

# ENGLISH ABSTRACTS ENGLISCHE ZUSAMMENFASSUNGEN

## ABSTRACTS

CONSTANCE E. PUTNAM (p. 165)

**What Kind of a Right is the ‘Right to Die’?:** Those who argue in favor of a putative right to die rarely look carefully at what kind of a right such a right might be. Yet deciding whether we have a particular right requires understanding what it means to have a right in the first place as well as what kinds of rights in fact exist. In this paper, I use philosopher Judith Jarvis Thomson’s discussion of the concept of a moral right and her analysis of rights as a basis for exploring a crucial question in doctor–patient relations when end-of-life care is at issue: If there is a right to die, what kind of a right is it? Thomson applies to the realm of *moral* rights the distinctions Wesley Newcomb Hohfeld made regarding *legal* rights. Briefly put, it turns out there are four different kinds of rights: *claims*, *privileges*, *powers*, and *immunities*. The task I have set myself is to see what emerges from using the Hohfeld–Thomson analysis of rights to evaluate common arguments put forward by those who support the idea of a ‘right to die’. I will consider three such arguments: the *Argument from Law*, the *Argument from Autonomy*, and the *Argument for Assistance*. Each of these arguments yields what Thomson calls a ‘cluster-right’. A right to die seems best supported by the Argument from Autonomy. Yet the Argument for Assistance is the one most people seem implicitly to rely on when they talk about having a right to die; I therefore focus my primary attention primarily on it. This argument remains unpromising, however, as a consequence of which it turns out that even if a right to die exists, it may be a fairly limited right after all. I conclude with a reminder that whether for a physician to give assistance in dying to a patient who invokes a right to die is the *right thing to do* can in any case not be deduced from a dying patient’s right to die.

**Keywords:** right to die, kinds of rights, kinds of arguments, assisted dying, euthanasia

ECKHARD FRICK (p. 181)

**Manipulated Body – Planned Soul? Psychoanalytical and Philosophical Considerations Regarding the Image of Man in Medicine, with a Special Focus on German Language Literature:** Psychosomatic anthropology carries within it the burden of the duality of two ontologies excluding one another (body–soul or mind–spirit duality). According to those arguing for a holistic approach to therapy, spiritual healing that ignores the body is to be avoided in the same way as corporeal medicine bypassing the soul. As opposed to such holistic statements, this work argues for replacing the traditional metaphysical aporia of medicine with the duality of two points of view, namely the living body (*Leib*) experienced from the first and second person perspective on the one hand and the physical body (*Körper*) described from the third person perspective on the other hand. This anthropological theory is based on philosophical anthropol-

ogy (Plessner), a phenomenological view of the body (Fuchs) and the sociology of the body (Villa). The traditional hysteria model, seized at the dawn of psychoanalysis in a novel way, serves as an example in medical history of the materialization of the living human body.

**Keywords:** duality of the living body and the physical body, embodiment, psychosomatic anthropology, hysteria

**ISTVÁN VINGENDER, JUDIT MÉSZÁROS & JÚLIA KIS (p. 195)**

**Migration Potential of Hungarian Healthcare Professionals: Dynamics of Attraction and Repulsion:** The reason why the migration of healthcare professionals has not been described and analyzed yet in Hungary can obviously be found in the authenticity and the lack of this of the Hungarian society. There are several theoretical approaches to the migration processes. Each and every one of them analyzes and defines migration from a different point of view. Our goal was to find out the nature of the migration willingness and activity of Hungarian healthcare specialists. We intended to concentrate primarily on the sociological, cultural-anthropological and social-psychological aspects of this complex phenomenon. This sub-cultural phenomenon can be derived from numerous factors: (a) the family background of Hungarian healthcare specialists, (b) their typical, modal system of values when choosing a profession, (c) the fact that they are typically women, (d) the lack of former experience and knowledge of inspirations in mobility. At the Semmelweis University Faculty of Health Sciences we have already carried out several research projects and their synthesis might lead to the description of the migration trends of healthcare specialists. Four years ago, when we did a study about migration to work abroad, the number of those who predicted leaving the country for sure was the same as today. But the number of those who rejected the whole idea was far higher than nowadays. At that time 20% of healthcare specialists considered a career like this impossible, while now their number is less than 5%. When taking into consideration the fact that the recruiting processes are far more intensive and organized than they used to be, we can expect that a larger number of people can be convinced than ever before. However, the migration intentions are not definite, homogenous or final. The interventions, aiming to keep healthcare specialists in Hungary, still have a chance.

**Keywords:** acculturation problems, healthcare professionals, human resource management, labour market, mental problems, migration, migration of women, motivation, social integration

**ROBERT J. BIEL (p. 221)**

**Charitable Activities in the Shadow of the Communist System in the People's Republic of Poland:** In addition to liturgy and preaching, charity is one of the most important tasks of the Church. This holds true for the Polish Catholic Church as well, where benevolence has a long-standing tradition. An Episcopal Committee dealing with the affairs of victims of war was established as early as 1915 in Krakow, while only 7 years later, in 1922, the Caritas Association was set up. Before the Second World War, the Church in Poland was considered a major charitable institution. World War II wrote a strange chapter in the history of charitable activities of the Church in Poland. On 23 June 1940, the occupying German forces abolished all structures of Caritas. In their stead in 1940 they established the 'RGO' (Central Welfare Council) and the

'PolKo' (Polish Welfare Committees) that could provide charitable assistance. Right after the end of the war, in June 1945, the Polish Bishops' Conference set up the national centre of Caritas, which immediately restarted its official activities. Not long after the change in power, communist attacks targeting the activities of Caritas started. The difficult times of communist persecution increasingly meant the obstruction of charitable Church activities, which were also manifested in various forms of charitable mental health care. As a result, by 1950, Caritas – along with its institutions – came under the forced control of the state. The national centre of Caritas had to be disbanded, and its assets were confiscated by the state authorities. Following the 1950 dissolution of the national headquarters of Caritas, the church organisation was replaced by the newly founded 'Caritas Association of Catholics' which answered to the communist government. In response, the Polish Bishops' Conference established the National Secretariat for Charity Matters. The declaration of the state of emergency in 1981 also prompted the Church to step up its charitable activities. The 1980s saw a considerable surge in institutional charity work in Poland, when the social role of the Church broadened significantly in the growing economic crisis. The Charity Commission was convened in January 1981, and not long after the overthrow of communism, on 10 October 1990, following a 40-year hiatus, a church-run Caritas was established again, which today needs to be ready to deal with contemporary challenges like unemployment, social insecurity and emigration.

**Keywords:** diaconate, Poland, communism, state socialism, dictatorship, history, retrospect, helping profession, mental health care, age of changes, emigration

#### CHRISTIAN EWHRUDJAKPOR (p. 247)

**Case Studies of Family Expressed Emotion for Persons Living with Schizophrenia in Delta State of Nigeria:** This study is aimed at assessing family expressed emotions as a predictor of health status of family members living with schizophrenia as well as identifying some characteristics for high or low emotions of family members towards a 'sick' member. There were thirty-one families with members suffering from schizophrenia as diagnosed by psychiatrists (using DSM-IV-TR) in government owned hospitals. They were judgmentally sampled with the assistance of social workers. The instrument for gathering data was a validated modified Camberwell Family Interview (CFI) schedule reflecting three major areas: Hostility, Critical comments, and Over-involvement of expressed emotions of family members. The procedure was using trained research assistants from the area to conduct these interactive sessions in their lingua franca. The data generated was subjected to qualitative analysis which shows that out of the 31 families studied, 25 or 80.65% had high expressed emotions while six families or 19.35% had low expressed emotions. However, only five 'sick' members had not experienced a relapse since the first treatment and discharge. Seven 'sick' members were vagrant of the 25 high expressed emotion families. The study revealed that expressed emotions significantly determine the number of relapses of the member living with schizophrenia; that the gender of a 'sick' member does in fact determine the level of expressed emotion from family members. The study also revealed that the poverty of families or shame for families from low and high socio-economic backgrounds respectively are motives for emotions expressed. A model of family therapy was proffered.

**Keywords:** Nigeria, Camberwell Family Interview, expressed emotions, family care, predictor, relapse, schizophrenia

**DIETMAR MIETH (p. 257)**

**Self-Determination and Responsibility in the Final Stage of Life:** The way we think about dying is mostly dependant on our experiences and concepts. In addition to this, passing away is frequently considered the most personal thing in the world. This nearly always reflects protest against some kind of a situation experienced first hand or related by others, which lacked quality of life and quality of death. Once self-determination made a stellar career in medicine, and rightly so, as opposed to foreign decisions made by doctors and nurses, some attempted luring it past this goal. Therefore, some feel safe while caring for sick people and those requiring treatment if they can prove they are acting on express agreement or rejection. With an increase of distrust, the need to take measures against it also increases. Many benefits accrue from self-determination. But as in traffic, this right of way requires one to be circumspect, and to consider others. It is one thing to be able to decide about ourselves, and an entirely different thing to set up rules regarding how everybody else should decide. It escapes the attention of many that passing legislation about the freedom of care, treatment and accompaniment to death is not only about an existential point of view, but also the shared responsibility of society. Those, who regard self-determination only as an unopposed choice, which all other concerned parties need to subject their responsibility to, ignore the fact that responsible self-determination always needs to take others into consideration. Responsibility is, at the same time, an obligation to ourselves. Those who see they are a burden to others and remain isolated will lose some of the meaning they give to life. Self-determination often becomes the focus of discussion when money becomes scarce, and people no longer feel they have time for those requiring care. What they are left with is often – improperly – called ‘self-determination’. Responsibility means seeing people in relationships that do not treat everything individually. This is precisely why we have a civic responsibility to ensure that people do not remain on their own and receive help in carrying their burden once their life becomes restricted. In this case we not only honour their self-determination to save ourselves some responsibility, but rather to give them respect.

**Keywords:** relationships, shared responsibility, declared agreement, quality of life/death, rules, assumption of obligations, dying