children, to be a mother; however, a deeper knowledge of the world, including the study of philosophy, could harm her. First and foremost, she must have some practical knowledge. She must ground her outlook on the views of her husband. Moreover, in her family, she should have an appropriate upbringing to ensure that she will be: natural, good, honest, insightful, kind, intelligent and free from hypocrisy in her behavior. Interestingly enough, there is a belief that she should be sent away from home at the age of around 15. Being in society is not only a way to find a husband but also provides the training necessary to be a house-wife. At home, however, she cannot behave like a "smart woman", but must be a suitable companion for her husband (Rousseau, 2011, pp. 285–370).

Ethical eroticism, which is supposed to be the guiding principle for erotic self-education, cannot be based on the patriarchal system, following the contemporary ethical standard (Hartman, 2015, pp. 24-26), because it should assume a relationship between two partners (Grzybek & Bielak 2015, pp. 79–90). In the theory of "Development ethics", the definition of ethics is related to three aspects: firstly, ethics as a philosophical discipline, knowledge of the art of life, and secondly, life ethos, i.e. personal ethical standards. The third approach opposes morality as an external regulatory system that exerts pressure on the individual to perform a particular behavior pattern (Grzybek, 2014, pp. 71–72). The approach of "ethical eroticism"

refers to the opposition to social morality, including sexual development of each individual's ethical standards with relation to sexuality (Grzybek, 2020, pp. 45–49).

"Ethical eroticism" can be understood as integration, that is, the development of cognitive and volitional capacities. Eroticism is then ethical when it approaches the development of cognitive and volitional skills. The moral dimension of eroticism is "dressed up" in the impact of the morality of pressure. The morality of pressure rules eroticism through prohibitions, orders, and commandments. "Ethical eroticism" contributes to the development of an ethical personality. The basic references are not norms – orders, prohibitions, commandments, but values, above all the following basic ones: freedom, wisdom, love, happiness, the dignity of a person. Eroticism is a quality that can be well or badly used; it can value or destroy, depending on the reference to values, but not norms. Wisdom justifies the choice, freedom creates the space of choice, love constitutes the object of eroticism, happiness confirms its quality, dignity of a person, and his/her integration (Grzybek, 2015, pp. 11–17; Grzybek & Tobiczyk, 2018, pp. 82–91).

Being based on "ethical eroticism", erotic self-education should mean the integration of one's sexuality with one's life ethos (understood as a specific way of being, which is not determined by morality of pressure, but by ethically justified principles of life activity and goals, Grzybek, 2014, pp. 72, 84). The ethical reference for self-education based on ethical eroticism should not be morality as such, but human rights, as well as respect for the dignity and integrity of another person. Morality, being the main component of socialization, absorbs not only positive but also negative elements. Maturity, including ethical personality, should allow acceptance of what is positive and rejection of what is negative in sexual morality based on socialization pressure. According to assumptions of Development Ethics, an ethical personality means "such a state of development of the cognitive and volitional powers of man, which allows a person to persistently strive for one's moral perfection. From the beginning of existence, a man possesses his moral being, and his ethical personality is created through his work, cognitive and volitional efforts" (Grzybek, 2013, pp. 102–103). Thus, sexual morality is above all the nature of external pressure, while "ethical eroticism" is the conscious attitude of the subject of activity.

The theory of Development Ethics emphasizes the subjectivity of the individual concerning social unity (the social wholeness). Socially specified sexuality puts pressure on the behavior of the individual, while "ethical eroticism" together with the concept of erotic self-education provides moral arguments for the right to development, including the sphere of sexuality, and the possibility of self-determination concerning the directions of self-realization (Grzybek, 2020, pp. 186–200; Grzybek & Siwek, 2020, pp. 137–141). In this context, it should be reasonable to refer to the autonomy of the moral subject, where the social consequences of an action depend on the level of the subject's responsibility (Gluchman, 2018, pp. i–xxvii; Kalajtzidis, 2017, pp. 37–49).

Conclusions

The above-mentioned, however, does not mean the rejection of social morality regarding sexuality, which is culturally diverse today; rather, it emphasizes the personal concept of erotic development. In developing an individual concept of erotic development, one can address the category of existence aesthetics (Grzybek, 2020, pp. 201–206; Foucault, 1978, pp. 378–379). Moreover, sexuality means the approach that is of the character of socially and culturally defined norms, while eroticism appears to be a kind of space for development by an individual and, in this, it is the opposite of sexuality. Due to the generally accepted terminology in ethical thought, one should refrain from using the term erotic ethics, but rather choose erotic self-education, which emphasizes its unique personal dimension.

When considering the ethical dimension of erotic self-education, two aspects should be taken into account: 1) moral interest in sex, which can adopt a negative meaning, and 2) "ethical eroticism" which in terms of Development Ethics means positive integration of sexuality with life ethos. Such an approach to sexual ethics is based on the right of a person to express his/her eroticism, guided by the aesthetics of existence, rather than on the social aspect.

Sexual ethics based on the concept of Development Ethics emphasizes above all the right to be guided by individual ethical standards, which should not violate the law, nor the freedom and dignity of others (Grzybek, 2014, p. 68).

References

BATAILLE, G. (2008): *Historia erotyzmu* [*L'Histoire de l'érotisme*], trans. I. Kania. Warszawa: Aletheia.

BAUMAN, Z. (2006): *Liquid fear*. Cambridge: Polity Press.

BAUMAN, Z. (2010): *Liquid times: Living in an age of uncertainty*. Cambridge: Polity Press.

FOUCAULT, M. (1978): *The history of sexuality*, trans. R. Hurley. New York: Random House.

FROMM, E. (1999): *Love, sexuality and matriarchy: About gender*, ed. R. Funk. New York: Fromm International.

GLUCHMAN, V. (2018): Ethics of social consequences: The past and the present. In: V. Gluchman (ed.): *Ethics of social consequences: Philosophical, applied and professional challenges*. Newcastle: Cambridge Scholars Publishing, pp. i–xxvii.

GRZYBEK, G. (2010): *Etyka rozwoju a wychowanie* [*Development ethics and upbringing*]. Rzeszów: UR.

GRZYBEK, G. (2013): *Etyka rozwoju a pedagogika opiekuńcza* [*Development ethics and pedagogy of care*]. Rzeszów: UR.

GRZYBEK, G. (2014): *Etos życia. Wychowanie do małżeństwa w założeniach etyki rozwoju* [*The ethos of life*: *Marriage education according to the principles of development ethics*]. Rzeszów: UR.

GRZYBEK, G. (2016): *Etyka zawodowa jako subdyscyplina naukowa* [*Professional ethics as a scientific subdiscipline*]. Rzeszów: UR.

GRZYBEK, G. (2020): *Etos i eros. Etyka rozwoju wobec seksualności a samowychowanie*. [*Ethos and eros: Development ethics towards sexuality in relation to self-education*]. Rzeszów: UR.

GRZYBEK, G. & BIELAK, A. (2015): The ethics of the teacher and the debate about gender. In: *Ethics & Bioethics (in Central Europe)*, 5(1–2), pp. 79–90.

GRZYBEK, G. (2015): Ethics, education and the gender dispute. In: *Zbirnyk naukovykh prac Kamianets-Podilskoho Natsionalnoho Universytetu imeni Ivana Ohiyenka. Seria pedahohichna*, Vypusk 18 (1) [*Collection of scientific papers Kamianets-Podilskyi National Ivan Ohiienko University. Pedagogical series*]. Kamianets-Podilskyi: Medobori, pp. 11–17.

GRZYBEK, G. & SIWEK, SZ. (2020), Satysfakcja seksualna, prawa człowieka, samowychowanie erotyczne. Refleksja etyczna. [Sexual satisfaction, human rights and erotic self-education]. In: *Scientific Bulletin of Flight Academy. Section: Pedagogical Science*s, 7, pp. 137–141.

GRZYBEK, G. & TOBICZYK, P. (2018): Sexual ethics of Catholic religion versus development ethics. In: *Zbirnyk naukovykh prac Kamianets-Podilskoho Natsionalnoho Universytetu imeni Ivana Ohiyenka. Seria pedahohichna*, Vypusk 3 [*Collection of Scientific papers Kamianets-Podilskyi National Ivan Ohiienko University. Pedagogical series*]. Kamianets-Podilskyi: Medobori, pp. 82–91.

HARTMAN, J. (2015): *Etyka! Poradnik dla grzeszników* [*Ethics*: *Manual for Sinners*]. Warszawa: Agora SA.

HILDEBRAND, D. v. (2017): *Małżeństwo* [*Marriage*], trans. J. Kubaszczyk. Poznań: „W drodze".
KALAJTZIDIS, J. (2017): Moral agency in the ethics of social consequences and its comparison in the context of consequentialism. In: V. Gluchman (ed.): *Ethical Thinking Past & Present (ETPP 2017/18). Human being in contemporary ethics*. Prešov: Filozofická fakulta Prešovskej univerzity, pp. 37–49.
KATECHIZM KOŚCIOŁA KATOLICKIEGO [*Catechism of the Catholic Church*]. Poznań & Warszawa: PALLOTINUM, 1994.
OSHO (2003): *Sex matters*: *From sex to superconsciousness*. New York: St. Martin's Press.
PISMO ŚWIĘTE Starego i Nowego Testamentu w przekładzie z języków oryginalnych. Poznań & Warszawa: PALLOTINUM, 1990.
PLZÁK, M. (1973): *Strategia i taktyka w miłości* [*The strategy and Tactics of Love*], trans. T. Siemek. Warszawa: Wiedza Powszechna.
RANKE-HEINEMANN, U. (2015): *Seks odwieczny problem Kościoła* [*Sex as Eternal Problem of the Church*]. Warszawa: RM.
ROUSSEAU, J. J. (2011): *Emile, or on education*, trans. B. Foxley. London & Toronto: J.M. Dent and Sons.
SINGER, P. (1999): *Practical ethics*. Cambridge: Cambridge University Press.
ŚLIPKO T. (2012): *Przedmałżeńska etyka seksualna* [*Pre-marriage sexual ethics*]. Kraków: Petrus.
ŚLIPKO, T. (2005): *Zarys etyki szczegółowej. T. 1: Etyka osobowa* [*The Outline of Specific Ethics. V. 1. Personal Ethics*]. Kraków: Wyd. WAM.
THOMAS AQUINAS (2006). *The Summa Theologica*, trans. Fathers of the English Dominican Province. [online] [Retrieved April 11, 2020] Available at: http://www.documentacatholicaomnia.eu/03d/1225-1274,_Thomas_Aquinas,_Summa_Theologiae_%5B1%5D,_EN.pdf
WOJTYŁA, K. (2013): *Love and responsibility*, trans. G. Ignatik. Boston: Pauline Books.

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Unethical practices in the Slovak business environment: Entrepreneurs vs. the State?

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Abstract

This paper critically analyses one of the unexpected results of qualitative research aimed at detecting the presence of unethical business practices in Slovakia. The authors seek to find out why entrepreneurs participating in this research do not take responsibility for the development of business ethics and why, in their primary reflections on unethical practices in the Slovak business environment, have they shifted it almost completely to the State level (1), and whether their attitude is morally justified (2). The main theoretical foundation in the following analysis is the theory of development of business ethics on three levels (micro, mezzo and macro), also known as the "subject-matter of business ethics" approach. The paper discusses attitudes of the research sample, including Slovak entrepreneurs and company representatives, towards the State, and the consecutive critical reflection of their opinions shows that businesspersons tend to give up on their own proactive approach to the development of business ethics and position themselves in the role of an "expectant" instead of a "creator" of ethical standards in society. Furthermore, the paper points out that businesses lack ethical self-reflection in relation to corruption, more precisely, they lack reflection of their place in the corrupt relationship with the State. Given these findings, the paper concludes that an essential basis for the long-term development of business ethics in our country is the establishment of partnerships between the State and business entities, while recognizing the place of non-governmental democratic institutions.

Keywords: subject-matter of business ethics, micro level, mezzo level, macro level, business ethics, unethical practices, entrepreneurs, state, Slovakia, CEE.

Introduction

This paper deals with an unplanned and unexpected finding obtained during the currently conducted research project on the recent state of business ethics in Slovakia. More specifically, one of the main research questions that was posed to research participants (i.e., Slovak entrepreneurs, business owners and higher management representatives) during the qualitative stream in the respective research project was "What unethical practices do you encounter in the Slovak business environment?" Contrary to common expectations, the respondents did not begin by pointing out the unethical practices carried out by businesses, but they started by naming those practices of the State they perceived as unethical. In other words, in reflecting on the state of ethics in the Slovak business environment, entrepreneurs spontaneously primarily focused on sharp, in some cases even antagonistic, criticism of the State.

Resentment in business–State relations is not a new phenomenon in Slovakia. Research evidence implies that there are problems in the relationship between entrepreneurs and the State, connected with the fact that business is not nested in society and cooperates with other societal institutions (Remišová et al., 2019). Research shows that small firms in Slovakia especially see the business environment as a battlefield, in which they are fighting constantly with the State administration and against harsh legal obligations (Remišová & Lašáková, 2018). Prior foreign studies on small and medium-sized enterprises (SMEs) also show that smaller companies must fight for survival in global competition (Enderle, 2004), they find it extremely difficult to translate socially responsible behaviors into their practice (Ciliberti et al., 2008), they often struggle with the pace of changes in the business environment that might lead to reduced ethical considerations in business decisions (Arend, 2013), and would definitely need more know-how on how to build ethical infrastructures in their companies (Fernández & Camacho, 2016). The authors note the need to especially reflect small retailer-supplier relationships from an ethical

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perspective (Hwang & Chung, 2018) and some studies point also towards the local embeddedness of SMEs and the related social proximity that influences the quality of the relationships with stakeholders and under certain conditions may facilitate unethical structures (Lähdesmäki et al., 2019).

From a more global point of view, some authors note on a "return of the State" in business, with intensified State-led interventions causing imbalance between the public and private domains (Sallai & Schnyder, 2020). However, for Slovak businessmen, it seems that the State has never actually left the business arena, since insensitive interventions in the form of frequent changes in legislation, senseless regulations, non-transparent and chaotic information provided to the business community and occurrence of exceptions from rules, all pertain to the Slovak business environment. As intensified regulation discourages the formation of trust (Aghion et al., 2010), it seems the more the State intervenes in business, the less entrepreneurs believe in the legitimacy of State interferences. On the other hand, another factor that undermines trust in society-business relations is the divergence between what companies say and what they do in practice. This phenomenon is commonly known in the available literature as the problem of corporate social responsibility (CSR) decoupling, which refers to the gap between CSR disclosure and CSR performance and a discrepancy among CSR policies, implementation of CSR programs, and CSR practices (García-Sánchez et al., 2020; Graafland & Smid, 2019; Sauerwald & Su, 2019). In addition, prior studies warn that unsatisfactory relations between business and society might stem from the principally negative attitude of the public towards entrepreneurs who are often stereotypically accused of unethical wealth accumulation at the expense of the legitimate needs and interests of other stakeholders (Haynes et al., 2015; Hofstede, 2009; Petrovskaya et al., 2016).

Capitalizing on a rich array of qualitative data, this paper aims to pinpoint the negative attitude of business entities towards State institutions, but on the other hand, and more importantly, it points to an absence of their own ethical self-reflection. This intriguing finding was one of the main conclusions of the qualitative research strand, carried out within broader comprehensive research on the development of business ethics in the Slovak business environment, which was conducted at the *Faculty of Management, Comenius University in Bratislava* between 2017 and 2018. In this article, we attempt to locate and adequately interpret the relevant causes, which led entrepreneurs to asymmetrically allocate responsibility for the development of business ethics at the macro and mezzo levels.

Research methodology in brief

The abovementioned qualitative research strand that serves as the data source for the purposes of this paper, was originally designed as an exploratory study with a broader aim to create a map of unethical practices in the Slovak business environment and best practices ethics management firms in Slovakia use to build an ethical workplace. We planned to use the acquired data as an objective initial database of knowledge for the subsequent quantitative representative research that was aimed at mapping the current state of business ethics development in Slovakia.[3]

The main research informants were company representatives and entrepreneurs, mainly because these people are directly involved in business and might therefore understand best the current problems and challenges of the business environment. The main method utilized in this research was the focus group method (FG). It is a relatively frequently used and well-established qualitative method of data acquisition (Cowton & Downs, 2015), which collects data through a discussion between the participants in a small group under the guidance of a

[3] This comprehensive multi-method research project no. APVV-16-0091 "Development of business ethics in the Slovak business environment" is being conducted at the Faculty of Management, Comenius University in Bratislava between 2017 and 2021.

moderator/facilitator in order to find out the attitudes and opinions of respondents in relation to the research object. The output of the focus group is qualitative information, how people understand certain issues or phenomena, or alternatively what opinions appear between them in relation to the object of investigation. The respondents should be individuals who have something to say on the subject matter. In the selection of respondents, we focused on ensuring that each FG was different in its composition, with the intention of eliminating the potential unilateralism of entrepreneurs' opinions and experiences. This approach was followed in our research in selecting respondents for individual FGs, thus ensuring a relatively wide range of knowledge about unethical practices in our business environment.

In this research, we carried out four FGs. The first (FG1) consisted of representatives of business and employer organizations in Slovakia (BEOs). This FG was supposed to guarantee a broader perspective in the analysis of the business environment and to provide the already generalized experience of hundreds of business units. We assumed that these business associations have an objective reflection of the Slovak business environment, are able to grasp the issues from several points of view and they also know the legislative framework for doing business in our country. The conclusions and attitudes of BEOs regarding the business environment are also recognized by State institutions. BEOs actively enter into discussions on business-related laws. In total, eight respondents from seven BEOs participated in FG1.

The respondents for the second FG2 were selected from a set of business entities that had already actively applied business ethics or corporate social responsibility into their organizational structures and were rewarded for doing so. We have labelled these enterprises as "rewarded enterprises" (REWs). As a guarantor of their ethical activity and responsibility, we have chosen the prestigious *Pontis Foundation*, which has been dedicated to the promotion of socially responsible companies since 1998 (Nadácia Pontis) and the results of its decisions are widely recognized. The selection of respondents for FG2 aimed at gaining data from companies that are more critical as well as sensitive to unethical practices in business. There were eight respondents from eight companies in this focus group in total.

The selection of respondents for the other two FGs was based on company size. Actually, it is company size that was methodologically important in our research on the application of business ethics. We are of the opinion that it is one of the factors that influence the process and quality of application of business ethics in practice (Remišová, 1997; Remišová, 2011). Differentiation of companies was done according to the recommendations of the European Union[4] based on the number of employees, apart from the economic indicators of the given company. The classification by size was as follows: micro company with 0 – 9 employees, small enterprise with 10 – 49 employees, medium-sized enterprise with 50 – 249 employees, and large enterprise with 250+ employees.

The third focus group (FG3) consisted of respondents whose companies belonged to micro, small and medium-sized enterprises (SMEs) category. The social and economic importance of these enterprises is undeniable – they account for 99.99% of all business units and employ approximately 74% of the workforce in Slovakia.[5] We anticipated that these respondents would have first-hand detailed experience with the common ethical issues related to economic and entrepreneurial activity, as they are direct actors in everyday economic life. Six respondents from six SMEs attended FG3.

The mosaic of views on unethical practices was completed by the respondents of the fourth focus group (FG4), which consisted of respondents from large companies (LACs). We assumed that FG4 would mainly be represented by the local branches of foreign multinationals that might not only have the desired "outside perspective", but, above all, these organizations might have

[4] Recommendations of the *European Commission* no. 2003/361/EC, or regulation of the EU no. 651/2014.

[5] The given data are from the year 2017. See the report by SBA: *Malé a stredné podnikanie v číslach v roku 2016* [Small and medium-sized entrepreneurship in numbers in the year 2016]. Bratislava: Slovak Business Agency.

rigorous leadership ethics, compliance programs and codes of conduct (Bohinská, 2018a; Bohinská, 2018b; Lačný et al., 2018; Remišová et al., 2016). Therefore, we assumed these companies could offer new and valuable insights into the way Slovak business is flawed by various unethical issues. This FG consisted of seven respondents from six large companies.

The number of respondents in each FG was proven adequate as, according to Cowton and Downs (2015), the general practice is to use smaller groups in order to secure for the participants enough space for their own contribution to the topics. In their summative analysis of focus groups used in business ethics research that appeared in reputable journals, the authors show that the number of respondents per FG usually varies from twenty to four (Cowton & Downs, 2015). Likewise, other authors also note that the number of respondents is not as critical as the appropriately addressed methodological rigour in conducting FGs. For instance, Breen (2006) suggested ten to twelve respondents, Painter-Morland and Deslandes (2017) utilized three FGs, Schons et al. (2017) conducted three FGs with four to six participants each, Fernández and Camacho (2016) included 28 respondents in their qualitative research, Carter and Baghurst (2014) conducted their research with two focus groups with eleven participants altogether, and Clarke et al. (2013) worked with 22 respondents in interviews and two mini FGs (each consisting of three people). Thus, the use of FGs is proven to be a standard methods of data acquisition in business ethics research, where not the quantity of respondents, but the quality of the methodological background is essential. As for the respondents in this study, they had diverse experiences from various spheres of business, with direct involvement in doing business on a professional basis. Overall, we gathered a rich dataset encompassing the opinions of 29 respondents, who were knowledgeable experts in their areas as business owners, business executives, top managers, ethics and compliance managers, human resources managers, spokespersons and chief executive secretaries in their respective organizations.

The FGs were carried out from November 2017 to April 2018. They all had the same scenario. The discussion moderator (one of the research team members) introduced the topics to the respondents, informed them about the main objectives of the project and what the purpose of the FGs was in the overall research design. Respondents were informed that the research focused on ethical issues of the business environment at the mezzo level; that is at the organization/company level. The main inquiry tied to the purposes of this paper aimed at answering the question "*What unethical practices do you encounter in the Slovak business environment?*"

The course of the meetings was open, respondents did not choose from default answers, but formulated their experience in their own words. Since the aim of the FGs was not to ascertain whether the respondents' claims were true or false, the moderator's role was to conduct a discussion with the intention not to derail from the topic and to ensure that all respondents had an equal opportunity to express their views. The FGs took three hours on average. During the meeting, three research team members noted down what was discussed. Their transcripts were then compared, and the missing verified data were added into the final transcript of the individual FG meetings. After finalizing the transcripts, the personal data on the respondents were anonymized and the materials were thoroughly analysed. Each of the respondents was coded as R1, R2, etc. In this paper, we code respondents based on the FG in which they took part; for instance, the individuals who took part in the FG3 are coded as FG3R1, FG3R2, etc.

After the last FG4, the research team produced a summative report on the state of business ethics in the Slovak environment. In the process of detailed scientific processing of the content of FGs, we applied scientific methods of analysis, synthesis, abstraction, induction, deduction, generalization, interpretation and hermeneutics. At this stage, one of the most difficult theoretical problems was to compare the answers of respondents across the FGs, because the research participants expressed their opinions freely in a language natural to them and thus sometimes the same phenomena were labelled using different expressions. In connection to

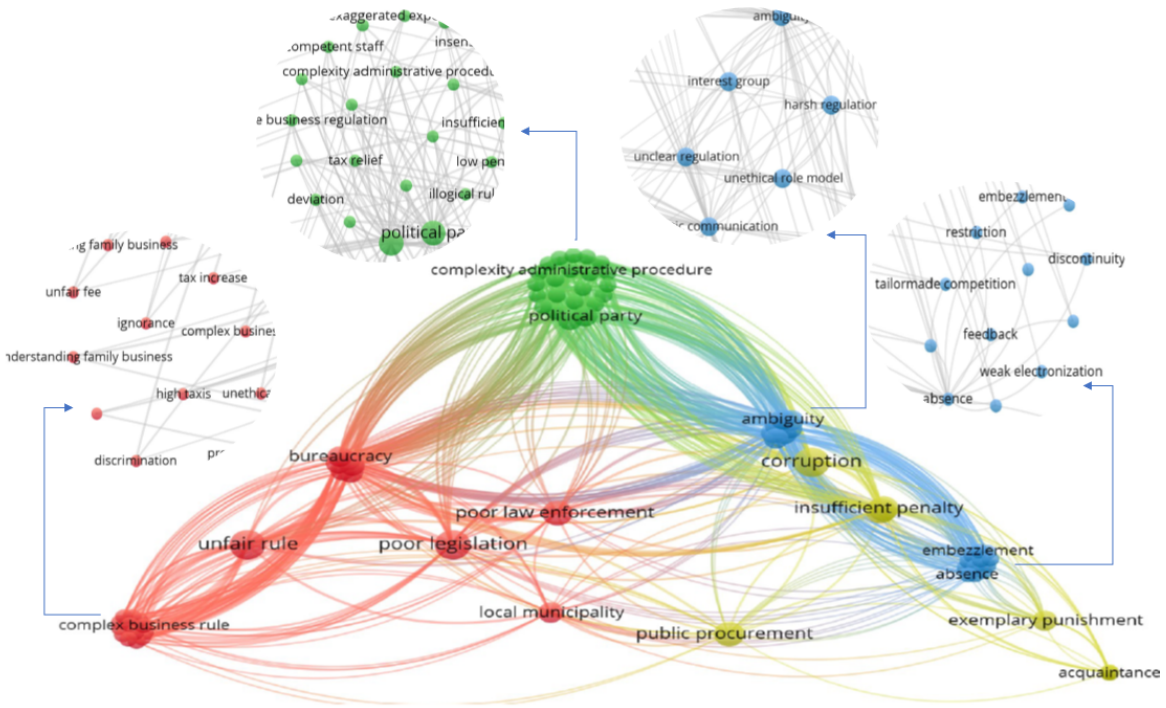
that, in order to locate the core themes and raise the clarity of findings, we coded the transcribed material in VOSviewer for constructing and visualizing the network of co-occurring terms that appeared across the four FGs. The thematic map, which emerged from textual data, and related discussion to the research findings are presented in the next section.

Results and discussion

A comprehensive critical analysis of the responses in the FGs has shown that, in addition to the expected results – to gain an overview of unethical practices in the Slovak business environment and of the best practices in ethics management according to our respondents, there is another issue that we did not originally plan to address. In other words, a new task of analysing "unplanned scientific externalities" emerged during this research. The stated issue is as follows: Despite the diversity of FGs, as well as their varied representation in terms of economic areas or respondents' professional positions, in nearly all FGs, and especially in FG3 with SMEs, the respondents began to reflect on unethical practices in the business environment with uncompromising and massive criticism of the State practices they experienced while conducting business as unethical and negatively affecting the development of business ethics in Slovakia. In FG3, the discussion even started with the sentence: "*We welcome your activity, because frankly speaking, it is about time that something happened at State level*" (FG3R3). The respondents did not turn their attention to the unethical practices carried out by the business entities themselves until the discussion facilitator cautioned that the actual purpose of the meeting was to reveal how the business entities, by their unethical practices, harm other businesses as well as the overall economic system in the country.

Figure 1 presents the thematic variety in respondents' authentic reactions to the abovementioned research question.

Figure 1: Thematic map of respondents' perceptions of the State in the four focus groups



Looking at Figure 1, FG3 with SMEs (red colour cluster) brought up topics like the complexity of the business environment, high levels of bureaucracy, unfair and harsh business regulations with poor law enforcement and overall inadequate legislation. FG1 with BEOs (green colour

cluster) shared some of these topics with the other FGs and added some issues like the intrusion of politics into business, financing political parties using private business, running the party as a business entity. Overall, respondents from FG1 perceived the State as a bad role-model for business. The issues brought up in FG2 with REWs (blue colour cluster) were somewhat less intense and focused mainly on topics commonly found in the other FGs (e.g., poor State communication State with businesses, ambiguity in the business environment, embezzlement of money in public procurement, absence of standards and clear regulations). Finally, FG4 with representatives of large companies (LACs, yellow colour cluster) shared the perception of corruption, problematic public procurement, insufficient penalties for unethical business conduct, lack of exemplary punishments, nepotism and doing business with close acquaintances like friends or family with the other FGs.

As mentioned above, the issue we are addressing in this paper was not one of our core research questions. However, its moral intensity "forced us" to seek answers to it. Why did business entities spontaneously concentrate on the unethical practices of the State, and not on the unethical practices of business entities themselves? Why did business entities transfer responsibility for the development of ethics in the Slovak business environment primarily to the State? Does the Slovak business environment lack critical self-reflection?

Obviously, the approaches to find answers to these questions are diverse, and we find it particularly interesting to consider a new institutional theory where the roots of this phenomenon are associated with the influence of informal and formal institutions on contemporary economic life (North, 2005; Van Liedekerke & Dubbink, 2008). In addition, a historical-political view that would take into account the impact of the political and economic transformations that our country experienced in the last century might be instructive in this context (Baláž, 2006; Bohatá, 1997). In our study, we decided to apply the theoretical basis, according to which the development of business ethics takes place simultaneously on three social levels, that is at the micro, mezzo and macro levels. These are also known as the subject-matter of business ethics – an approach that underpins the understanding of business ethics in the *Bratislava School of Business Ethics* (Remišová & Lašáková, 2017). Such an approach seems methodologically legitimate: in our research we have focused on the unethical practices of organizations – on the mezzo level of the development of society, nevertheless, the research informants focused on the unethical activity of the State, that is on a macro-level entity. We consider it meaningful to analyse the attitudes of our respondents on the basis of a theory that strictly defines the roles and responsibilities of the business subjects for the development of business ethics in a given country.[6]

What is the essence of the theory of the development of business ethics at three levels of society? The acceptance of the multilevel analysis of business ethics is based on the fundamental works of Kenneth E. Goodpaster (Goodpaster, 1992) and Georges Enderle (Enderle, 1993; Enderle, 1996; Enderle, 1997). It is not quite possible to speak about ethics, values, interests or responsibilities in connection with economic activity at a flat rate, because these values, interests and responsibilities always have their specific bearer – either a particular person, an organization, or an entire social system. Goodpaster titled this analysis "the subject-matter of business ethics" (Goodpaster, 1992, p. 112). The primary starting point of this differentiation is the identification of the key subject/actor of human activities in the society. At the *micro level*, the central subject is an individual, at the *mezzo level* it is an organization, and at the *macro level* it is the State with its governing and legislative bodies and the related judiciary. The micro level in business ethics represents an individual as a real existing and operating entity in the sphere of the economy, who can act as an employee, client, consumer,

[6] The literature gives evidence that besides these three levels, the global level of business ethics might be considered, too. The main actors in business ethics development at this level are organizations that operate worldwide, and their impact is truly global, for instance the UN, WTO, AVAAZ, or Greenpeace.

entrepreneur, shareholder or manager, etc. Entrepreneurial ethics at the micro level is the ethics of each individual and thus does not only apply only to a manager or an entrepreneur.

At the mezzo level, it is the organization that bears the values, conscious decisions, as well as responsibility for its activities. Here, the organizations operate in various forms, for instance as businesses, multinationals, trade unions, professional associations, NGOs, hospitals, schools, etc. In other words, any legal person whose activity is in some way related to economic and commercial activity. However, it is the business actors who remain the key actors of business ethics at this level.

At the macro level, the business ethics is connected to the activities of governmental and legislation authorities and the judiciary, that is with the activity of the State in the unity of its three pillars of power. By its activities, measures and laws, the State creates a political-legislative framework within which economic, financial, tax and social policies are implemented, and international economic strategies are set. In particular through legislation, the State creates a social space for the pro-ethical or unethical behaviour of organizations and individuals.

An important moment in the three-level theory of business ethics is the understanding of the interconnection of these three levels. All three levels are essential for the development of business ethics. These levels are not isolated from each other but overlap and interact. In terms of long-term development, every level is essential, and everyone counts. If one level fails in the development, its role may temporarily be replaced by another, but cannot be fully compensated. "The idea that there are three distinct but interrelated levels of business ethics in not only an expository convenience. It suggests that each of the three levels presents appropriate subjects or objects of ethics inquiry. This means that there is some degree of freedom or discretion assumed at each level, i.e., that the ethical values found at one level are not merely deterministic functions of the other levels" (Goodpaster, 1992, pp. 112–113).

The division of the micro, mezzo and macro levels in business ethics is of key methodological significance because of three reasons. First, it enables to clearly define who specifically applies business ethics into practice in various spheres of economic life. Second, this approach defines who is the subject of responsibility – moral agents, thus determining who is responsible for the ethical and moral state and development of business ethics in practice, and who is responsible for unethical behavior in economic life.[7] Third, it is possible to coordinate the development of business ethics among the three pivotal social actors, or to temporarily compensate for the "failure" in activities and the loss of responsibility of a social entity.

We will try to explain the critical attitude of our respondents on the basis of these three dimensions. The first dimension of the theory of the three-level development of business ethics shows that each level represents a different social territory, where the competence to develop business ethics is attributed to a specific social subject. This means that the State has its social

[7] We are aware that there are many definitions and understandings of the phenomenon of responsibility in philosophical and ethical literature. In our business-ethical considerations, we understand the moral responsibility as a three-dimensional social relationship in which an entity (an individual or a collective) voluntarily subscribes to its actions and its consequences and accepts the rewards or sanctions associated with them. Reflection of one's own behaviour and acceptance of responsibility takes place based on the relationship to the respected moral authority. Such a moral authority may be personal conscience, God, a group, but also nature, or future generations. There are three questions to be answered in the definition of responsibility: Who bears the responsibility? What is the subject responsible for? Who or what is the "judge" (evaluator) of his/her actions? Our understanding is based on an understanding of responsibility developed by Ottfried Höffe and Gertrud Nunner-Winkler (Höffe, 1992, Höffe, 2008; Nunner-Winkler, 1993) and see also works by Anna Remišová (Remišová, 1997; Remišová, 2011). In addition, as for the ethical quality of an action, we assume that the motives as well as the consequence of one's actions must pass the test of both the deontological and the teleological ethics. What outcomes are considered to be ethically correct, positive or good within the context of consequentialist ethics see also the works by Vasil Gluchman (Gluchman, 2008; Gluchman, 2017).

territory, in which it manifests itself as a developer of business ethics in the economy. On the other hand, the company also has a pre-defined territory, where it acts as the creator and developer of business ethics. Such a social territory for a business entity is its company as a social organization. In other words, if business ethics is not developed in the company, ethical mechanisms are not applied or an ethical infrastructure is not created, it is not caused by the State's inactivity, but by ignoring business ethics by the management of a particular business entity. In this context, it should be noted that the situation will not change even if people with a high degree of personal ethical integrity and a positive attitude to business ethics work at the micro level in a given company.

The State, in the unity of its three pillars of power, is an active designer of legislative, executive and judicial policies to promote the short- and long-term development of business ethics in society. In the legislative area, laws are adopted that guarantee the development of a market economy on the basis of respect for its main principles – the respect for private property, entrepreneurial freedom, and fair competition. Laws enacted by ruling political parties support the development of business ethics when their content is professionally sound and fair in ethical terms. Executive power is responsible for the governance of the state, and the judiciary guarantees the rule of law, without which the economy in a democratic society cannot develop. Promoting business ethics takes the form of a political-legal framework on the macro level (Ulrich, 1997),[8] of executive directives and guidelines, and of judicial control and enforcement. State support for business ethics at the macro level can be both direct and indirect. In direct support, the State adopts specific laws that are directly and openly aimed at promoting business ethics. These laws include for instance the law on reporting socially dangerous activity, known as the *Whistleblowing Act* (Zákon č. 54/2019), or the law on the criminal liability of companies (Zákon č. 91/2016). Promoting ethics is done through the government attitudes and guidelines, but it can also take the form of rewarding ethical firms, or vice versa, creating blacklists for those businesses that break the law. Such forms of support are the *Tax Reliability Index*, which has been in force since 2018 and is created by the financial administration unit. According to this index, the State rewards business entities that fulfill their tax obligations with 20 different benefits (The state will reward, 2019). Moral sanctions at the national level are, for example, applied in case of entrepreneurs who do not pay levies related to social or health insurance.

Indirect support for the development of business ethics from the State takes place through the impact of laws with a strong ethical charge on the population and entrepreneurs. For example, if taxes are considered unfair by entrepreneurs, this creates a social environment that does not support the development of business ethics, and vice versa. A positive indirect impact on the development of business ethics in our country has been the *Civil Service Act*, which at first glance is not dedicated to business ethics, but should result in a fundamental uplift in the quality of civil stewardship and improved quality of ethics management in State and public administration organizations, i.e. in ethical cultivation of one of the dominant business partners of the entrepreneurial sector. This law should also contribute to reducing corruption in both the government and the business sphere.

In line with the theory of business ethics development at micro, mezzo and macro levels, we conclude that the criticism expressed by our respondents on the role of the State in the development of business ethics was justified. However, the moral legitimacy of the businessmen's attitude that reflected the logic of "first you, then me", still remains questionable. Businesses put the State first as the creator of the development of business ethics in the country, and assigned themselves a secondary position, as if less important. The perception of themselves as actors in the development of business ethics was absent. Such a view of one's place in the development of business ethics refers to a lack of ethical self-reflection. According

[8] Peter Ulrich notes on the so-called *Ordnungspolitik*.

to such a view, it is possible to justify the absence of one's own ethical activities both in the organizations as well as the lack of systematic support of the State in the development of business ethics throughout the country. For the entrepreneurs, the State is the primary creator of the ethical-economic environment and business entities are just secondary in that. This idea was quite openly expressed in FG3, composed of respondents from SMEs, who believe that the State must first change and then an ethical approach of the business can be expected. In other words, when respondents were asked to talk about unethical practices in the business environment, their responses should include not only reflections on unethical practices by the State, but also self-reflection of their own engagement in developing business ethics, their social responsibility for applying business ethics and for shaping the business environment in our country. Based on the first dimension of the three-level theory of business ethics, we conclude that our respondents had the moral right to criticize the State for failing to develop ethics and to point out practices that they perceive unethical, but it was not morally right to perceive the State as the sole actor responsible for business ethics and to exclude themselves and the other actors from this process, or to condition their ethical actions by waiting for the State first to act and just then enter the process of long-term development of business ethics.

In terms of redistribution of responsibility for the development of business ethics and from the perspective of the second dimension of the theory of three-level development of business ethics, the situation is similar: it is beyond doubt that the State is morally responsible for the state of business ethics in society and must be held accountable for all unethical practices perpetrated by its people in charge. Our respondents' criticism of State representatives is morally justified. However, entrepreneurial subjects, including employers' and professional organizations that defend their interests, as well as individual citizens, are also responsible for developing business ethics. It is therefore essential that entrepreneurs take their own responsibility for the state of business ethics in Slovakia and, from a moral point of view, they will actively cope with the unethical practices they are committing or that are happening with their silent acceptance.

What unethical practices in relation to business ethics have been pointed out by our respondents? The unethical practices could be arranged in three main groups: the first is a summary of unethical practices in the field of legislation, in particular unprofessional legislation, unfair legislation and low law enforcement (1); the second group includes corruption with particular emphasis on abuse of public procurement (2)[9], and the third group is linked to the absence of disciplinary actions applied by the State on those businesses that behave unethically and illegally, but also the absence of rewards for businesses for their ethical conduct (3).

As we have already mentioned, our goal is not to prove whether our respondents' statements are true, but as long as these practices and attitudes of the State pose a problem for businesses, the State should critically reflect on its activities in the field of business ethics. The results of a long-term international survey of the business environment in the *Global Entrepreneurship Monitor* (GEM) project show that the Slovak business environment is characterized as one in which "other chronic shortcomings persist – administrative and bureaucratic burdens, high tax and levy burdens, complicated, changing and unpredictable business legislation, problematic law enforcement, clientelism and corruption" (Pilková et al., 2019, p. 17).

[9] "Public procurement involves the rules and procedures that award contracts, concessions and design contests" – acc. to the Zákon č. 343/2015 Z.z o verejnom obstarávaní a o zmene a doplnení niektorých zákonov [Act no. 343/2015 Coll. on public procurement and on amendments to certain acts], which came into force on 3 December 2015. [online] [Retrieved August 08, 2019] Available at https://www.slov-lex.sk/pravne-predpisy/SK/ZZ/2015/343/20190901

It is therefore clear that the views of our respondents need to be taken seriously, even more because they attribute to these characteristics the "status of unethical practices", which have a negative impact on the development of business ethics in our environment. In line with the theory of the three-level development of business ethics, the idea is that legislation is the exclusive and key sphere of State-led action that creates rules of play for all actors of social life, including the business community. It is also true that only professionally prepared and morally fair legislation supports the long-term development of business ethics in Slovakia. Regulatory directives for entrepreneurship through laws adopted by the executive authorities is clearly perceived negatively by the respondents, as these "are meaningless, illogical, unfair or exaggerated" (FG3R5). It is also clear that if the State fails to ensure respect for the law through a fairly functioning judiciary, collective and individual entities cease to believe in the rule of law and apathy rises, or alternatively, a specific practice is becoming widespread, namely when the injured ones take justice into their own hands. This creates an environment in which the law is not respected. One of the respondents openly admitted that "the established regulatory environment motivates to circumvent the rules" (FG3R6). In this respect, our respondents' critical attitude towards the State in the unity of its three pillars of power is justified and is legitimate. In addition, it can be seen as one of the main reasons why the relationship of businesses towards the State was uncompromising, even antagonistic.

The respondents also criticized the attitude of the State in the application of moral mechanisms of behavior towards entrepreneurs. The State was reproached that it does not use the institutions of rewards and punishments in the business environment at all. Their opinion is clear: "[It is important] to reward ethical and punish unethical behaviour, such an initiative is needed in society" (FG3R2), because "we lack a positive example of someone being affected if they did something unethical" (FG2R1). They believe that disciplining those who violated business ethics would significantly contribute to the development of business ethics, similarly, as the recognition and possible economic advantage to businesses that respect the principles of business ethics would be beneficial for ethical development. In our opinion, this criticism of the State is justified because both the disciplinary actions and the rewards are key regulators in the moral system. It is a process of forming public opinion in which the role of the State is irreplaceable. By publicly recognizing business entities, the State provides citizens with a positive pattern of behaviour, which is a structural element of any moral system. Disciplinary actions have a great impact on citizens' behaviour – to show disagreement with the conduct of a business entity and to openly distance themselves from its conduct is a strong moral lesson. A negative public image is a hidden "nightmare" for any business entity, because if an entrepreneur is serious about business, he must care about the reputation of his company among his customers and in society as a whole. If respondents have pointed out that the State is not active in shaping public opinion favourable to ethical entrepreneurs and vilifying the unethical, it is clear that they have expressed their own experience with the State as an opinion-forming actor and their criticism of the State can be considered relevant.

Corruption was considered the most widespread unethical practice in our business environment. Again, the perception of our respondents corresponds to the results of other researchers, too (for e.g., Zemanovičová & Vasáková, 2017). According to the *Corruption Perception Index* (CPI), which is one of the most widespread and recognized international indicators of the state of corruption in individual countries carried out on a yearly basis by one of the NGOs dedicated to the fight against corruption, *Transparency International*, the level of corruption in Slovakia in 2018 was 50, which ranks Slovakia in 57th place in the CPI ranking (out of 185 surveyed countries) (Corruption perceptions index, 2018). Corruption, in accordance with *Transparency International*, is understood as misuse of entrusted authority for personal benefit – "Corruption is the abuse of entrusted power for private gain" (What is corruption). Corruption has many forms; it encompasses diverse types of actions like the

bribery, nepotism, protectionism, or clientelism. In our research, corruption was conceived primarily in connection with the public procurement process: "Regarding unfair practices, I would like to mention ... first, public procurement conditions are set up to fit a particular firm. ... Second, an advantage is created in public procurement through the supply of information to selected firms" (FG4R5).

Traditionally, corruption has been linked with State elites and decision-makers, and this is what our respondents have done, in that, in terms of corruption, they have transferred the moral responsibility to the State. But can macro-level corruption be analysed and tackled? Is it possible to solve corruption without the involvement of business entities in this process? Do the organizations at the mezzo level and the individuals at the micro level bear some degree of moral responsibility for corruption? If corruption and the intrinsically linked abuse of public procurement is the major problem for entrepreneurs, is it not necessary to make a critical ethical self-reflection in terms of developing business ethics? A question is at hand: Am I ready to fight corruption in public procurement? It is widely accepted in the literature that corruption is an economic, political and also an ethical problem. It should be pointed out, however, that corruption is primarily entwined in a socio-economic relationship; at one end of this relationship is someone who has been entrusted by an institution with a certain authority, and on the other end is someone who wants to get a service, no matter whether this is justifiable or illegitimate. In order to secure this claim, whatever other stakeholders might be involved, and the social damage that could be done, one provides the other with some kind of payment (in the form of money, donations, services, promises, help, etc.). In other words, corruption is a business involving two business partners. However, their transaction is socially toxic. As the representatives of legislative, executive and judicial institutions have the competencies, on which entrepreneurs actually rely, the unethical nature of the State *en bloc* directly affects their business activities and effectiveness. From our perspective, it is morally justified to hold the State accountable for unethical practices associated with corruption. From an ethical point of view, however, it is wrong to assume that corruption is a problem that does not concern the morality of the business environment. Corruption between government and business will continue as long as only one business has an interest in violating fair competition rules. Therefore, as one of our respondents noted, "entrepreneurs need to understand their place in society and take the responsibility" (FG1R5).

In this context, we would like to note three examples that show that the Slovak business environment is not yet sufficiently morally prepared to radically put an end to corruption by its own powers, and thereby distorting "corrupt trade". When the *Anti-Corruption Charter*, prepared with the support of the then government by *Transparency International Slovakia*, was signed in 2003, only about 30 business entities signed this commitment.[10] Here it should be added that it was a document that committed business entities in their business activities to not providing bribes to State representatives. If more businesses were to join this initiative, a strong anti-corruption movement could have been created and the rate of corruption in Slovakia would be significantly lower today. The power of corporate movements is just one, but still a very relevant, factor that can change the landscape of the society. For instance, responsible businesses can be the engine of positive social change (Haugh and Talwar, 2016), can actively participate in peace processes and peacebuilding (Rettberg, 2016), or can redefine roles and responsibilities of various stakeholders and thereby improve the quality of life in wider society (Girschik, 2020). Another example of a similar initiative brought up in 2006 was introduced by the well-established and widely recognized multinational consulting company *Accenture*, which radically opposed corruption in Slovakia and publicly announced that, for fundamental

[10] Prvých tridsať subjektov podpísalo protikorupčnú chartu [The first thirty subjects signed the Anti-corruption charter].[online] [Retrieved August 31, 2019] Available at https://domov.sme.sk/c/1116762/prvych-30-subjektov-podpisalo-protikorupcnu-chartu.html

reasons, it would no longer trade with the government to avoid any corruption (Čišovský & Valášek, 2019). It was their own protest against corruption. Even this initiative did not find support among Slovak entrepreneurs. Similar problems occurred with regard to the publicly declared fight against corruption in obtaining government contracts by *Skanska* in 2009 (Správať sa nekorupčne, 2012). These initiatives, which could play the role of moral role model in the fight against corruption in the business environment, were left alone. Business entities did not join them.

Thus, it can be concluded that the State bears moral responsibility for the state of corruption in our country, but moral responsibility can also be attributed to the business environment. And until the business environment consciously accepts responsibility for its participation in corrupt activities and finds a way to fight corruption in its own ranks and finds the courage to openly name the offenders, the Slovak business environment will be burdened with this poisonous phenomenon that harms the economy, democracy and the social good.

In our article we only marginally focus on the micro level, i.e., on the application of ethical principles by individuals in everyday economic situations. This level is closely related to the culture of the country, its traditions, rituals, customs. For our respondents, this subject was not primarily associated with unethical practices. However, its functioning is also irreplaceable by other spheres. If we use the example of corruption, it is generally accepted in our culture to thank for services provided and not to take them as something natural to which a citizen of a democratic country is entitled. Therefore, tackling corruption in our country is not possible unless all three levels are involved. The third dimension of the analysis of respondents' replies based on the three-level theory of business ethics development is tied to the understanding of the importance of cooperation between entities operating at the micro, mezzo and macro levels. As we have already mentioned, the development of business ethics is relatively independent at every level, but in general it is not possible to build an integrated business ethics system that guarantees a functional economic order without the cooperation of all entities at the different levels, that is of individuals, businesses and State agencies.

The optimal model of the long-term development of business ethics in this country is the simultaneous active participation of all three levels in the achievement of higher moral standards in the economy. But the reality is different. At some stages of social development, some levels may fail or fall behind. Experience shows that such a failure can be temporarily replaced by an active approach at one of the other levels. The situation that arose in the early economic and political transformation in our country in the 1990s could serve here as an example – the transition from a planned economy to a market presupposed the first major step in privatization of State property; the new system was primarily to create a legislative framework for private ownership and the functioning of a market economy. However, the transfer of State property to private owners took place without any ethical regulation. The then State authorities fundamentally ignored the role of ethics in economic development. For various reasons, they did not declare or support the idea that a market economy presupposes a stable ethical order. Paradoxically, in addition to new business entities that behaved very unethically in relation to the acquired State assets, there were also business entities that were serious about business, and perhaps were the first in our country to understand that their intention to remain on the market in the long term entails the application of ethics into business practice. At this stage, the business environment partially counterbalanced the role of the State in developing business ethics. However, such compensation can only be temporary, as the role of the State in the development of ethics is irreplaceable. On the other hand, it is also possible that the State understands the importance of business ethics, but the business environment prevents its application in business units, or when the business environment is dominated by the instrumental understanding of business ethics, that is if entrepreneurs use business ethics only if it has an immediate positive economic effect for the company. The fact that some of our

research respondents are aware of their low involvement in the development of business ethics can be documented by one respondent's statement: "Developments in legislation force companies to address ethical issues, but companies are not interested in the spheres [of business activities] that are not legally treated" (FG1R1).

As mentioned above, our respondents attributed a key position in the discussion about unethical practices to the actions that link with the activity of the State in the unity of its three main pillars of power. They also transferred the moral responsibility for unethical practices in business and their consequences to the State. It was only after the moderator intruded on the discussion and refocused the participants' attention that they revealed unethical practices, of which the actors, and thus the bearers of responsibility, were the business entities at the mezzo level. We have not noticed in the attitudes and opinions of business entities that they perceive the State and themselves as partners in the development of business ethics, which could have a future negative impact on the long-term development of business ethics in practice.

It is the separation, or in our opinion, the lack of cooperation between the State and the business entities, which causes negative or hostile attitude of business entities towards the State. Research shows that solutions to the current societal challenges – economic, social, environmental, but also cultural – are not possible without partnership between the State, businesses and non-governmental democratic institutions (Remišová & Lašáková, 2018; Remišová et al., 2019). In other words, neither the State, business entities nor individuals can create mechanisms for the long-term development of business ethics and introduce them into practice alone. And if so, only for a certain time. The future of business ethics in our country in practice lies in the cooperation and partnership of those who are responsible for its development.[11]

In our study, we focused on analyzing attitudes and relationships between subjects at the mezzo and macro levels. Intentionally, we have not addressed the micro level, but this does not mean that we do not attach importance to this level in the development of business ethics. The level of human moral development, as a specific human product and an outcome of cultural evolution (Gluchman, 2005), needs to be considered with utmost importance. The development of business ethics should be ensured in parallel at all three levels, the bodies responsible for the development of business ethics must communicate with each other, lead a discourse and seek joint solutions. The cooperation to achieve social good is the foundation of a civil society. It is possible that some of the levels may not fulfill their responsibilities for some time or may not have enough moral powers to accept moral responsibility, but this should not be a reason for antagonism between the three levels.

Conclusions and limitations

This paper critically analysed the underlying reasons for the apparently negative attitudes of the entrepreneurs and company representatives participating in this research. It concluded that our respondents did not consider their responsibility for the development of business ethics, and in their primary reflections on unethical practices in the Slovak business environment, they shifted the responsibility almost completely to the State level. Given that, the paper argued whether their attitude could be morally justified. The main theoretical framework in the respective analysis was the theory of the development of business ethics at three levels – macro, mezzo and micro – also known as the "subject-matter of business ethics" approach. The main conclusions might be structured according to this theoretical approach as follows:

[11] For instance, an initiative of the IT sector was developed, where representatives of business associations have proposed how the State could reduce unethical practices in trading. See also: Navrhli sme zmeny k lepšiemu, na rade je štát [We have proposed changes for the better, now it is the State's turn]. [online] [Retrieved August 31, 2019] Available at https://www.etrend.sk/trend-archiv/rok-2019/cislo-21/navrhli-sme-zmeny-k-lepsiemu-na-rade-je-stat.html

1) Based on the first "macro" level in the three-level theory of business ethics development, it is legitimate for a business entity to perceive the State as an actor in the development of business ethics and to demand an active professional approach to the long-term development of business ethics. It is not morally justified, however, to give up its own proactive approach to the development of business ethics and to take on the role of an "expectant" instead of the role of a "creator".
2) Based on the second "mezzo" level in the three-level theory of business ethics development, it is legitimate to attribute moral responsibility to the State for its unethical practices. As it turned out, our respondents' views on unethical practices of the State correlate with other research studies, and therefore a critical attitude towards the State is justified in all the three areas of unethical practices. However, it is not morally justified to not accept one's own moral responsibility for the state of corruption in our country. On this issue, there is no ethical self-reflection of business entities in relation to corruption, more precisely the loss of reflection of one's place in the corrupt relationship with the State.
3) Based on the third "micro" level in the three-level theory of business ethics development and the underlying idea of the essential cooperation between these three levels, we conclude that the long-term development of business ethics is impossible without a systematic and purposeful approach of the individual subjects to the responsibility for their activities in the broader business arena, whilst an essential basis for the long-term development of business ethics in our country is the establishment of partnerships between the State and business entities, while recognizing the place of NGOs representing the citizens.

We are aware of the limits of this study. The conclusions are generalized based on a limited sample of business representatives, and, in addition, our results encompass perceptions of entities located at one level only, namely the mezzo level of business ethics development. Nevertheless, our sample included respondents representing diverse areas of business, having different experiences of applying business ethics in companies, with varied experience from professional, employer and business organizations, as well as experiences from various large enterprises. As it was mentioned above, we originally had the intention "only" to monitor unethical practices in the Slovak business environment. However, the findings from the qualitative research strand seemed so serious for our research and for business practice as well, that we considered it our scientific duty to deal with them. By the means of this paper we would like to open up the issues regarding the relationship between the State and business entities in the development of business ethics, as we believe this topic needs to be addressed further both in theory and practice.

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References
AGHION, P., ALGAN, Y., CAHUC, P. & SHLEIFER, A. (2010): Regulation and distrust. In: *Quarterly Journal of Economics,* 125(3), pp. 1015–1049.
AREND, R. J. (2013): Ethics-focused dynamic capabilities: A small business perspective. In: *Journal of Business Ethics*, 41(1), pp. 1–24.
BALÁŽ, V. (2006): Politická ekonómia slovenského kapitalizmu: Inštitucionálna perspektíva [Political economy of the Slovak capitalism: An institutional perspective]. In: *Politická ekonomie,*54(5), pp. 610–631.

BOHATÁ, M. (1997): Business ethics in Central and Eastern Europe with special focus on the Czech Republic. In: *Journal of Business Ethics*, 16(14), pp. 1571–1577.
BOHINSKÁ, A. (2018a): Human resource manager's responsibility in creating a culture of legal compliance and ethics in an organization. In: *Journal of Human Resource Management*, 21(2), pp. 8–15.
BOHINSKÁ, A. (2018b): Role of a compliance program in an organization. In: V. Bartošová & J. Belas (eds.): *Globalization and its socio-economic consequences.* Žilina: Žilinská univerzita v Žiline, pp. 476–483.
BREEN, R. L. (2006): A practical guide to focus-group research. In: *Journal of Geography in Higher Education*, 30(3), pp. 463–475.
CARTER, D. & BAGHURST, T. (2014): The influence of servant leadership on restaurant employee engagement. In: *Journal of Business Ethics,* 124(3), 453–464.
CILIBERTI, F., PONTRANDOLFO, P. & SCOZZI, B. (2008): Investing corporate social responsibility in supply chains: a SME perspective. In: *Journal of Cleaner Production*, 16(15), pp. 1579–1588.
CLARKE, C., HARCOURT, M. & FLYNN, M. (2013): Clinical governance, performance appraisal and interactional and procedural fairness at a New Zealand public hospital. In: *Journal of Business Ethics,* 117(3), pp. 667–678.
COMMISSION RECOMMENDATION OF 6 MAY 2003 CONCERNING THE DEFINITION OF MICRO, SMALL, MEDIUM-SIZED ENTERPRISES (2003/361/EC). [online] [Retrieved August 31, 2019] Available at: https://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:124:0036:0041:EN:PDF.
COMMISSION REGULATION OF 17 JUNE 2014 (651/2014). [online] [Retrieved August 31, 2019] Available at: https://op.europa.eu/en/publication-detail/-/publication/1291bb4c-fcfe-11e3-831f-01aa75ed71a1/language-en.
CORRUPTION PERCEPTIONS INDEX (2018): [online] [Retrieved August 08, 2019] Available at https://www.transparency.org/cpi2018#results.
COWTON, C. J. & DOWNS, Y. (2015): Use of focus groups in business ethics research: Potential, problems and paths to progress. In: *Business Ethics,* 24(S1), pp. S54–S66.
ČIŠOVSKÝ, K. & VALÁŠEK, M. (2006): Peter Škodný: IT je špinavý biznis [Peter Škodný: IT is a filthy business]. [online] [Retrieved August 31, 2019] Available at: https://www.trend.sk/technologie/peter-skodny-it-je-spinavy-biznis.
ENDERLE, G. (1993): *Handlungsorientierte Wirtschaftsethik. Grundlagen und Anwendungen*. Bern: Haupt.
ENDERLE, G. (1996): Towards business ethics as an academic discipline. In: *Business Ethics Quarterly*, 6(1), pp. 43–65.
ENDERLE, G. (1997): In search of a common ethical ground: Corporate environmental responsibility from the perspective of Christian environmental stewardship. In: *Journal of Business Ethics*, 16(2), pp. 173–181.
ENDERLE, G. (2004): Global competition and corporate responsibilities of small and medium-sized enterprises. In: *Business Ethics: A European Review*, 13(1), pp. 51–63.
FERNÁNDEZ, J. L. & CAMACHO, J. (2016): Effective elements to establish an ethical infrastructure: An exploratory study of SMEs in the Madrid region. In: *Journal of Business Ethics,* 138(1), pp. 113–131.
GARCÍA-SÁNCHEZ, I., HUSSAIN, N., KHAN, S. & MARTÍNEZ-FERRERO, J. (2020): Do markets punish or reward corporate social responsibility decoupling? In: *Business and Society,* doi:10.1177/0007650319898839
GIRSCHIK, V. (2020): Managing legitimacy in business-driven social change: The role of relational work. In: *Journal of Management Studies,* 57(4), pp. 775–804.

GLUCHMAN, V. (2005): Idea humanity v kontexte súčasnej etiky [The idea of humanity in the context of contemporary ethics]. In: *Filozofia*, 60(7), pp. 512–531.
GLUCHMAN, V. (2008): *Etika a reflexie morálky* [Ethics and Reflections of Morality]. Prešov: FF PU.
GLUCHMAN, V. (2017): G. E. Moore and theory of moral/right action in ethics of social consequences. In: *Ethics & Bioethics (in Central Europe)*, 7(1–2), pp. 57–65.
GOODPASTER, K. E. (1992): Business ethics. In: L. Becker & C. Becker (eds.): *Encyclopedia of Ethics*. New York: Garland Publishing, pp. 111–115.
GRAAFLAND, J. & SMID, H. (2019): Decoupling among CSR policies, programs, and impacts: An empirical study. In: *Business and Society,* 58(2), pp. 231–267.
HAUGH, H. M. & TALWAR, A. (2016): Linking social entrepreneurship and social change: The mediating role of empowerment. In: *Journal of Business Ethics,* 133(4), pp. 643–658.
HAYNES, K. T., HITT, M. A. & CAMPBELL, J. T. (2015): The dark side of leadership: Towards a mid-range theory of hubris and greed in entrepreneurial contexts. In: *Journal of Management Studies,* 52(4), pp. 479–505.
HÖFFE, O. (1992): *Lexikon der Ethik,* 4. neubear., Aufl., Munchen: Beck.
HÖFFE, O. (2008): *Lexikon der Ethik,* 7. neubear., Aufl., Munchen: Beck.
HOFSTEDE, G. (2009): Business goals for a new world order: Beyond growth, greed and quarterly results. In: *Asia Pacific Business Review,* 15(4), pp. 481–488.
HWANG, J. & CHUNG, J.-E. (2018): The roles of business ethics in conflict management in small Retailer–Supplier business relationships. In: *Journal of Small Business Management,* 56(2), pp. 348–368.
LAČNÝ, M., LUKÁČOVÁ, J. & KOVALČÍKOVÁ, I. (2018): Specifics of introducing a code of ethics into the academic environment. In: *Ethics & Bioethics (in Central Europe),* 8(1–2), pp. 91–108.
LÄHDESMÄKI, M., SILTAOJA, M. & SPENCE, L. J. (2019): Stakeholder salience for small businesses: A social proximity perspective. In: *Journal of Business Ethics,* 158(2), pp. 373–385.
MALÉ A STREDNÉ PODNIKANIE V ČÍSLACH V ROKU 2016 [Small and medium-sized entrepreneurship in numbers in the year 2016]. Bratislava: Slovak Business Agency, 2017.
NADÁCIA PONTIS [Pontis Foundation]. [online] [Retrieved August 31, 2019] Available at: http://www.nadaciapontis.sk/o-via-bone-1.
NAVRHLI SME ZMENY K LEPŠIEMU, NA RADE JE ŠTÁT [We have proposed changes for the better, now it is the State's turn]. [online] [Retrieved August 31, 2019] Available at https://www.etrend.sk/trend-archiv/rok-2019/cislo-21/navrhli-sme-zmeny-k-lepsiemu-na-rade-je-stat.html.
NORTH, D. (2005): *Understanding the process of economic change*. Princeton: Princeton University Press.
NUNNER-WINKLER, G. (1993): Verantwortung. In: G. Enderle, K. Homann, M. Honecker, W. Kerber & H. Steinmann (eds.): *Lexikon der Wirtschaftsethik*. Freiburg im Breisgau, Basel & Wien: Herder, pp. 1185–1192.
PAINTER-MORLAND, M. & DESLANDES, G. (2017): Reconceptualizing CSR in the media industry as relational accountability. In: *Journal of Business Ethics,* 143(4), pp. 665–679.
PETROVSKAYA, I., ZAVERSKIY, S. & KISELEVA, E. (2016): Putting assumptions into words: money and work beliefs and legitimacy of entrepreneurship in Russia. In: *European Journal of International Management*, 10(2), pp. 157–180.
PILKOVÁ, A., HOLIENKA, M., KOVAČIČOVÁ, Z., REHÁK, J. & MIKUŠ, J. (2019): *Podnikanie na Slovensku: aktivita, prostredie a vybrané druhy podnikania* [*Entrepreneurship in Slovakia: Activity, Environment and Selected Types of Entrepreneurship*]. Bratislava: Univerzita Komenského v Bratislave & Kartprint.

PRVÝCH TRIDSAŤ SUBJEKTOV PODPÍSALO PROTIKORUPČNÚ CHARTU [The first thirty subjects signed the Anti-corruption charter]. [online] [Retrieved August 31, 2019] Available at: https://domov.sme.sk/c/1116762/prvych-30-subjektov-podpisalo-protikorupcnu-chartu.html.
REMIŠOVÁ, A. (1997): *Podnikateľská etika. Úvod do problematiky* [*Business Ethics*: *Introduction*]. Bratislava: Ekonóm.
REMIŠOVÁ, A. (2011): *Etika a ekonomika* [*Ethics and Economics*]. Bratislava: Kalligram.
REMIŠOVÁ, A. & LAŠÁKOVÁ, A. (2017): Theoretical foundations of the Bratislava school of business ethics. In: *Ethics & Bioethics (in Central Europe),* 7(3–4), pp. 177–186.
REMIŠOVÁ, A. & LAŠÁKOVÁ, A. (2018): On NGOs' role in the development of business ethics in Slovakia. In: *Athens journal of business and economics.* 4(4), pp. 389–404. [online] [Retrieved August 31, 2019] Available at: https://www.athensjournals.gr/business/2018-4-4-3-Remisova.pdf
REMIŠOVÁ, A., LAŠÁKOVÁ, A. & BOHINSKÁ, A. (2019): Reasons of unethical business practice in Slovakia: The perspective of non-governmental organizations' representatives. In: *Acta Universitatis Agriculturae et Silviculturae Mendeliane Brunensi*, 67(2), pp. 565–581.
REMIŠOVÁ, A., LAŠÁKOVÁ, A., RUDY, J, SULÍKOVÁ, R., KIRCHMAYER, Z. & FRATRIČOVÁ, J. (2016): *Ethical leadership in the Slovak business environment*. Praha: Wolters Kluwer.
RETTBERG, A. (2016): Need, creed, and greed: Understanding why business leaders focus on issues of peace. In: *Business Horizons,* 59(5), pp. 481–492.
SALLAI, D. & SCHNYDER, G. (2020): What is "Authoritarian" about authoritarian capitalism? The dual erosion of the Private–Public divide in state-dominated business systems. In: *Business and Society,* doi:10.1177/0007650319898475 (forthcoming).
SAUERWALD, S. & SU, W. (2019): CEO overconfidence and CSR decoupling. In: *Corporate Governance: An International Review,* 27(4), pp. 283–300.
SCHONS, L. M., CADOGAN, J. & TSAKONA, R. (2017): Should charity begin at home? An empirical investigation of consumers' responses to companies' varying geographic allocations of donation budgets. In: *Journal of Business Ethics,* 144(3), pp. 559–576.
SPRÁVAŤ SA NEKORUPČNE NIE JE JADROVÁ FYZIKA [TO BEHAVE UNCORRUPTED IS NOT NUCLEAR PHYSICS]. (2012) [online] [Retrieved August 31, 2019] Available at https://euractiv.sk/section/csr-spolocenska-zodpovednost/news/spravat-sa-nekorupcne-nie-je-jadrova-fyzika-019242/.
ŠTÁT ODMENÍ FIRMY, ČO SI RIADNE PLNIA DAŇOVÉ POVINNOSTI [The State will reward companies for proper tax compliance]. [online] [Retrieved August 31, 2019] Available at https://finweb.hnonline.sk/ekonomika/1853853-stat-odmeni-firmy-co-riadne-platia-dane.
ULRICH, P. (1997): *Integrative Wirtschaftsethik. Grundlagen einer lebensdienlichen Ökonomie*. Bern, Stuttgart & Wien: Haupt.
VAN LIEDEKERKE, L. & DUBBINK, W. (2008): Twenty years of European business ethics – past developments and future concerns. In: *Journal of Business Ethics*, 82(2), pp. 273–280.
WHAT IS CORRUPTION: [online] [Retrieved August 08, 2019] Available at https://www.transparency.org/what-is-corruption
ZEMANOVIČOVÁ, D. & VASAKOVÁ, L. (2017): Corruption as a global problem. In: T. Kliestik (ed.): *17th International Scientific Conference: Proceedings (Part VI.). Globalization and Its Socio-economic Consequences.* Žilina: University of Žilina, pp. 3069–3075.
ZÁKON Č. 54/2019 Z. Z. O OCHRANE OZNAMOVATEĽOV PROTISPOLOČENSKEJ ČINNOSTI A O ZMENE A DOPLNENÍ NIEKTORÝCH ZÁKONOV [Act no. 54/2019 Coll. on protection of whistleblowers of anti-social activity and on amendments to certain acts] [online] [Retrieved August 08, 2019] Available at https://www.slov-lex.sk/pravne-predpisy/SK/ZZ/2019/54/20190301.

ZÁKON Č. 91/2016 Z. Z. O TRESTNEJ ZODPOVEDNOSTI PRÁVNICKÝCH OSÔB A O ZMENE A DOPLNENÍ NIEKTORÝCH ZÁKONOV [Act no. 91/2016 Coll. on the criminal liability of legal entities and on amendments to certain Acts] [online] [Retrieved August 08, 2019] Available at https://www.slov-lex.sk/pravne-predpisy/SK/ZZ/2016/91/20190801.
ZÁKON Č. 343/2015 Z. Z. O VEREJNOM OBSTARÁVANÍ A O ZMENE A DOPLNENÍ NIEKTORÝCH ZÁKONOV [Act no. 343/2015 Coll. on public procurement and on amendments to certain acts]. [online] [Retrieved August 08, 2019] Available at https://www.slov-lex.sk/pravne-predpisy/SK/ZZ/2015/343/20190901.

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Perceptions of the importance of business ethics in SMEs: A comparative study of Czech and Slovak entrepreneurs

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Abstract

This article focuses on the perception of the importance of business ethics among Czech and Slovak entrepreneurs (this includes business owners and managers) within the SME sector. The comparison is based on an analysis of the approach to business ethics according to a set of parameters, namely company size, years in business, and the gender and education of the entrepreneurs. Empirical research was conducted in 2020 on a sample set consisting of 454 respondents in the Czech Republic and 368 respondents in Slovakia. The most important outcome of the research was the finding that business ethics is considered extremely important in both countries. The research results not only revealed that just over 90% of Czech entrepreneurs and 88% of Slovak entrepreneurs within the SME sector agreed that they should take into account the moral and ethical consequences of their decisions, but that the structure of their answers was very similar. Also, of interest were the findings that women were more aware of business ethics than their male counterparts, as were those entrepreneurs who possessed a higher education over those with a secondary education.

Keywords: business ethics, small and medium-sized enterprises, Czech Republic, Slovakia

Introduction

Much research is being conducted into business ethics because of the inspirational influence of entrepreneurial behaviour. There is strong motivation to act ethically among entrepreneurs. To understand why, it is important to determine what the perceptions and attitudes behind such motives are. The reasons lie in the responsibility of entrepreneurs (this includes business owners and managers) for the development and growth of a company, for maximizing profitability, for keeping investors happy with good returns, for improving customer loyalty through new products and services, and for productivity gains by motivating employees. Likewise, they are responsible for planning, strategy development, resource management, competitivity, decision making, and overall business operations (Kearney, Harrington & Kelliher, 2019).The crucial role of entrepreneurs, their approaches and attitudes towards the utilisation of natural resources, the effects on the environment, and its consequences on society and people, cannot be separated from daily business operations (Kolb, 2018). Jamnik (2011) states that entrepreneurs routinely encounter ethical issues in their work, and that it is very rare for ethical issues to be absent in their decision making. The diverse roles of business owners and managers cannot, therefore, be overlooked because of the negative and positive moral and ethical consequences of their actions and decisions on businesses, the economy, people, society and the environment. Furthermore, cut-throat competition, company survival, risk of failure, limited resources, etc., all pose challenges, thereby conflicting the priorities of entrepreneurs. The dilemma of deciding what is right and what is wrong is therefore not only limited to big corporations, but also plays a role in the day to day operations of small businesses (Robinson, Davidson, Van Der Mescht & Court, 2007). Another study confirmed that entrepreneurs are increasingly facing ethical decision-making challenges (Enyioko, 2017). At present, they not only have direct responsibility to

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maximise stakeholders' returns and improve business performance, but also to make decisions that do not negatively affect society, the economy or the environment (Carroll, 1991).

An entrepreneur's personal characteristics, overall values, ethical behaviour, decision-making style, differentiation between right and wrong, also cannot be separated from an SMEs' daily business operations. The smaller the business, the more significant the entrepreneur's influence (Öksuzoglu-Guven, 2015).This study therefore focuses on SMEs because the economic growth of the nation can be measured by the growth of SMEs (Rahman, Belas, Kliestik & Tyll, 2017; Taiwo, Ayodeji & Yusuf, 2013). Furthermore, the growing economic importance of SMEs means that ethical challenges are no longer limited to big corporations (Robinson et al., 2007). This means that investigating the factors that influence business ethics and the ethical behaviour of entrepreneurs within the SME sector, and the impact thereof, is warranted.

This study assesses the state of ethical decision-making in SMEs in the Czech Republic and Slovakia. The novelty and excellence of the research lies in the fact that it is based on the attitudes of entrepreneurs themselves and on a representative sample of respondents.

The study is divided into four parts. The first part sets out the theoretical background and factors that affect business ethics, as well as the roles and demographics of entrepreneurs. The second part covers the aims, research methodology and data. The third part consists of analysis and a discussion of the results, with the conclusions presented in part four.

Theoretical background

An entrepreneur's decision-making process is not influenced by one factor, but rather by a complex system of factors that may have multiple impacts. This therefore requires a multi-facetted approach to evaluating an entrepreneur's decision making, one that takes into consideration factors such as human nature, workplace relationships, competition, etc. (Öksüzoğlu-Güven, 2015). Hence, the literature review is split into two parts. The first part focuses on important factors affecting ethical decision-making in business, as well as on the roles and perceptions of entrepreneurs and the impact and consequences of moral and ethical decision-making on business performance, the environment and society. The second part looks to identify how demographic factors, such as gender, age and education, influence the ethical decision-making (Öksüzoğlu-Güven, 2015) of entrepreneurs within the SME sector.

According to Lewis (1985),business ethics is about the moral rules, code of conduct, principles and standards that guide correct and truthful behaviour in specific situations. This definition identifies the ethical ways in which to manage a business and therefore provides guidance to business owners and managers with regard to determining, drafting and following their own set of rules, both personal and organisational, for conducting their own business activities. In their study, San-Jose & Retolaza (2018) state that there are three levels of business ethics, namely individual, organisational and macro. This particular explanation suggests that business ethics has wide implications. To be an ethical manager, you must possess the characteristics of a moral person, a moral manager, and a moral entrepreneur (Kaptein, 2019). According to Iacovino (2002), business ethics is about the difference between right and wrong, it is about following acceptable and justified rules and regulations, and the truthful behaviour of business owners and managers with regards to upholding the law, respecting people and the environment. Adkins & Radtke (2004) highlight a number of unethical corporate incidences by owners and managers that negatively affected the environment and stakeholders. Ethics is about human conduct or human actions. Ethical decision-making is a unique human activity because it is related to the human ability to find a reason to justify and to investigate their actions and activities, and to find self-fulfilment as part of a social cluster or, in the contemporary world, as a member of society as a whole. Ethics is also not just about how a human feels about something. Instead, it is a rational process that may become normal or instinctive once a set of

values is defined for constant application (Iacovino, 2002). Studies also show that managers and employees have basic knowledge of and favourable attitudes towards the concept of social responsibility (Milenkovska, Petrovska & Stoilkovska, 2019).

The interpretation of ethical issues has also drastically changed in the last few years. If a company wants to be perceived as being trustworthy and a dignified member of the business community, it must reflect and constantly implement the increasing standards being applied to business ethics (Sroka & Szántó, 2018). Many studies have shown that companies that show concern for social and environmental issues can attract consumers to their products and services because they appreciate such initiatives. Pivato et al. (2007) state that a company's social contribution builds trust, which is reflected in a positive impact on brand loyalty. In a similar vein, Turyakira (2018) concludes that in order to be competitive in the market and protect their business interests, business organisations and managers must learn to behave ethically. This also relates to other organisational issues such as the utilisation of natural resources, the creation of jobs and the payment of taxes. In other words, the performance of their legal and economic responsibilities. Within this context, the ethical behaviour of a company is defined by the rules, code of conduct, procedures and policies it should uphold and apply to managerial decision-making. However, the responsibility this entails for putting all the aforementioned into practice depends very much on how managers and business owners perceive and implement them (Sexty, 1995).

SMEs and entrepreneurs are the driving force behind the growth of economies. Ribeiro-Soriano (2017) concluded that the key people in SMEs are behind the functioning of an economy and contribute to a nation's economic development.

A study covering the V4 countries found that business ethics is considered to be an important factor affecting both the profitability and success of a business. The same study also revealed the expectation that the role of business ethics will expand in the future (Sroka & Lőrinczy, 2015). Some studies have found that business ethics has a positive effect on business competitivity (Turyakira, 2018), brand loyalty and trust (Pivato et al., 2007), and business trustworthiness and dignity (Sroka & Szántó, 2018).

Many studies have also found that demographic factors, such as the gender, age and education of entrepreneurs, influence ethical business management (Dalton & Ortegren, 2011; Marín, Nicolás & Rubio, 2019; Peterson, Rhoads & Vaught, 2001; Serwinek, 1992). It is therefore relevant to study how these and other demographic factors influence the perception and implementation of business ethics and the ethical behaviour of entrepreneurs, business owners and managers.

A recent study on the social orientation of entrepreneurs found that this is stronger in women, in the more educated, and in older people, although the latter required further research (Marín et al., 2019). Although gender is considered to be an important factor in determining attitudes to ethics, a study by Serwinek (1992) failed to detect any strong differences in perception between men and women. Another study found an indirect link between gender and ethical decision-making, but advocated for further research into the issue due to the mixed outcomes of previous studies. Earlier studies found that gender influences ethical responses, whereby women were reported to be more sensitive to social issues than men. However, when taking the overall findings into consideration, it is hard to draw a specific conclusion with regards to the ethical decision-making differences between men and women (Dalton & Ortegren, 2011). This conclusion reflects our own findings, which also revealed mixed results for almost all of the chosen demographic variables.

However, a study into environmental issues, e.g. buying organic food, recycling, etc., revealed that women show deeper concern than men. Women display better ethical behaviour towards environmental protection (Hunter, Hatch & Johnson, 2004). Another study by Peterson, Rhoads & Vaught (2001) tested the relationship between the gender and age of

business professionals and the influence of external factors on their ethical beliefs. The study outcomes indicated that young female professionals possess higher levels of ethical beliefs than their male equivalents, and that older males only display a slightly higher level than their younger equivalents. Age and gender are therefore both relevant to ethical beliefs. The study found that the most significant predictor is age (Serwinek, 1992). A study by Loe, Ferrell & Mansfield (2000) found that the majority of research conducted into gender differences and ethical sensitivity either concluded that there were no significant gender differences or that females are more ethically sensitive than males. The same study also included an analysis of eighteen studies into the relationship between education and ethical decision-making. Half of them found no significant relationship, whereas the remaining ones were inconclusive. However, a positive correlation was found to exist between age and ethical decision-making.

Grbac & Lončarić (2009) conducted research among managers of Croatian firms and found that ethics and social responsibility were considered to be highly important for business success. They found a positive relationship between the perception of ethics and the role of social responsibility in the productivity, performance and profitability of a business. A study into the influence of organisational ethics programmes found that ethics training helps to boost the trust of managers in such programmes. Ethics programmes can be used as a management tool to prevent unethical actions, improve employee conduct, differentiate between desired and undesired patterns of behaviour, and improve organisational culture in order to improve day to day operations (Remišová, Lašáková & Kirchmayer, 2019).

A study by Sroka & Szántó (2018) looked into the perceived ethical behaviour of 48 companies from three different industrial sectors, pharmaceuticals, tobacco and alcohol, in Poland and Hungary. It was found that business ethics is considered an important factor for business success and corporate image. No differences were found with regard to perceived ethical behaviour in Poland and Hungary. According to Chen-Fong (2002), when a company wants to implement a higher level of business ethics and enhance the opportunities for ethical decision-making by employees, the company's non-financial organisational performance improves. Improvements in organisational performance are directly dependent on the application of high-level ethics at both the individual and corporate level. A study by Lam & Shi (2008) into the moral judgement and ethical attitudes of working people found diverse influences of a number of demographic factors on law- and social-based ethical issues. The outcomes failed to support the assumption that males are more sensitive towards law-based ethical issues and females more sensitive towards social-based ethical issues. Another outcome of the study was that females have a lower acceptance threshold towards unethical behaviours in both areas, but failed to find a statistically significant relationship between gender or university education on attitudes to ethics. It is clear that the onus of ethical decision-making falls on business owners and managers. Within this context, and that of the literature review, it is therefore logical to study whether demographic factors influence their ethical decision-making and how they view the moral and ethical consequences of the outcomes of that process. This argumentation forms the basis for the present paper

Aims, research methodology and data

The aim of this article is to determine how important business ethics is to Czech and Slovak entrepreneurs (this includes business owners and managers) within the SME sector. The comparison is based on an analysis of the approach to business ethics according to a set of parameters, namely company size, years in business, and the gender and education of the entrepreneurs.

Empirical research was conducted among SMEs from October 2019 to March 2020 in the Czech Republic (CR) and the Slovak Republic (SR) using an on-line questionnaire. From the Cribis database, we randomly selected a sample of respondents whom we addressed by e-mail.

In total, more than 8,000 companies were approached in the Czech Republic, and more than 10,000 in the Slovak Republic. The total number of accepted questionnaires for the Czech Republic was 454 and for the Slovak Republic 368. The questionnaires were filled in by company owners or top managers. For the CR, this concerned 354 company owners and 100 managers. For Slovakia, 285 and 83 respectively.

In summary, the CR sample set included: 290 micro-companies, 107 small companies and 57 medium-sized ones. Years in business: 119 companies have been in business for up to 10 years and 335 for over 10 years. The educational level of the entrepreneurs was as follows: 231 indicated secondary education and 223 indicated higher education. Gender participation was: 323 men and 131 women.

In summary, the SR sample set included:216 micro-companies, 106 small companies, and 46 medium-sized ones. Years in business: 105 companies have been in business for up to 10 years and 263 for over 10 years. The educational level of entrepreneurs was as follows: 77 indicated secondary education and 291 indicated higher education. Gender participation was: 253 men and 115 women.

The assertion: "entrepreneurs (this includes business owners and managers) should take into account the moral and ethical consequences of their decisions" was the focus of the research. Respondents could choose from the following responses: strongly agree, agree, neither agree nor disagree, disagree, and strongly disagree.

Based on the estimation method, the following scientific hypotheses were formulated:

H1: Business owners (managers) should take into account the moral and ethical consequences of their decisions. A maximum of 70% of respondents in the Czech Republic and Slovakia agree with this assertion.

H1a: There are no statistically significant differences between the CR and the SR in the overall response structure and in the positive attitudes of entrepreneurs when evaluating this assertion.

H2: There are no statistically significant differences in the positive attitudes of entrepreneurs when evaluating this assertion according to the given parameters (company size, years in business, highest level of completed education) in the CR.

H2a: There are statistically significant differences in the positive attitudes of entrepreneurs when evaluating this assertion by gender in the CR.

H3: There are no statistically significant differences in the positive attitudes of entrepreneurs when evaluating this assertion according to the given parameters (company size, years in business, highest level of completed education) in the SR.

H3a: There are statistically significant differences in the positive attitudes of entrepreneurs when evaluating this assertion by gender in the SR.

For descriptive statistics (percentages, means), the Chi-square and Z-score methods were used to evaluate the defined scientific hypotheses. Statistically significant differences were compared through Pearson statistics at a significance level of 5%. The calculations were performed using free software available on the Internet.

Results and discussion

The following tables show the results of the empirical research, as well as the results of the statistical processing thereof.

Table 1: Entrepreneurs' views on business ethics in the Czech Republic and Slovakia

Entrepreneurs (including business owners and managers) should take into account the moral and ethical consequences of their decisions.	CR 454	SR 368	Z-score/p-value CR/SR

1. Strongly agree	263	192	0.4122
2. Agree	146	133	
1+2 together: percentage, quantity	90.01/409	88.32/325	
3. Neither agree nor disagree	31	35	
4. Disagree	9	6	
5. Strongly disagree.	5	2	
Chi-square/ p-value: 4.8687/0.3010			

Source: Authors

In the Czech Republic, up to 90.01% of entrepreneurs agreed with the assertion that they, as a group, should take into account the moral and ethical consequences of their decisions. For the Slovak Republic, this stood at 88.32%.

The Chi-square test value (p-value = 0.3010) confirmed that there is no statistically significant difference in the overall response structure between the respondents in the Czech Republic and Slovakia. We can therefore state that the weight of the answers of the Czech and Slovak respondents for the defined parameters is approximately the same.

The Z-score (p-value = 0.4122) for the test criterion confirmed that there are no statistically significant differences in the positive responses of entrepreneurs in the Czech Republic and Slovakia. We can therefore state that the positive responses in both countries are approximately the same.

H1 was refuted.

H1a was confirmed.

Table 2: Entrepreneurs' views on business ethics in the Czech Republic

Entrepreneurs (including business owners and managers) should take into account the moral and ethical consequences of their decisions.	Micro/-10/M/SE	Others/10+/W/UE	Z-score p-value
1. Strongly agree	183/64/187/132	80/199/76	*0.2891
2. Agree	75/44/98/72	71/102/48	**0.7795
1+2 together: quantity percentage	258/108/285/204 89/91/88/88	151/301/124/205 92/90/**95**/92	***0.0385 ****0.1971

Source: Authors

Notes: comparison by*company size (micro-, small and medium-sized),**years in business (up to 10 years and over 10 years),***gender,****completed education(secondary education and higher education).

The highest level of agreement with the assertion was found among female entrepreneurs (95%) and the lowest level among men and entrepreneurs with secondary education (88%).

The Z-score (p-value = 0.2891 / 0.7795 / 0.1971) for the test criterion confirmed that there are no statistically significant differences in the positive responses of entrepreneurs based on company size, years in business, and the entrepreneurs' education.

The Z-score (p-value = 0.0385) for the test criterion confirmed that there are statistically significant differences in the positive responses of entrepreneurs based on their gender. Women agreed more intensely with the assertion.

H2 was confirmed.

H2a was confirmed.

Table 3: Entrepreneurs' views on business ethics in the Slovak Republic

Entrepreneurs (including business owners and managers) should take into account the moral and ethical consequences of their decisions.	Micro/-10/M/SE	Others/10+/W/UE	Z-score p-value
1. Strongly agree	116/50/133/32/	76/142/59/160	*0.3628
2. Agree	72/40/92/31/	61/93/41/102	**0.3271
1+2 together: quantity percentage	188/90/225/63 87/86/89/82	137/235/100/26290/89/87/90	***0.5823 ****0.0455

Source: Authors

Notes: comparison by *company size (micro-, small and medium-sized),**years in business (up to 10 years and over 10 years),***gender,****completed education (secondary education and higher education).

The highest level of agreement with the assertion was found in larger companies and among entrepreneurs with a higher education (90%), and the lowest level of agreement among entrepreneurs with a secondary education (82%).

The Z-score (p-value = 0.0455) for the test criterion confirmed that there are statistically significant differences in the positive responses of entrepreneurs in Slovakia based on their level of education. Those entrepreneurs with a higher education showed a higher level of agreement with the assertion.

The Z-score (p-value = 0.0385) for the test criterion confirmed that there are statistically significant differences in the positive responses of entrepreneurs based on their gender.

H3 was refuted.

H3a was refuted.

The analysis, which is based on relatively robust empirical research in both countries, provides surprising results. They reveal that up to 90.01% of Czech entrepreneurs and managers and 88.32% of Slovak entrepreneurs and managers agree with the assertion that they should take into account the moral and ethical consequences of their decisions.

Several factors may explain this phenomenon. For example, it is possible that the respondents purely expressed their opinion knowing that it does not oblige them to act ethically in their business activities. An alternative explanation is that on some issues, people's self-assessment is highly subjective and that some of the respondents see themselves in a better light.

The Slovak Compliance Circle survey of 2014 confirmed this trend; entrepreneurs and managers rated the overall situation concerning business ethics in Slovakia with an average score of 3.3 (1 = best and 5 = worst), but, within their own industry, rated the situation with a score of 2.7, and within their own company with a score of 1.9 (Slovak Compliance Circle,

2015).While the perception of the market situation was slightly negative, there was considerable optimism in their self-evaluation. The difference between the average assessment of the overall market situation and that of the company itself was approximately 30%. The survey also revealed that 65% of respondents believed that strict adherence to ethical behaviour would not lead to the failure of their business and that 43% of respondents considered the consistent application of ethical principles in their own company was a basis for building a competitive advantage that would bring success to the company in the long term.

A study of managers' opinions on business ethics in Iceland revealed that only 42% of respondents agreed or strongly agreed that Icelandic firms practice good business ethics, with 26% disagreeing or strongly disagreeing (Sigurjonsson, Arnardottir, Vaiman & Rikhardsson, 2015).A similar study in Italy found that only 38.8% of business owners and managers agreed that integrity in their commercial practices (honesty and truthfulness in publicity, fair delivery conditions) was a priority (D'Andrea & Montanini, 2015).

In contrast, a study in Romania found that 80% of business owners and managers disagreed with the statement that moral and ethical values are irrelevant for business, that 41% agreed that competition creates difficulties when making ethical decisions, that 68% disagreed that profit should supersede ethics, and that 92% agreed that there is a long-term correlation between ethics and profits (Echevarria-Cruz, Vaduva, Fotea & Neagoie, 2015).

According to joint research conducted by EY and the Association of Small and Medium-Sized Enterprises and Crafts in the Czech Republic, up to 35% of Czech entrepreneurs and managers stated that it is not possible to get a public contract without a bribe and that for 81% of them, corruption is a widespread phenomenon in society (EY & AMSP ČR, 2019).

Burduja & Zaharia (2019) found that nearly half (47.1%) of all business leaders believed that the "high prevalence of unethical behaviour in society" is a major hurdle to tackling corruption in privately owned businesses.

The presented results, which confirm the high interest in ethical aspects of entrepreneurship, counter the criticisms of the concept and role of Corporate Social Responsibility (CSR) in several economic theories. Within these theories, entrepreneurship and economics takes priority over ethics and environmental issues.

A study in Romania among business leaders and managers of micro-, small, medium-sized and large enterprises found that, on a scale of 1 to 5 (1 = not important and 5 = very important), economic responsibilities were rated the most important (4.57), followed by legal responsibilities (4.21) and ethical responsibilities (3.94), and that philanthropic responsibilities were the least important (3.44) (Gorski, 2017).

In the Czech Republic, we found that a higher number of women agreed with the assertion that entrepreneurs (including business owners and managers) should take into account the moral and ethical consequences of their decisions. This is not particularly surprising because women are generally perceived as being more responsible, empathetic, and more socially oriented in the economic environment, albeit with a higher risk aversion. However, what is surprising is that we did not find a similar trend in Slovakia.

The perception of women referred to above is reflected, for example, in the scoring models of banks, which rate the credit history of men and women differently. Women are considered to be more responsible, so they receive a better rating from banks than men. The regular payment of instalments on loans is, beyond the economic aspects thereof, considered to be an ethical issue.

Among the entrepreneurs in the SR sample set, those with a higher education showed a higher level of agreement with the assertion than those with a secondary school education. This is not surprising because it is assumed that university education opens up additional information channels that shape the attitudes of entrepreneurs with regard to how they should conduct their business activities in terms of business ethics, the environment and society.

This last point has been confirmed by research which clearly shows that university-educated entrepreneurs achieve better business results and have a better skills set for keeping a company on the market compared to entrepreneurs with only a secondary education. However, it is not gratifying to know that the interest of university students in going into business is low. For example, research conducted in 2016, showed that in the Czech Republic, only 49% of university students studying economic fields were interested in becoming entrepreneurs, compared to 59% in Slovakia (Belas et al., 2017).

Conclusions and limitations

This article aimed to present the views of entrepreneurs in the Czech Republic and Slovakia with regard to the importance of business ethics and to bring new knowledge about this field specifically with regard to the issue within SMEs. To achieve this, a comparative study was conducted of the attitudes of entrepreneurs (including business owners and managers) in both countries according to defined parameters.

The primary result of the research was that the importance of business ethics is viewed very highly in both countries, with the structure of the answers of Czech and Slovak entrepreneurs being found to be very similar. In addition, women were found to have a higher awareness of business ethics than men, as were entrepreneurs and managers with a higher education compared to those who have a secondary education.

Our research had some limitations. It is therefore within this context that the presented results should be viewed. Although we randomly selected respondents and conducted research on a representative sample, this is not and cannot be perceived as absolutely valid. The fact that the research was carried out during a favourable phase of economic development can also be viewed as a significant limitation. After all, during an economic crisis, it is to be expected that entrepreneurs' opinions may differ to those they currently hold.

Further research will focus on a detailed examination of ethical issues in business, particularly within the context of the economic viability of SMEs, in order to present the theoretical possibilities of increasing the ethical and social level of business activities without incurring economic losses.

References

ADKINS, N. & RADTKE, R. R. (2004): Students' and faculty members' perceptions of the importance of business ethics and accounting ethics education: Is there an expectations gap? In: *Journal of Business Ethics*, 51(3), pp. 279–300.

BELAS, J, DVORSKY, J., TYLL, L. & ZVARIKOVA, K. (2017): Entrepreneurship of university students: Important factors and the propensity for entrepreneurship. In: *Administratiesi Management Public,* (28), pp. 6–25.

BURDUJA, S. I. & ZAHARIA, R. M. (2019): Romanian business leaders' perceptions of business-to-business corruption: Leading more responsible businesses? In: *Sustainability (Switzerland)*, 11(20), p. 27.

CARROLL, A. B. (1991): The pyramid of corporate social responsibility: Toward the moral management of organizational stakeholders. In: *Business Horizons*, 34(4), pp. 39–48.

D'ANDREA, A. & MONTANINI, L. (2015): Corporate social responsibility practices in Italian SMEs. In: *Journal of Business and Economics*, 6(12), pp. 2040–2053.

CHEN-FONG, W. (2002): The relationship of ethical decision-making to business ethics and performance in Taiwan. In: *Journal of Business Ethics*, 35(3), pp. 163–176.

DALTON, D. & ORTEGREN, M. (2011): Gender differences in ethics research: The importance of controlling for the social desirability response bias. In: *Journal of Business Ethics*, 103(1), pp. 73–93.

ECHEVARRIA-CRUZ, S., VADUVA, S., FOTEA, I. & NEAGOIE, D. (2015): Business ethics and corporate social responsibility attitudes among SME leaders in Romania. In: *Proceedings of the 9th International Management Conference: Management and Innovation for Competitive Advantage*. Bucharest: b.n., pp. 830–839.
ENYIOKO, N. C. (2017): Ethical characterisation of entrepreneurs and their organisational growth in Nigeria. In: *SSRN Electronic Journal*, pp. 1–20.
EY & AMSP ČR. (2019): *Podnikatelé a vnímání korupce v České republice*. [*Businessmen and perception of corruption in Czech Republic*]. Praha: AMSP ČR.
GORSKI, H. (2017): Leadership and corporate social responsibility. In: *International Conference Knowledge-Based Organization,* 23(1), pp. 372–377.
GRBAC, B. & LONČARIČ, D. (2009): Ethics, social responsibility and business performance in a transition economy. In: *EuroMed Journal of Business*, 4(2), pp. 143–158.
HUNTER, L. M., HATCG, A. & JOHNSON, A. (2004): Cross-national gender variation in environmental behaviors. In: *Social Science Quarterly*, 85(3), pp. 677–694.
Chi-SQUARE TEST CALCULATOR. [online] [Retrieved March 10, 2020] [Available at: https://www.socscistatistics.com/tests/chisquare2/default2.aspx
IACOVINO, L. (2002): Ethical principles and information professionals: Theory, practice and education. In: *Australian Academic and Research Libraries*, 33(2), pp. 57–74.
JAMNIK, A. (2011): The challenges of business ethics – management and the question of ethics. In: *Tourism and Hospitality Management*, 17(1), pp. 141–152.
KAPTEIN, M. (2019): The moral entrepreneur: A new component of ethical leadership. In: *Journal of Business Ethics*, 156(4), pp. 1135–1150.
KEARNEY, A., HARRINGTON, D. & KELLIHER, F. (2019): Strategizing in the micro firm: A 'strategy as practice' framework. In: *Industry and Higher Education*, 33(1), pp. 6–17.
KOLB, R. W. (2018): Ethical role of the manager. In: R. W. Kolb (ed.): *The SAGE Encyclopedia of Business Ethics and Society*. Thousand Oaks, CA: SAGE, pp. 1–6.
LAM, K. C. & SHI, G. (2008): Factors affecting ethical attitudes in Mainland China and Hong Kong. In: *Journal of Business Ethics*, 77(4), pp. 463–479.
LOE, T. W., FERRELL, L. & MANSFIELD, P. (2000): A review of empirical studies assessing ethical decision making in business Terry. In: *Journal of Business Ethics*, 25(3), pp. 185–204.
MARÍN, L., NICOLÁS, C. & RUBIO, A. (2019): How gender, age and education influence the entrepreneur's social orientation: The moderating effect of economic development. In: *Sustainability (Switzerland)*, 11(17), pp. 1–16
MILENKOVSKA, V., PETROVSKA, J. & STOILKOVSKA, A. (2019): Positive attitude towards business ethics and social responsibility for improving corporate image. In: *UTMS Journal of Economics*, 10(1), pp. 97–107.
ÖKSUZOGLU-GUVEN, G. (2015): Entrepreneurial ethical decision making. In: D. E. Palmer (ed.): *Handbook of Research on Business Ethics and Corporate Responsibilities*. Hershey, PA: IGI Global, pp. 106–122.
PETERSON, D., RHOADS, A. & VAUGHT, B. C. (2001): Ethical beliefs of business professionals: A study of gender, age and external factors. In: *Journal of Business Ethics*, 31(3), pp. 225–232.
LEWIS, P. V. (1985): Defining business ethics: Like nailing jello to a wall. In: *Journal of Business Ethics*, 4(2), pp. 377–383.
PIVATO, S., MISANI, N. & TENCATI, A. (2007): The impact of corporate social responsibility on consumer trust: the case of organic food. In: *Business Ethics: A European Review*, 17(1), pp. 3–12.
RAHMAN, A., BELAS, J., KLIESTIK, T. & TYLL, L. (2017): Collateral requirements for SME loans: empirical evidence from the Visegrad countries. In: *Journal of Business Economics and Management*, 18(4), pp. 650–675.

REMIŠOVÁ, A., LAŠÁKOVÁ, A. & KIRCHMAYER, Z. (2019): Influence of formal ethics program components on managerial ethical behavior. In: *Journal of Business Ethics*, 160(1), pp. 151–166.
RIBEIRO-SORIANO, D. (2017): Small business and entrepreneurship: their role in economic and social development. In: *Entrepreneurship & Regional Development,* 29(1–2), pp. 1–3.
ROBINSON, D. A., DAVIDSSON, P., VAN DER MESCHT, H. & COURT, P. (2007): How entrepreneurs deal with ethical challenges: An application of the business ethics synergy star technique. In: *Journal of Business Ethics*, 71(4), pp. 411–423.
SAN-JOSE, L. & RETOLAZA, J. L. (2018): European business ethics agenda based on a Delphi analysis. In: *European Journal of Futures Research*, 6(1), Article 12.
SERWINEK, P. J. (1992): Demographic & related differences in ethical views among small businesses. In: *Journal of Business Ethics*, 11(7), pp. 555–566.
SEXTY, R. W. (1995):*Canadian Business and Society.* Scarborough, Ont.: Prentice Hall.
SIGURJONSSON, T. O., ARNARDOTTIR, A. A., VAIMAN, V. & RIKHARDSSON, P. (2015): Managers' views on ethics education in business schools: An empirical study. In: *Journal of Business Ethics*, 130(1), pp. 1–13.
SLOVAK COMPLIANCE CIRCLE. (2015): *Vnímanie podnikateľskej etiky na Slovensku* [*The perception of business ethics in Slovakia*]. Bratislava: SCC.
SROKA, W. & LŐRINCZY, M. (2015): The perception of ethics in business: Analysis of Research Results. In: *Procedia Economics and Finance*, 34(15), pp. 156–163.
SROKA, W. & SZÁNTÓ, R. (2018): Corporate social responsibility and business ethics in controversial sectors: Analysis of research results. In: *Journal of Entrepreneurship, Management and Innovation*, 14(3), pp. 111–126.
TAIWO, M. A., AYODEJI, A. M. & YUSUF, B. A. (2013): Impact of small and medium enterprises on economic growth and development. In: *American Journal of Business and Management*, 2(1), pp. 18–22.
TURYAKIRA, P. K. (2018): Ethical practices of small and medium-sized enterprises in developing countries: Literature analysis. In: *South African Journal of Economic and Management Sciences*, 21(1), pp. 1–7.
Z SCORE CALCULATOR FOR 2 POPULATION PROPORTIONS. [online] [Retrieved March 12, 2020] Available at: https://www.socscistatistics.com/tests/ztest/default2.aspx