Leadership in medicine: linking soft skills o moral values

Liderazgo en medicina: uniendo competencias sociales a valores morales

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Abstract

Leadership in medicine is still an underexplored field in Italy; while this topic is of increasing global importance in healthcare, its impact in italian academia is still limited to nursing and only few courses are available. Worldwide, leadership in healthcare is equate to possessing soft skills abilities; on the contrary, in Italy healthcare scholars still link leadership to technical abilities. In this paper, we will propose to address the problem of leadership in medicine more generally: the increasing complexity of management activities in healthcare poses new challenges to the medical profession, which actually requires not only possession of soft skills but also abilities in the implementation of organizational, societal and professional values which need a moral awareness based on transforming leadership.

Keywords: leadership in medicine, soft skills, leadership ethics, transforming and transactional leadership.

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1. Introduction: the emergence of leadership in medicine

Leadership studies is a discipline of increasing importance in many professional sectors and it is increasing academic importance today [1]. The study of leadership in medicine has only recently started to take its place as a common medical term [2]. As Dowton noticed, since a few years ago, «leadership has received little attention in […] peer-reviewed medical literature.» [3]. Things are changed: leadership literature in medicine has dramatically increased in recent years. Leadership interest in medicine was triggered by the change in the organizational climate –from old fashioned to new forms of governance [4:2]– which lead to an increasing role of doctors not only in general management [5], but also by the shift from the General Practice (often referred to "bedside medicine") towards a more centralized form of medical care provision such as the hospital medicine [2]. At the same time, «fresh health challenges loom. New infectious, environmental, and behavioral risks, at a time of rapid demographic and epidemiological transitions, threaten health security of all. Health systems worldwide are struggling to keep up, as they become more complex and costly, placing additional demands on health workers» [6].

Leadership, in those pioneering countries (such as UK and USA) which are facing change in the National Health System, seem to equate leadership to skills different than just practical medical abilities; in other, more traditional countries, such as Italy, leadership in medicine generally seems still to be equated to technical skills.[1] According to Warren and Carnall, «Good medical leadership is vital in delivering high-quality healthcare,[2] and yet medical career progression has traditionally seen leadership lack credence in comparison with technical and academic ability» [7].

In fact leadership in medicine is not about technical skills which are the specific abilities of any professionally trained doctor, but, according to the mainstream general idea of leadership, it involves

organizational aspects (such us followers-leader relation) and the so-called soft skills (such as persuasion, motivation, negotiation, networking, and so on)[3] across all the medical professions [8] [9]. Indeed, without these soft skills, technical aptitude and business savvy aren't worth much if leaders don't have the skills to execute them; in other words, soft skills are needed in support of existing professionalism in order to achieve leadership [10].

In his James MacKenzie Lecture 2010 Sir Lewis Ritchie argues leadership importance ranges from general practice to nursing up to hospital services. However, «The patient consultation remains at the hub of clinical practice, but is now being delivered in different ways, in new settings, and by a growing team of health professionals. The exceptional potential of general practice continues to unfold, including anticipatory care and health promotion, in addition to our traditional role of alleviating suffering, pain, and distress» [11]. According to Frenk et alii, «all health professionals in all countries should be educated to mobilize knowledge and to engage in critical reasoning and ethical conduct so that they are competent to participate in patient and population-centered health systems as members of locally responsive and globally connected teams» [6]. In other words, leadership in medicine should include the idea of person-centered medicine in which the moral element is a fundamental ingredient, as suggested by Ramsey [12], and is as much important as soft skills, as we will argue at the end of this paper.

2. Definitions of leadership and soft skills

While literature on leadership in medicine focuses basically on soft skills, the very nature (i.e. the "definition problem") of leadership is still a controversial matter.[4] Political leadership expert John Nye [14: X] claims there are about 211 different leadership definitions (from the literature of the Twenties to the Nineties of the past century). On the other had, Rost, an academic critical of leadership

studies, concludes that, looking at the popular press, leadership is a "hot word" which «has come to mean all things to all people» [15: 7]. Peter Drucker, one of the pioneers of management studies, famously stated that «The only definition of a leader is someone who has followers. Some people are thinkers. Some are prophets. Both roles are important and badly needed. But without followers, there can be no leaders» [16]. While controversial, the proposed definition is formally correct: whatever we mean with leadership functions in a particular profession (or leadership environment), a leadership is triggered only when someone gets followers: without followers there is no leadership. We can call this definition "a minimal leadership definition" [17]; any application of leadership to a particular field emerges specific skills that characterizes a leader in that particular professionalism. As Warren Bennis one of the pioneers of leadership studies, explained «To an extent, leadership is like beauty. It is hard to define, but you know when you see it» [18]. Harvard Business School professor John Kotter [19] defines leadership by what leaders do: they cope with change, they set direction, they align people to participate in that new direction, and they motivate people. The same difficulty is found when someone tries to define clinical or leadership in medicine; according to Daly and alii, «Like "leadership", the concept of clinical leadership can be defined in a range of ways; and while a standard definition of clinical leadership providing absolute agreement on meaning is not crucial to progress and is likely to prove difficult, it is useful to consider the various ways clinical leadership is conceptualized and presented in the literature. While effective clinical leadership has been offered up as a way of ensuring optimal care and overcoming the problems of the clinical workplace, a standard definition of what defines effective clinical leadership remains elusive» [20].

The "definition problems" match also with how to demarcating leadership from management. This is a vexata quaestio in leadership studies discussed since its infancy, yet there is no an agreed view on what managers or leaders should do and what they need to do.

According to G. Salaman, «there never can be, since such definitions arise not from organizational or technical requirements (which are themselves the product of manager's theory of organization), but from the shifting ways in which over time these functions are variously conceptualized» [21]. On the contrary, in his seminal paper, A. Zaleznik clearly distinguishes leaders from managers according to their tasks and their roles in organizations: the latter deals with day by day routinary tasks linked to their organizational rank, «ensuring that an organization's day to day business gets done» [22]. On the other hands leaders, «adopt personal, active attitudes towards goals. They look for the potential opportunities and rewards that lie around the corner, inspiring subordinates and firing up the creative process with their own energy» [22]. John P. Kotter, also adds other two elements that help us to distinguishing between leaders and managers: «Management is about copying with complexity» [19] its scope is to brings a degree of order and consistency to organizational key dimensions. «Leadership, by contrast, is about coping with change» [19], such as change in the very structure of organizations which needs to fit with new social and economical conditions and with technological change. These different functions, according to Kotter, shape the characteristic activities of management and leadership. Lewis Ritchie defines leadership more broadly as «the ability to influence and motivate people» and describes leaders as people who «cope with change, they set vision and direction, and stimulate team members to follow that vision» [11]. According to Rughani et alii «Ritchie makes a connection between (medical) professionalism and leadership and we should think of these as being intertwined, with leadership being both part of core professional behavior and a driver for its continual reform» [23].

To sum up, management seems linked to routinary competences linked to a person's role within an organization aiming at keeping oiled the organizational machinery, while leadership is more about vision, change[5] and the human factor in an organization. However,

the changing nature of the challenges faced by 21st-century societies drives new approaches to governance and leadership; Kickbusch and Gleicher claim «health is only one challenge and is not always given priority. Most of these challenges, however, have significant health effects, which have not been considered sufficiently so far. The challenges include systemic shocks, such as natural disasters and disease outbreaks, as well as longer-term processes, such as urbanization, epidemiological and demographic transitions, food insecurity, climate change and widening economic disparities» [4: VII-VIII].

Very importantly, recent leadership literature has focused on soft skills or powers (opposed to hard power which is linked to authority, hierarchical position in organizations and coercion); these powers or skills stem out from two different, albeit convergent facts: the shift from the military-industrial paradigm in macroeconomics and the increasing importance and complexity of information and the way in which that should be understood, elaborated and delivered [14: 45]. According to Kickbusch and Gleicher, living in a complex, information-based society «means that power and authority are no longer concentrated in government. Informed citizens, conscientious businesses, independent agencies and expert bodies increasingly have a role to play. Nevertheless, governments and health ministry's continue to be important in managing governance for health, setting norms, providing evidence and making the healthier choice the easier choice» [4: VIII]. The centrality of a leader's job shifted from skills linked to formal authority to soft skills that enable a leader to use information to persuade and attract followers.

In managerial and in political leadership, soft skills are not as central as in the medical field. While a certain amount of hard skills (skills that are connected to a formal position in a hierarchy) is required in the medical profession, they are less important than management. Interaction with colleagues and patients ask, as in universities, for a more flat hierarchy because complexity, knowledge

possession[6] and its sharing with peers require a different, more democratic approach than in management [14: 31] or even it requires a disperse leadership [4: VII]. According to Nye, indeed, political and management leadership benefits from the interplay between hard and soft powers which Nye calls *smart power* (14: X) which is a combination of skills derived by personal position (essentially coercion and rewards) and those personal skills we have seen above.

Therefore, there is a general agreement that soft skills are very important for leadership in medicine, especially in an organization such as the hospital in which doctors have to deal daily with clinical emergence, patient care and social relations with peers. Rughani et alii, indeed, claim that «General practice is characterized by uncertainty and complexity and operates through relationships with a wide range of people with whom partnership is a key principle» [23].

What are these soft skills? According to Warren and Carnall, doctors should «be able to take a macroscopic view on healthcare provision and resource allocation and to understand the political, economic, social and technological drivers for change that will influence this view throughout their careers. Doctors, who until now have been taught little of the NHS, will need to learn about the funding, organization, governance and management that are integral to its workings. They need to be supported by well-developed systems, clear lines of reporting and responsibility, and an organizational culture that provides good information and encourages its use as a vehicle for performance improvement. Finally, all doctors, whether they remain predominantly as medical practitioners, move to lead organizations or take on more strategic roles, need to learn more about "followership" […] that recognizes the importance of participation and allowing others to lead» [7]. Still Warren and Carnall suggest these skills however need to be supported by «a broader range of non-technical skills to allow (future medical leaders) to lead others, not just within medicine but across all professional boundaries» [7]. Basically, soft skills require doctors to «create and communic(ate) their vision, setting clear direction, service redesign

and healthcare improvement, effective negotiation, awareness of both self and others, working collaboratively and networking. They will need to be able to balance many different competing interests and priorities and manage themselves effectively; to enhance peer credibility; many will seek to continue to deliver high-quality clinical care alongside these prominent leadership positions. They must hold, voice and enact strong personal moral values and beliefs that impact positively on those around them and place the patient at the centre of decision-making, not the priorities of the provider» [7].

While a general consensus emerges about the ends of soft skills in leadership medicine, there is no consensus on which particular skills a medical leader should possess: some scholars emphasize on the ability at creating a vision [1; 9], some on enabling trust [11], others on empowering [8], and others –especially those dealing with nursing– on emotions [20] or emotional intelligence [24]; the importance of particular soft skills range not only on the kind of medical profession, but also, as happens in leadership, more generally, on the organizational and cultural context.

3. Leadership in medicine and moral values: the normative theory

We have claimed that, alongside with development of soft skills, those involved in leadership in medicine should develop a further sensibility for values. Values «can be defined as broad preferences for appropriate courses of action or outcomes; they therefore reflect a person's sense of right and wrong and what ought to be. Values influence attitudes and behavior and thereby shape policymaking and entire societies by setting the rules and standards (the principles) that determine acceptable (that is, ethical) actions in the area of family and community or in terms of governance of society and interactions between communities and societies with different values and principles» [4: 47-48]. Ritchie argues, indeed, that «Patients rightly

have increased expectations of involvement, accountability, and transparency but also have responsibilities as well as rights» [11]. It is not odd at all that Ritchie goes back to Plato's Republic when describing the ideal leader. Ritchie claims: «the Greek philosopher Plato, who first defined the ideal leader as someone who commits to, and is trained for, a life of service and devotion to their fellow citizens» [11]; Plato's ideal leader «has immediate resonance for us as GPs the link between commitment, continuous learning (or self renewal), and the needs of our patients. Irrespective of scientific, societal, or political change, our leadership credentials should be founded on the enduring rock of our moral values and obligations to patients and society. These values and obligations amount to our "professionalism" as GPs» [11].

This call for moral values in leadership in medicine not only implies themes already discussed in bioethics and medical ethics as it happens already in nursing, [24], but also includes the recent discussions on the role of ethics in leadership (Leadership Ethics). Leadership ethics indeed claims that ethics is central to the study of leadership which started the so called normative theories of Leadership. Normative theories of leadership were famously proposed by –among others– political scientist James MacGregor Burns [25], and taken as a starting point the ethical/moral dimension of leadership; scholars engaged in this school of ought believe that ethics is a crucial element of leadership or even, the essential element of leadership [26: 15], for no leadership can be effective without being ethical at the same time; and because choice –and therefore moral hazard– is coincident with leadership.

According to James MacGregor Burns, two basic kinds of leadership can be distinguished: *transforming* and *transactional* leadership.

Burns characterizes *transactional leadership* in terms of the notion of exchange: «Such leadership occurs when one person takes the initiative in making contact with others for the purpose of an exchange of valued things. The exchange could be economic or political or psychological in nature: a swap of goods or one good

for money; a trading of votes between candidate and citizen or between legislators; hospitality to another person in exchange of willingness to listen to one's troubles. Each party to the bargain is conscious of the power resources and attitudes of the other. Each person recognizes the other as a person. Their purposes are related, at least to the extent that the purposes stand within the bargaining process and can be advanced by maintaining that process». [25: 19-20]

The relationship, Burns argues, will last only as long as the bargain will be kept but does not really bind leaders and followers together in a mutual and continuing pursuit of a higher purpose. Once the aim of the bargain is fulfilled the leadership relation will end; that will result in an ethics of choice and individualism that characterizes the market and (arguably) contemporary politics [27].

On the contrary, *transforming leadership* takes on another path: it is normative. It is normative in two senses. Firstly, it describes how moral values and value-based choices may be influenced by the actions of leaders and ways in which followers perceive them. Secondly, it does not intend to simply describe how leaders in fact behave but, rather, prescribes how they ought to behave.[7] Burns defines transforming leadership as follows: «The transforming leader recognizes and exploits an existing need or demand of a potential follower. But, beyond that, the transforming leader looks for potential motives in followers. The result of transforming leadership is a relationship of mutual stimulation and elevation that converts followers into leaders and may convert leaders into moral agents». [25: 4]. Thence, according to Burns transforming leaders aim at moving beyond people's wants and wishes, thereby engaging their real needs and moral values. Burns argues that transforming leadership is the capacity to transcend the claims of multiplicity of everyday wants, needs and expectations by raising both leaders and followers to «higher levels of motivation and morality» [25: 20]. Therefore leaders and followers mainly start from a recognition of shared moral values that they leverage for collective actions. Pioneer leadership ethics scholar, J. Ciulla argues that «Burns's theory

of transforming leadership […] rests on a set of moral assumptions about the relationship between leaders and followers. Burns's theory is clearly a prescriptive one about the nature of morally good leaders» [26]. Very importantly, according to Ciulla, Burns's «transforming leaders have very strong values.[8] They do not water down their values and moral ideals by consensus but rather they elevate people by using conflicts to engage followers and help them reassess their own values and needs» [26]. In other words, Burns's transforming leaders are transforming because they find a resonance between their own and others' moral beliefs, such that those others experience themselves as followers. The motive force for leader and followers starts from shared moral values, morality and beliefs that create trust not only between GP and patients but also among peers.

4. Conclusions

The ethical component in leadership across the medical professions is fundamental; in nursing, for example an Italian empirical study demonstrated that «Ethical leadership acts on nurses' organizational behavior [...] The nurses' organizational behavior is crucial to the outcome of the health care service. Therefore, the ethical leadership indirectly affects the quality of the care and the cure offered to the patients» [24]. More importantly, the general literature on leadership in medicine seems to converge on the centrality of soft skills, but they very likely need to walk hand in hand with the moral elements based on transforming leadership. Even though, some soft skills (such as creating trust, negotiation and awareness), require some ethical sensibility. While in management the stakeholder view puts profit forward, for leadership in medicine special moral sensibility (which is also part of the medical tradition since the Hippocratic oath) plays a fundamental role: «Medicine is not a business, and the differences between it and a commercial enterprise are

profound, although perhaps less well-defined in the current entrepreneurial climate when compared to earlier times» [1]. As Ritchie has indeed highlighted, «Medical professionalism has been described as: 'A set of values, behaviors, and relationships that underpin the trust the public has in doctors'. For GPs, we must include our own core professional values [...] which form the basis of a moral covenant between GPs, patients, and society and, in turn, provide the foundation for effective leadership in general practice. While maintenance of professional values was once seen as the responsibility of individual doctors alone, I would argue that successful professionalism also vitally depends on the moral culture of the organizations in which we work» [11].

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[2] The NHS Leadership Academy in its webpage claims: «Why does leadership in the NHS need to change? Quite simply, because there's so much evidence connecting better leadership to better patient care. Francis, Berwick, Keogh point to it and so does leading academic, Michael West. They all make the link between good leadership and making a positive difference to patient care, care outcomes and the experience of care»; see https://www.leadershipacademy.nhs.uk/ retrieved 1.10.2017.

[3] This is actually what is being done in the Leadership in Medicine Altems Master provided by the Catholic University of the Sacred Heart since 2016.

[4] Levine and Boaks, for example, claim that the issue of the definition of leadership just what leadership is both central to the question of its relationship to ethics and it is problematic. It cannot be solved by either course of action taken by most authors namely either dismissing the question or answering it preemptively. But, nor can it be ignored. It must be answered in order to tell us what we need to know about the relationship between ethics and leadership and also to ground that answer [13].

[5] It is interesting to notice how change is advocated for the healthcare sector; according to Frenk et alii, «Health professionals have made huge contributions to health and socioeconomic development over the past century, but we cannot carry

out 21st century health reforms with outdated or inadequate competencies. The extraordinary pace of global change is stretching the knowledge, skills, and values of all health professions.

[6] Despite the tendency of the various professions to act in isolation from or even in competition with each other, i.e. the so called "tribalism of the professions": J. Frenk et alii, *Health professionals for a new century: transforming education to strengthen health Systems in an interdependent world* [6].

[7] Before Burns, leadership scholars were indeed ambiguous (or did not notice this point) regarding whether they were proposing a descriptive or a normative theory of leadership; this ambiguity led to a number of internal contradictions in much the same way as ambiguities between questions of ethics and law in normative reasoning lead to ethical and legal fallacies: J.B. Ciulla, *Leadership Ethics: Mapping the Territory and Id. Conversations and correspondence with Burns on the ethics of transforming leadership* [26; 28].

[8] Burns distinguishes between two main classes of values: modal and end values. Modal values include responsibility, fairness, honesty, and promise keeping. These rest on the values found in the means of an act. End values, on the opposite, include liberty, justice and equality. These enable leaders to turn their followers into leaders: J.B. Ciulla, *Leadership Ethics*… [26].

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Reseña

Review

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"Creo que harto más me cuesta digerir la idea de la muerte cuando estoy sano que cuando tengo fiebre". (Montaigne)

Sacks, Oliver. *Gratitud.* Anagrama, México, pp. 2016-61.

Montaigne escribió que tener presente a la muerte constituye por sí mismo un acto para liberarse de ella; el ensayista agrega que "[…] el imaginarla con antelación supone sin duda una gran ventaja." (Montaigne 2010, 130). Como médico que era, Oliver Sacks no tenía problema con hacer dicho ejercicio. Los médicos siempre están cerca de la muerte.[1] Pero no sólo la imaginan, sino que frecuentan con ella en su día a día: la combaten y –en otro casos– tratan de reconfortar a sus pacientes para afrontarla mejor.

En *Gratitud*, Sacks relata tres pasajes de su vida en que visualizó su propia muerte. El primero ocurrió cuando practicaba alpinismo, a los cuarenta y un años; entonces, recurrió a proporcionarse primeros auxilios. Relata brevemente esta experiencia en el primer ensayo del libro, que nos da una primera señal de su cercanía con la química desde su nombre: "Mercurio". También en "Mercurio", el autor transmite su inquietud ante la proximidad de su cumpleaños ochenta, pues el deterioro físico ha cobrado factura y la pérdida de personas cercanas a él está muy presente. En tercer lugar, "De

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mi propia vida" es el texto a través del que comparte su sentir al ver *la muerte cara a cara* (p. 28). Lo escribió después de enterarse que padecía cáncer de hígado, secundario a una metástasis generada por un melanoma ocular que le había sido diagnosticado en 2005.

El autor expresa que los tres momentos estuvieron acompañados de retrospección sobre su vida y, aún más, de amor por lo vivido. Por ello, podría colocar en la pluma del médico lo escrito por Etty Hillesum: "He saldado las cuentas con la vida" (Hillesum 2007, 118). He ahí la razón de su último ensayo, donde se descubre pensando en una tradición judía muy arraigada, a pesar de su alejamiento de la religión desde los dieciocho años. Me refiero al Sabbat: *cuando tienes la sensación de que tu obra está terminada y de que, con la conciencia tranquila, puedes descansar* (p. 61).

Sin haberse planteado ese objetivo, Sacks nos da su clave para lograr una vida plena que nos reconforte ante el desasosiego de la muerte: tener pasiones que disfrutemos hasta nuestro último día.

La natación fue una de ellas. La practicó desde que su padre lo llevó a tener "contacto con el agua antes de cumplir una semana" (Sacks 1997). Y lo siguió haciendo, aún después de enterarse de su metástasis, *cada día, pero más… lentamente* (p. 41).

Desde su primera década, *los elementos de la tabla periódica pasaron a ser mis compañeros* (p. 38), dice. Y empezó a relacionarlos con sus aniversarios *cuando* averiguó *lo que eran los números atómicos* (p.17).

También comprueba que no se equivocó de carrera, la medicina, porque se dio tiempo de *visitar pacientes* (p. 40) aún después de la embolización que le practicaron. Además, su trabajo como médico lo ayudó a superar la crisis personal que atravesó en la década de 1960.

Sus inicios en la escritura estuvieron ligados a la medicina, ya que, mediante la narración de las historias de sus pacientes del hospital Bronx, descubrió su vocación y se entregó *a ella en cuerpo y alma, con total determinación* (p. 54). Este libro es el reflejo más palpable: escribió hasta los días más cercanos a su partida.

No es coincidencia ver en las fotos –acompañando a los textos– a Oliver Sacks nadando, leyendo y escribiendo; así como una pequeña recopilación de objetos sobre una mesa, que (imagino) son parte de su colección de elementos químicos.

No sé si tuvo la oportunidad de morir bajo el *celestial resplandor* (p. 37), como lo quería; pero me reconforta saber que estaba rodeado*, igual que cuando era niño, de metales y minerales, pequeños emblemas de la eternidad* (p. 39).

El conjunto de ensayos que conforman esta obra fueron escritos y publicados en fechas distintas; pero la selección de los mismos logra la unidad temática sobre una preocupación no exclusiva de un médico, sino de todo hombre: la muerte. No es casualidad que el primer texto que vino a mi mente al leerlos fue *De cómo filosofar es aprender a morir*, de Montaigne, el ensayista de la condición humana. Confirmé la relación entre ambas obras al recorrer las páginas de *Gratitud*, donde supe que Sacks se acompañó de las enseñanzas que descubrió a través de la lectura de David Hume, *uno de mis filósofos favoritos* (p. 28), confiesa.

En todo momento, salta a la lectura la prosa que caracterizó a Sacks. Hay fluidez, producto –tal vez– de su habilidad en el agua; al fin, muchos de sus escritos se idearon mientras nadaba.[2] Tiene presencia la sensibilidad, que sólo puede ser resultado de las fuertes relaciones que cosechó. Y percibimos las referencias de un empático lector, tanto de las letras como de los hechos.

Para aquellos que no han leído a Sacks, *Gratitud* es una breve aproximación a su obra y permite vislumbrar la intensidad de su vida.[3] El libro es una oportunidad para acercarse a la escritura de quien bien Borges podría haber llamado el más literato de los médicos.[4] Mientras que para sus lectores recurrentes, Oliver nos deja en *Gratitud* una entrañable despedida.

El hombre cuyas plantas favoritas raramente eran los helechos[5] habrá de compartir las dos características por las que se maravilló con ellos:

> La belleza: "[…] son una forma de vida más simple pero tienen su belleza particular, una belleza muy delicada» (Sacks 2005), y la permanencia: "Son unos grandes supervivientes" (Sacks 2005).

La primera se refleja en su muy fructífera vida; la segunda es producto de su obra. Me da gusto ser cómplice en lograr dicha permanencia, que fue –a la vez– uno de sus deseos: *tan sólo albergo la esperanza de perdurar en el recuerdo de los amigos y de que algunos de mis libros puedan seguir* "*hablando*" *a la gente después de mi muerte* (p. 20).

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[1] En esto coincidiría conmigo, agregando a los militares, Svetlana Alexiévich.
[2] Su capacidad creadora bajo el agua la relata en "Nadar hasta morir".
[3] La descripción más profunda de su vida está en su libro *En Movimiento. Una vida*, publicado en español por Anagrama.
[4] Utilizo el adjetivo con el que Borges calificaba a Schopenhauer; en ese caso, como "el más literato de los filósofos". Dichas opiniones se encuentran en *Autobiographical*, donde además agrega que "Si hoy eligiera [yo, Borges]a un solo filósofo, lo elegiría a él [Schopenhauer]" (p. 29) [La traducción y los corchetes son míos].
[5] Sacks confesó su pasión por los helechos en la entrevista que le realizó Eduard Punset el 19 de enero de 2005.

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Review

Reseña

Érick Pérez-Mora*

"I believe that it is a lot more difficult for me to digest the ideas of death, when I am healthy, than when I have fever" (Montaigne)

Sacks, Oliver. *Gratitude.* Anagrama, México, pp. 2016-61.

Montaigne wrote that having death present, constitutes by itself, an act to break free from her; the essay writer adds that "[…] imagining it before hand, assumes without a doubt, a great advantage" (Montaigne 2010, 130). As a physician as he was, Oliver Sacks had no problem with doing such exercise. Physicians are always close to death.[1] However, they not only imagine it, but they frequently meet her in their day-by-day lives: they fight it, and –in other cases– they try to comfort their patients, in order to cope with it in the best way.

In *Gratitude,* Sacks describes three passages of his life, in which he visualized his own death. The first one happened when he was practicing mountaineering, when he was forty-one years old; then, he turned to provide himself with first aid. He briefly describes this experience in the first essay of the book, which gives us a first signal of his closeness with chemistry right from his name: "Mercury". Also in "Mercury", the author transmits his uneasiness

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in face of the proximity of this eightieth birthday, because the physical deterioration has collected a toll and the loss –of people very close to him– is very much present. In third place, "Of my own life" is the text through which he shares his feelings when seeing death face to face (p.28). He wrote it after finding out that he had liver cancer, secondary to a metastasis generated by an ocular melanoma, which he had been diagnosed in 2005.

The author expresses that the three moments were accompanied by a retrospection on his life and, even more, for love for what had been lived. For that, he could place in the physician's pen, what was written by Etty Hillesum: "I have come to terms with life" (Hillesum 2007, 118). There lies the reason of his last essay, where he discovers himself thinking about a deep-rooted Jewish tradition, despite of his separation from the religion since he was eighteen years old. I am referring to the Sabbath: *when you have the feeling that your job is done and that, with a clean conscience, you can rest (p. 61)*

Without planning that objective, Sacks gives us his clue to achieve a plentiful life, which would comfort us in face of the emotional distress of death: to have passions that we would enjoy until our last day.

Swimming was one of them. He practiced it since his father took him to have "contact with water before even to be one week old" (Sacks 1997). He kept doing it even after finding out about his metastasis, every day but more… slowly (p.41).

Since his first decade, *the elements of the periodic chart, "became my companions" (*p.38), he said. Then, he started to relate them with his anniversaries, *when* he found out *what the atomic numbers where* (p.17).

He also verifies that he was not mistaken by choosing medicine as a career, because he took the time *to visit patients* (p. 40) even after the embolization that was performed on him. Furthermore, his work as a physician helped him to overcome the personal crisis he endured in the 1960's decade.

His beginnings in writing were linked to medicine; although, by means of the story telling about his patients at the Bronx hospital,

he discovered his vocation and he rendered himself to it *in body and soul, with full determination* (p.54). This book is the most tangible mirror image: he wrote, up until the closest days to his departure.

It is not a coincidence, to see in the photographs –together with the texts– Oliver Sacks swimming, reading and writing; as well as, a small gathering of objects on a table, that (I imagine) are part of the collection of chemical elements.

I don't know if he had the chance to die under the *celestial glares* (p. 37), as he wanted; but it comforts me to know that he was surrounded, *the same as when he was a little child, of metals and minerals, small insignia of eternity* (p.39).

The set of essays, which form this piece of work, were written and published in different dates; but the selection of the same, achieves a theme unity over the worries not exclusive of a physician, but by every men: death. It is not by chance that the first text that came to my mind when reading them was about how to philosophize *is to learn to die,* by Montaigne, the essayist of the human condition. I confirmed the relationship between the two works by going through the pages of *Gratitude,* where I learned that Sacks was accompanied by the teachings he discovered through the reading of David Hume, *one of my favorite philosophers* (p.28), he confessed.

At every moment, it was evident when reading, the prose that characterized Sacks. It flows, as a product –maybe– of his ability in the water; after all, many of his writings were thought while he was swimming.[2] Sensitivity has presence that it can only be the result of the strong relationships that he gathered. We perceive the references of an emphatic reader, as of the letters as well as of the facts.

For those who have not read Sacks yet, *Gratitude* is a brief approximation to his work and allows visualizing the intensity of his life.[3] The book is an opportunity to get closer to the writing of whom Borges could have well called the greatest writer of all physicians,[4] while for his constant readers, Oliver leaves in *Gratitude* an endearing farewell.

The man, whose favorite plants were rarely the ferns,[5] would have had to share the two characteristics for which he had marveled with them:

> Beauty "[…] are a simple form of life, but they have their own beauty, a very delicate beauty" (Sacks 2005), and the survival: "They are great survivors" (Sacks 2005).

The first one is reflected in his very fruitful life; the second one is a product of his work. I am very glad to be an accomplice in achieving such permanence, which was –at the same time– one of his wishes: *I only have the expectation to endure in the memory of friends, an of that some of my books can remain «speaking» to people after my death (p.20).*

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[1] In this, I would concur with you, by adding the military, Svetlana Alexiévich.
[2] His creative capacity under the water is described in "To swim until death".
[3] The deepest description of his life is in his book "*In Movement. A life*", published in Spanish by Anagrama.
[4] I am using the adjective with which Borges used grade Schopenhauer; in this case, as "the greatest writer of the philosophers" such opinions are found in *Autobiographical*, where moreover he adds that "If I would choose [me, Borges] to a single philosopher, I would choose him [Schopenhauer]" (p. 29) [The translation and the brackets are mine].
[5] Sacks confessed his passion for the ferns in the interview made to him by Eduard Punset on January 19, 2005.

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Reseña

Review

José Enrique Gómez Álvarez*

Netzahualcoyotl, Cruz. *Bioética y donación altruista de órganos. Aciertos y problemas*. Editorial Fontamara. Observatorio Mexicano de Bioética, México, 2014. 109 pp.

El libro, como apunta el propio título, aborda los límites del modelo altruista en la donación de órganos. Dicho de otro modo, «… el altruismo como único elemento regidor de los programas de donación, es una cuestión problemática» y «… el modelo de donación altruista en términos de equidad es desventajoso para la familia donante» (p. 17).

Para el logro de esos propósitos, la autora divide el tema en cuatro capítulos. El primero es la delimitación del problema (pp. 17-24). En él se plantea el carácter problemático de los trasplantes en el modelo de la total gratuidad sin ningún tipo de retribución por parte de los otros actores involucrados; es decir, la persona receptora y la institución de salud. En este capítulo se establece que entre los dos extremos de comercializar los órganos y el altruismo total, cabe una posición intermedia, que es recibir cierta retribución social y ética por la donación.

El capítulo segundo, «El altruismo como elemento regidor de la donación de órganos» (pp. 25- 43), se estudia, por una parte, el sig-

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nificado e implicaciones del concepto de «altruismo» y, por otra, se presentan los resultados empíricos de un estudio de casos, en donde se muestran las complejas consecuencias en la familia cuando se realizan donaciones de personas vivas. El estudio empírico muestra muy bien las afectaciones psicológicas, costos económicos y sociales de ser donante. En particular, resalta la sensación de cosificación que perciben los sujetos involucrados al pasar por todo el protocolo que se centra en los aspectos clínicos básicamente. La autora no se queda sólo en el diagnóstico, sino que propone mejoras a ese proceso de donación, en donde se deba atender a los donadores con su nombre propio en todo el proceso, recibir atención psicológica, y absorber los gastos del proceso de donación entre otros. En conclusión: «atender la afección emocional y paliar en lo posible la afección económica –de los donadores- hace que toda una sociedad luche por evitar el consecuente impacto negativo en la cultura de donación que precariamente hemos logrado desarrollar» (p. 43).

En el siguiente capítulo, «Estudios cualitativos» (pp. 45-68), se estudian las consecuencias en las familias donantes del proceso de donación, pero ahora en donaciones cadavéricas. Se dio un seguimiento a seis familias donantes, de modo que se pudiera evaluar las implicaciones de la donación. El estudio demuestra que hay implicaciones psicológicas, económicas y sociales en los involucrados. Se dan implicaciones en el proceso de duelo debido a la dificultad de aceptar la muerte cerebral, y al mismo tiempo ver signos como la respiración o el latido cardiaco. Existen problemas entonces con el proceso del duelo y la aceptación de la donación.

Asimismo, el capítulo presenta otro estudio en población abierta acerca de la posibilidad de ser donadores. Se muestra que el hecho de descubrir que existen costos económicos en el mismo proceso de donación disminuye significativamente la posible aceptación de donar y tiene claras implicaciones éticas al no disponer de una información completa del proceso de la donación por lo que

es: « …una trasgresión al principio de autonomía, beneficencia y no maleficencia… El protocolo de donación cadavérica debería establecer como punto de corte, el momento en que se determina que el paciente tiene muerte encefálica. A partir de ese momento, todos los gastos derivados –por cualquier concepto- deben ser considerado parte del protocolo de donación de órganos» (p. 67).

El siguiente capítulo, «Donación cadavérica en reciprocidad» (pp. 69-102), se centra ya en la propuesta central de todo el trabajo. Examina así las implicaciones filosóficas, jurídicas, médicas y sociales de la retribución recíproca de la donación. Asimismo, la autora no desdeña los posibles riesgos de esta perspectiva, como pudiera ser el convertir la reciprocidad en una «forma soterrada de compra-venta de órganos» (p. 92), la reciprocidad altruista que se convierta en egoísmo al atender la familia donante sólo sus intereses. La posible corrupción del mecanismo para así obtener beneficios sociales es otro peligro. El capítulo cierra con las conclusiones generales del estudio presentado.

Entre las conclusiones resalto la siguiente que va a ser un *leitmotiv* de todo el libro: «la propuesta de una donación cadavérica que no se base únicamente en el altruismo, surge de la necesidad que vemos de reestructurar los aspectos que ya están presentando problemas en el modelo de donación cadavérica altruista. En particular el aspecto económico, porque consideramos que el hecho de que la familia donante llega incluso a absorber parte de los gastos derivados del protocolo de donación, se debe a la tergiversación que el concepto de altruismo ha sufrido; es decir, altruismo se iguala a gratuidad… La familia donante puede ser altruista, pero eso no significa que esté dispuesta a absorber gastos» (p. 99).

En suma, la autora demuestra bien la complejidad en los protocolos de donación y las implicaciones en los donantes que, a veces, pasan desapercibidos. La investigación presentada es equilibrada y aunque algunos temas, como el de la justicia distributiva, por ejemplo, podrían ampliarse, logra muy bien lo que se propone.

El libro es un buen ejemplo de que hacer bioética no implica necesariamente sofisticadas elucubraciones conceptuales. Tiene el enorme mérito de hablar con claridad, argumentar con precisión equilibrar lo conceptual con los datos empíricos.

Review

Reseña

José Enrique Gómez Álvarez*

Netzahualcoyotl, Cruz. *Bioethics and Altruistic donation of organs. Successes and Problems.* Editorial Fontamara. Observatorio Mexicano de Bioética, México, 2014. 109 pp.

The book, as the title itself aims at, addresses the limits of the altruistic model in the donation of organs. In other words that «… altruism as the sole regulating element of the donation programs, is a problematic issue» and «… that the altruistic donation model in terms of equality is a disadvantage for the donor family» (p.17).

For the achievement of theses purposes, the author divides the topic in four chapters. The first one is the delimitation of the problem (pp. 17-24). In it, it is presented the problematic character of the transplants in the model of total gratuity, without any kind of retribution by the other actors involved, that is, the receptor person and the health institution. In the chapter, it is established that, between the two extremes of commercializing the organs, and total altruism, fits an intermediate position which is to receive certain social and ethic retribution, due to the donation.

In Chapter II. «Altruism as a regulating element of the organ donation» (pp.25-43) it is studied, on one part, the meaning and

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implications of the concept of «altruism», and on the other hand the empiric results are shown that a study of cases where the complex consequences in the family when living people make donations, is shown. The empiric study shows very well the psychological consequences, and the social ones, of being a donor. Particularly it is highlighted the sensation of reification that the involved subjects perceive by passing through all the protocol which is centered in the clinical aspects. The author does not stay only in the diagnostics, but proposes improvements in that donation process, where the donors must be attended and taken care with their own name, through the whole process, to receive psychological advice, and absorb the expenses of the whole donation process, among others. In summary: «To take care of the emotional affliction, and ease as much as possible the economical impact of the donors, makes that all the society should fight to avoid the consequential negative impact in the culture of donation, that scarcely we have achieved to develop» (p.43)

In the next chapter «Qualitative Studies» (pp. 45-68), the consequences in the donor families from the process of donation are studied, but now in corpse's donations. Six donor families were given a follow-up, in a way that the implications of the donation could be assessed. The study shows that there are psychological, economic and social implications in the involved people. Implications are given in the mourning process, due to the difficulty to accept brain death, and at the same time see signs as the breathing or the cardiac beat. Then, there exist problems with the mourning process and the donor acceptance.

Similarly, the chapter presents another study to the open population, about the possibility to be donors. It is shown that the fact of discovering that there exist economic costs in the donation process itself, diminishes significantly the possibility of donor acceptance, and has clear ethical implications, by not having available a complete information of the donation process, for what it is:»… a transgression to the principle of autonomy, of beneficiency and

no-maleficiency… The protocol for corpse donation should establish as a cut-off point, the moment it is determined and declared that the patient has brain death. Beginning at that moment, all the expenses incurred for any concept whatsoever, must be considered as a part of the protocol of organ donation» (p.67).

The following chapter «Corpse donation in reciprocity» (pp.69-102), focuses now in the central proposal of the entire job. Reviews this way the philosophical, legal, medical and social implications of the reciprocal retribution of the donation. Similarly, the author does not spurn the possible risks of this perspective, as it could be to convert the reciprocity into a «buried form of purchase- sale of organs» (p.62), meaning that the altruistic reciprocity, would be converted in selfishness, by the donor family, in attending and taking care only, of their own interests. The possible corruption of the process or mechanism, in order to obtain in this way, social benefits, is another danger. The chapter ends with the general conclusions of the presented study.

Among the conclusions, I want to highlight the next one, which is going to become the *leitmotiv* of the whole book: «The proposal of a corpse donation that will not only be based on altruism, emerges from the necessity we see of restructuring all the aspects that are already presenting problems, in the altruistic corpse donation model. Specially the economic aspect, because we consider that the fact that the donor family, also has to absorb and cover part of the expenses derived from the donation protocol, and it is due to the misrepresentation and distortion which the concept of altruism has suffered, that is to say, altruism is equated with gratuity… The donor family can be altruistic, but that does not mean for them to be ready to cover expenses». (p.99).

In summary, the author shows well the complexity in the donation protocols, and the implications affecting the donors, which sometimes, go unnoticed. The research presented is balanced, and even though some topics, such as the distributive justice, for example, could be enhanced, she achieves what she wanted to aim at.

The book is a good example of doing Bioethics, which not necessarily implies the use of sophisticated conceptual lucubrations. It has the great merit of speaking with clarity, discuss with precision, and balance the concepts with the empirical data.

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5. La oficina de integridad en Investigación define también como mala conducta investigadora, la **fabricación de datos**, de resul-

tados, y el reporte de los mismos. En caso de que eso suceda, el artículo será retractado.

6. También es fraude, la **falsificación**, y la **fabricación** de datos. La fabricación de datos se refiere a que por ejemplo en una encuesta se cambien los datos de sujetos, o se dupliquen las encuestas con otros nombres. La falsificación de datos se refiere a omitir resultados no deseables, a modificar datos que no convienen en los resultados etc…

7. Puede consultar las siguientes ligas para evitar incurrir en estas malas prácticas:

https://grants.nih.gov/grants/research_integrity/research_misconduct.htm
https://ori.hhs.gov/

Criteria for publication in the Journal “Medicine and Ethics”

1. *Medicina y Ética* (*Medicine and Ethics*) is a journal that specializes in the field of Bioethics, focusing on the **academic dissemination in the context of Bioethics, Medical Ethics and fields related to Ethics applied to health issues,** among professionals familiar with prevailing topics and discussions in this field. Consequently, **this journal does not accept** documents **for diffusion**, or material that might be considered as **propaganda** for institutions, companies, people or others. The journal is not confined to a particular Bioethical standpoint, as long as the articles comply rigorously with its particular methodology for the presentation of ideas. The journal only agrees to revise and possibly publish original articles and reviews, product of scientific research.

2. In compliance with the statement above, **the expressed opinions are the exclusive responsibility of the author**, and do not necessarily reflect the standpoint of the Faculty of Bioethics or the *Universidad Anáhuac* (*Anáhuac University*). In no instance will the **Editorial Board** assume that the Institution of origin or the one where the author works subscribes to the point of view stated by the latter in the corresponding article.

3. Any **material must be unpublished**, except for articles from the Italian journal *Medicina e Morale*, as mutually agreed. This Journal uses the anti-plagiarism software **Turnitin®**. All articles are reviewed using this software.

4. Two types of publications are considered: articles and reviews. **Articles** must have a minimum length of 15 pages and a maximum of 30. They should concern monographic topics. **Reviews** must have a minimum length of one page and a maximum of five. Reviews can be either critical or merely expository.

5. Articles should be clear and concise and submitted in either **Spanish** or **English**. The title must be written in English, followed by the title in Spanish in the same typography and size. They should be accompanied by a summary in Spanish and 5 to 6 keywords not included in the title. This should be followed by an abstract in English with the keywords below.

6. **Bibliographical references** should be numbered in the text, with a list at the end containing the bibliography referred to in the text. The DOI of the referred article must be indicated in the references. Footnotes may only contain the author's notes. References should be written in Vancouver format. A book written by a single author would thus appear as follows:

   Last name and first initial of the name. Title. Edition. Place of publication: Publisher; year.

   LUCAS, R. *Anthropology and bioethical problems.* 1st ed. Madrid: BAC; 2001.

A list of the guidelines for different types of documents can be found at:

http://biblioguias.uam.es/citar/estilo_vancouver

7. The text of the article should be written in **ARIAL 12** with 1.5 line spacing. The title should come first and below the name of the author with an asterisk (*) which will state in a footnote his/her job assignment (where he/she works), exclusively, and their e-mail. Next, the summary with keywords follows, at last the abstract with 5 or 6 keywords.

8. **Tables** and **Figures** should be clearly indicated in the text. The title should be in bold, including «Figure/Table» and the corresponding number; 1, 2, etc, and an indication of the source. If it is created solely by the author, it should say «Source: own elaboration».

9. After this, you must mention any conflict of interest with reference to financing, at a professional or personal level. Concerning financing, you must provide relevant data and the amount. If the article involved patients, it should include their informed consent and confidentiality. If the article concerns work with animals, it should indicate international guidelines for their treatment.

10. Original works must be sent electronically, **exclusively** to this address:

Dr. Martha Tarasco, Editorial Coordinator
Faculty of Bioethics
Universidad Anáhuac México
mtarasco@anahuac.mx

11. The articles will be **judged** by at least two academics with relevant competence on the subject, over a maximum three month

period. The names of reviewers and authors will remain anonymous during this process. The authors will receive the corresponding answer. In case of a **negative response**, authors could make the corrections they consider pertinent and re-submit, although *Medicina y Ética* will be in no way obligated to publish the material.

12. Accepted articles will be published in the media as *Universidad Anáhuac México* deems appropriate.

13. As it occurs with other journals, if the article does not comply with the format, it will be returned without comment.

Anáhuac México

DOCTORADO EN BIOÉTICA APLICADA

Muchos de los problemas que se están viviendo en las sociedades del mundo tienen que ver con la conducta ética del ser humano. Cada vez toma mayor relevancia el estudio y la formación en ética y valores, pero en particular, todo aquel acto humano que tiene consecuencias en la vida y la salud de las personas, campo de estudio de la Bioética.

Dirigido a:
Profesionales con maestría en disciplinas de Filosofía, Bioética, Derecho o Ciencias de la Salud o en otra área profesional y experiencia laboral vinculada a la Bioética con aprobación de las autoridades universitarias. En caso de no provenir de alguna de las áreas mencionadas el alumno requerirá tomar algunos cursos propedéuticos.

Competencias Laborales que se desarrollarán
1. Identifica los problemas que la Bioética enfrenta.
2. Integra los conocimientos en las diversas áreas relacionadas con la Bioética.
3. Propone soluciones a problemas bioéticos, mediante modelos y metodologías de decisión centrados en la persona.
4. Colabora en equipos de trabajo, de forma interdisciplinaria para sintetizar el conocimiento vertido por diferentes áreas del saber, para alcanzar consensos en el ámbito de la Bioética.
5. Diseña metodologías de investigación innovadoras.

Modalidad y horario:
Semipresencial, 5 fines de semana por semestre, viernes de 18:00 a 21:00 hrs. y sábado de 8:00 a 14:00 hrs. Las demás semanas del semestre son para investigación, estudio y preparación de actividades de aprendizaje vinculadas al proyecto de tesis.

Duración:
6 semestres.

PLAN DE ESTUDIOS

Primer Semestre:
- Seminario de Antropología y Ética para la Bioética
- Seminario de Metodología de Investigación Documental
- Electiva 1

Segundo Semestre:
- Seminario de Inicio y Final de la Vida
- Seminario de Marco Teórico
- Electiva 2

Tercer Semestre:
- Seminario en Bioética Clínica y Consultoría
- Seminario de Derecho y Bioética
- Seminario de Protocolo de Tesis

Cuarto Semestre:
- Seminario de Bioética Ambiental
- Seminario de Argumentación en Bioética
- Seminario de Métodos de Investigación Científica en temas de Bioética

Quinto Semestre:
- Seminario de Investigación Avanzada I

Sexto Semestre:
- Seminario de Investigación Avanzada II

ÁREAS ACADÉMICAS

Investigación · Bioética · Filosofía · Derecho

Inicio:

Agosto de 2019

Coordinación académica:
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Facultad de Bioética

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