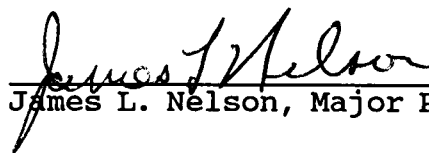


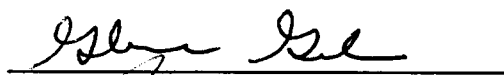
To the Graduate Council:

I am submitting herewith a dissertation written by Robert Matthew Stolick entitled, "Training Medical Students to Care Compassionately." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Philosophy.


James L. Nelson, Major Professor

We have read this dissertation
and recommend its acceptance:









Accepted for the Council:


Associate Vice Chancellor and
Dean of the Graduate School

Training Medical Students to
Care Compassionately

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Robert Matthew Stolick
August, 1998

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DEDICATION

To my two models of compassionate care:

Randi and Aunt Georgiann

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I thank my father for raising me to get into the batter's box, and for impressing upon me the import of preparing myself before doing so. I thank Danny, my brother, for participating in years of spirited discussions and for providing a challenge for my every position. I thank my Aunt Mary Jane for being a model of professionalism. I thank my Uncle John for his diplomacy and for demonstrating the value of living life in a cool and collected manner. I thank John Zavodny for being a friend and for candidly and compassionately considering my contingencies. For initiating me in the field of medical ethics, I thank Lisa Parker and Françoise Baylis. They each encouraged me to be conscientious in preparing for class and also took a personal interest in how I handled assigned material. I thank Glenn Graber for being an optimistic and enthusiastic part of my medical ethics education. I thank Bill Verplanck for being a mentor and a friend, as well as for instructing me on various political challenges of academia. Finally, I thank Jim Nelson for being one of the very few teachers who seemed to understand me. He gave me direction and channeled my positive energy to get work done, while always doing so respectfully.

ABSTRACT

Patients share their vulnerabilities with health care workers on the condition that they are not mistreated in doing so. The treatment deserved by vulnerable patients includes compassionate care. In this dissertation, I argue that a partialist ethic is morally appropriate for health care relationships. This moral appropriateness rests primarily on the nature of medical practice itself. Compassionate care, as an example of the type of emotional involvement called for in a partialist ethic as applied to health care relationships, is shown to promote several instrumental and intrinsic values in health care relationships. Building upon the moral appropriateness of compassionate care, I consider the medical school admissions process and training methods of the medical school curriculum. I argue that these processes inadequately consider the ability of applicants to care compassionately, and that training methods neither explicitly nor adequately train medical students to care compassionately. In responding to these inadequacies, I propose a two-level program for training medical students and post-graduate residents to care compassionately for patients. This program involves self-assessment exercises as well as various training methods which build upon such exercises. I conclude that introducing the humanities into medical education promises to effectively train medical students and residents to care compassionately.

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INTRODUCTION

The Compassionate Artists

Medicine, then, is an activity whose essence appears to lie in the clinical event, which requires that scientific and other knowledge be particularized: in the lived reality of a particular human, for the purpose of attaining health or curing illness, through the direct manipulation of the body, and in a value-laden decision matrix. It is in this sense that medical theory is a theory of practical reality, and not just the theory of the sciences which contribute to it.¹

The American Medical Association recently stated its "Core Purpose" as the following: "To promote the art and science of medicine and the betterment of public health."² The art of medicine is the application of medical knowledge to specific individuals. Goals of medical practice include the effective treatment and subsequent prevention of illness and disease. In other words, both treating and healing are a part of medical practice, properly understood. Such goals are successfully met by applying medical knowledge to both treat illness or disease and heal the individual who has the illness or disease. Medical knowledge is used to define and treat specific instances of illness or disease. However, the medical knowledge does not heal the patient. This is where the art of medicine is crucial. The medical art involves the

¹Edmund D. Pellegrino, Humanism and the Physician (Knoxville: University of Tennessee Press, 1979), 79.

²Adopted by the Board of trustees of the American Medical Association, June 19, 1997.

way in which this knowledge is used to heal the unique life of an ailing individual. Without understanding the unique person involved, it is not only unlikely that the patient will be healed, but also less likely that the illness or disease being considered, as a lived ailment, will be competently diagnosed and treated.

T.A. Long states:

So if the assumption is that the goal of clinical medicine should be patient well-being, then medicine must be practiced with an understanding of those beliefs, meanings and values which shape the patient's perspective on suffering and/or disease.³

The suffering patient, who is theoretically the reason for the existence of medical practice, must be cared for. This requires compassionate treatment, which starts with acknowledging the import of the life and values of the patient. Physicians who make diagnoses and provide treatments without explicitly and sincerely acknowledging the values of the person involved neglect the art of practicing medicine. As such, the patient, likely feeling ignored and in the way, may find himself in an unfortunate predicament: to either follow the advice of someone who does not seem to care about his values, suffering, or the implications of his illness, or to choose not to comply with the treatment suggested by a powerful medical authority.

³T.A. Long, "Narrative Unity and Clinical Judgment," Theoretical Medicine 7 (1992): 77.

Martha Nussbaum nicely captures the challenge of medicine:

But the challenge of medicine is always to make connection with people's deepest desires and needs and their sense of what has importance. It must deliver to them a life that they will in the end accept as an improvement, or it cannot claim success.⁴

The challenge for health care workers is to gain access to the life in which the illness is happening. In this way, the illness is seen as the patient sees it.⁵ The patient knows the illness by living with it. He describes it not in terms of underlying physiology, but rather in terms of its meaning in light of his life work and goals, effects on his life routine, and reactions from intimate others regarding it.

The point of this dissertation is two-fold: to illuminate the nature of compassionate care and to present an argument which demonstrates that health care workers should compassionately care for patients, and also to present several different training methods which promise to develop medical

⁴Martha Nussbaum, The Therapy of Desire (Princeton: Princeton University Press, 1994), 21.
In defense of Nussbaum, "improvement" could more specifically be considered as "better than she would have been had she not entered the health care system when she made the decision to enter."

⁵This similarity of understanding is one which is exemplified by the similarity between those who are said to have experienced the "same thing." For example, people who have cancer can understand what it is like to live with cancer and how the other is experiencing cancer in her life. They do not have exactly the same experience, but they do have experience which is similar enough so that they can understand what the other is going through.

students' ability to care compassionately.

In Part 1 I argue that emotional involvement is morally required in close relationships. I then argue that health care relationships are close relationships by virtue of the vulnerability of the patients involved. After presenting several intrinsic and instrumental values of caring compassionately in such relationships, I conclude by providing a thematic description of the compassionate event.

In Chapter 1 I argue that in close relationships, emotional involvement is morally required. A common practice among ethical theorists is to represent alternative ethical reasons as constituting a dichotomy. This dichotomy is exemplified by the concepts of partiality/impartiality. I argue that each term of such a dichotomy may be appropriate depending on the specific type of relationship involved in a particular situation. In close relationships, the appropriate ethic is a partialist ethic. This ethic requires emotional involvement. I strengthen the argument for the appropriateness of the partialist ethic in close relationships by citing specific instrumental and intrinsic values which are promoted by acting in accordance with it.

In Chapter 2 I argue that because of the vulnerability of the patient and the choice made by the health care worker to enter into health care relationships, the appropriate ethic for health care situations is one of partiality. The partialist ethic argues that compassionate care on the part of

the health care worker is morally required. I conclude by arguing that practicing medicine compassionately is intrinsically and instrumentally valuable to those involved in the health care relationship.

The focus of Chapter 3 is compassionate behavior. I describe such behavior by means of a phenomenological study. The data of the study is derived from the participants' responses to the question: "Could you tell me of a time in which a health care worker had acted compassionately towards you?" I present a thematic description to represent a compassionate event. This study provides specific examples of compassionate health care practice to be used in the training methods of Part 2.

In Part 2 I argue that current medical school admissions criteria and clinical training programs lack an adequate focus on students' ability to act compassionately. In light of this lack, I present a two-stage training program: the first stage is based on self-assessment, and the second on teaching how to involve oneself emotionally in treating patients. The goal of this program is to enable the students to care compassionately for their patients.

Chapter 4 presents an overview of the medical admissions process and training methods of medical schools and post-graduate residency programs. The current admissions process does not adequately test applicants' ability to care

compassionately. I suggest ways of evaluating the moral character of applicants to medical school. Then I propose a two-part program of training medical students which is intended to enable them to treat patients compassionately. The program begins with self-assessment exercises and concludes with various training methods.

Chapter 5 presents the first part of the training program. It is intended to foster an understanding of the nature of emotions, which will lead to a detailed evaluation of actions considered by others (and especially patients) to be compassionate. Self-assessment exercises require that the student considers in detail their emotions. These exercises also have the student reflecting upon his own personality and clinical style. A consideration of the way in which the emotions involved symbolize the quality of the care provided is given. This most importantly includes how particular emotions are experienced by patients. The self-assessment course concludes with the prescription of specific emotions in the situations discussed. As in a medical ethics seminar, values involved in health care decision-making are considered. The student is challenged to appreciate the import of both the science and the art of medical practice.

Chapter 6 describes the second part of the training program. Here, residents are encouraged to invest themselves emotionally while learning about the consequences of illness and disease by observing the suffering of their patients. I

suggest ways of acquiring this deep understanding of the suffering of the patient. Curricula changes likely to produce compassionate medical practitioners are suggested.

This dissertation is aimed at motivating medical students, residents, medical school curriculum advisors, and health care practitioners of all specialties to further reflect upon the nature of the relationships in health care. The appropriateness of closeness and compassionate behavior in health care practice will become obvious. I will view this dissertation as a successful work when it enables clinicians to care compassionately for the lives of patients.

PART ONE

COMPASSIONATE CARE AS AN INTEGRAL PART OF CLOSE RELATIONSHIPS

Chapter 1

Morally Requiring Emotional Involvement in Close Relationships¹

. . . I am concerned to show the falsity of a certain popular view according to which our emotions are merely incidental events in our lives, in that they typically just 'happen to' us, and so cannot reflect well or poorly on us in any important sense. Contrary to this picture, I want to show that our emotions may actually be essential and ensuring features of our moral character, and that we therefore have a fundamental reason to seek to develop our emotional capacities in ways which enrich our lives.²

There exist strong moral reasons to involve ourselves emotionally in our relationships with others. Emotions are important to the ways in which we are described and how we describe others. They play a major part in characterizing who we are. Consider that in close relationships we expose many of our vulnerabilities. In doing so we trust these others, and assure them that we are trustworthy as well. An important part of showing that one is trustworthy in close relationships

¹This chapter originally used the term "intimate" instead of "close." I use the latter to emphasize that the distinction I am drawing is between those relationships which have one sharing important information about oneself to another and also expecting the other to do the same, and those which do not. The closeness is in the information which is shared. "Intimate" is commonly used to describe romantic, physical situations. As such, intimate relationships can be understood as a type of close relationship.

Consider also that when we are vulnerable, exposing personal information about ourselves, we are close to the other. The main point I will make in Part 1 is that the morally appropriate way for a health care worker to treat patients is with compassionate care.

²Justin Oakley, Morality and the Emotions (N.Y.: Routledge, 1992), 5.

is through involving oneself emotionally. Those in close relationships are expected to be concerned and interested. Those who do not invest themselves emotionally in close relationships are commonly regarded as morally inferior and not trustworthy. Without the emotional involvement of those with whom we are in close relationships, such relationships are experienced as especially risky and dangerous, as we are vulnerable and exposed to someone who does not show that we can trust them.

Those who choose not to involve themselves emotionally in close relationships avoid making themselves vulnerable and are typically seen as defensive and as protecting themselves. This behavior inhibits the existence of a close relationship, as what results is a relationship in which one individual is vulnerable and involved emotionally, and the other is not vulnerable and not involved emotionally. Although individuals may be seen as protecting themselves by distancing themselves emotionally from others, such individuals miss out on the many psychological benefits which close relationships seem to provide.

In what follows, I present an argument morally requiring emotional involvement in close relationships. This argument is primarily based upon the justified expectations of parties involved in such relationships. I also argue that emotional involvement is instrumentally and intrinsically valuable to those in relationships with others (especially in close

relationships).

Partialist vs. Impartialist Ethics

In describing the appropriate ethic for close relationships, it will be helpful to revive a discussion of partiality and impartiality.³ Although many contributors to the literature discussing this distinction have written it off as plagued by serious ambiguities, I show that for certain relationships (i.e., close relationships) this distinction exposes a salient difference between two different ethics.

A partialist ethic is appropriate for close relationships. This is by virtue of the expectations of those who choose to be in such a relationship, and especially the expectations of those who are vulnerable in such a relationship. Close relationships are characterized by a vulnerable party or parties.

Certain conceptions of virtue ethics can be taken as exemplifying the partialist position, specifically those which value properly developed traits of character which have us acting in a partial way (e.g., loyalty, friendship, a sense of community, and a compassionate disposition). A partialist encourages emotional involvement in moral decision-making, as such involvement seems to promote such traits.

³These words, although used in the early 90's, seem to have been subsumed by the more general terms of "care" and "justice," no doubt as a result of the Gilligan/Kohlberg debate.

The impartialist places primary value on principles of impartiality and egalitarianism. Such a view can be seen as represented by some versions of Kant's moral philosophy and specifically his categorical imperative. The impartialist sees emotional involvement as interfering with moral decision-making- that is, encouraging individuals to take moral actions motivated by something other than duty (or categorical principles).

The distinguishing characteristic between the partialist and impartialist is found in the reason given (or motivation cited) by each for (morally) acting as she does.⁴ The partialist actor acts as the virtuous actor would. This means considering the salencies of the situation and reasoning practically before choosing a certain way of behaving. Being objective and impartial is considered by partialists to be an extreme way of behaving, and one which is obviously not appropriate in many relationships (e.g., close relationships). Although practical reason plays an integral part of such decision-making, there is a clear place for being emotionally involved in the situation. The impartial actor acts in accordance with a categorical imperative or general principle, out of a duty which is binding on him as a rational being who is part of the community of rational beings (because this is how rational beings must act to show that they respect the

⁴see Justin Oakley, "A Critique of Kantian Arguments Against Emotions as Moral Motives," History of Philosophy Quarterly (Oct 1990): 441-459.

inherent value of rational beings). Here, an ultimate rationale for acting is being given. This rationale is something usually taken to apply to many (if not all) situations, as if found beyond all situations. If this ultimate reason is something found beyond the situation, then a premium is being put on understanding and reasoning. Such a premium commonly gives second-class status to emotional involvement in moral decision-making, something the partialist would never grant.

The partialist defends emotional involvement for its motivational, communicative, and epistemic value. These are the values which will be discussed in considering the instrumental value of emotional involvement.

Given these two basic characterizations of partialist and impartialist ethics, emotional involvement in moral decision-making is necessary for the partialists while not necessary for the impartialists. The partialists' moral actor must be involved emotionally in order to appreciate the salient features involved in the situation. Such features are unavailable to the impartial actor. For example, one must be emotionally involved to act compassionately. Without being so involved, one will neither feel as another is feeling nor be able to recognize that the other needs a certain type of help. Furthermore, impartial consideration is typically taken as a sign that the actor simply does not care. The impartialist, on the other hand, is troubled about the prospect of becoming

involved emotionally, as she believes that as a result she is apt to be led in a way inconsistent with the categorical imperative ("pulled by the emotions"). Although impartialists may attempt to incorporate emotional involvement into their conception of moral action, their defining allegiance is to the categorical imperative.

There have been and continue to be attempts to cite a middle view between partialists and impartialists, and between similar moral poles, such as virtue ethics and deontology, and care and justice.⁵ In one attempt at combining these positions, Marcia Baron distinguishes between two different levels of an impartialist position. Level 1 focuses on specific decisions in specific situations. Level 2 focuses on the general principles which should always be conformed to in making the specific decisions which are the focus of Level 1. Instead of merely characterizing the impartialist as one who

⁵Consider the following by Marcia Baron [from Kantian Ethics Almost Without Apology (Ithaca: Cornell University Press, 1995), ftnt 54, 226.]:

The differences between Aristotle and Kant are often exaggerated, and the fact that Aristotle, like Kant, thought that emotions should be carefully modulated and controlled is sometimes neglected. Recall, for example, that in discussing mildness, the man concerned with anger, Aristotle says that "being a mild person means being undisturbed, not led by feeling, but irritated at whatever reason prescribes and for the length of time it prescribes." Nichomachean Ethics 1125b 33-35, trans. Terence Irwin (Hackett, 1985), p. 105.

See also: Peter Allmark, (1995); Hilde L. Nelson, (1992); Nancy Sherman, (1997); Ellen L. Fox, (1993); Carse/Nelson (1996); Virginia Sharpe, (1992).

holds a Level 2 position, Baron presents an impartialist position which uses both levels. She states, "Impartiality at level 2 is consistent with partiality at level 1, as long as principles accepted at level 2 approve partiality at level 1."⁶

However, even though Baron elaborates upon various ways of defining the partialist and impartialist positions to show that they are indistinguishable, the reason given for acting in any particular situations still seems to distinguish the two different types of thinking. A partialist could question Baron's very division of the impartialist position into these two levels, arguing that our actions are all a part of "concrete situations." The partialist would thereby present a position which has only one level consisting of concrete situations.

Another attempt at bringing two such positions together is found in Nancy Sherman's recent, Making a Necessity of Virtue. Aristotle and Kant on Virtue.⁷ Citing Kant's The Doctrine of Virtue (Part II of The Metaphysic of Morals), a case is made for the usefulness of developing virtuous dispositions for acting consistently with the categorical imperative. Sherman attempts to show that developing certain

⁶Marcia Baron, "Impartiality and Friendship" Ethics 101 (July 1991): 843.

⁷see Nancy Sherman, Making a Necessity of Virtue. Aristotle and Kant on Virtue (U.S.: Cambridge Univ. Press, 1997). (hereafter MNV)

habits and character traits can be helpful to (and consistent with) doing one's duty in a Kantian way.

In her consideration of care and justice, Grace Clement criticizes attempts to assimilate the ethic of care into the ethic of justice, pointing out that:

The moral importance of care suggests that we should not understand care as optional or a supererogatory but as in some sense obligatory. Although it is true that one cannot be obliged to care in the same way that one is obligated to pay taxes, this has to do with the fact that caring requires not just that one act in a certain way but that one feel a certain way, and one cannot be forced to have certain feelings. The ethic of justice is not so much a moral minimum that is in some sense adequate as it is as much as we can successfully demand of people. But none of this diminishes the necessity of caregiving, nor the fact that we do hold people accountable for their feelings or lack thereof.⁸

And of failed attempts to reduce the ethic of care down into a principle such as benevolence, Robert Goodin states:

They have argued that what seems to be distinctive of the ethic of care can be translated into the language of the ethic of justice. However, this assimilation is accomplished only by distorting the ethic of care. For instance, it has been argued that care is included in the ethic of justice under the general heading of benevolence. However, benevolence is directed toward people in general, while care is directed toward persons in particular, so care is not properly understood as benevolence.⁹

Instead of attempting to resolve these disputes concerning the appropriateness of one or the other side of the

⁸Grace Clement, Care, Autonomy, and Justice (U.S.: Westview Press, 1996), 115-116.

⁹Robert E. Goodin, Protecting the Vulnerable (Chicago: The University of Chicago Press, 1985), 119.

dichotomy involved, I hold that each ethic is especially plausible for certain situations. In situations which do not intuitively fall under the guise of one or the other ethic, it will be assumed that each ethic can provide good reasons for acting in accordance with that ethic. In assuming the dichotomy of partiality and impartiality in what follows, I should not be taken to hold that there are no other types of ethics (in addition to those represented by the dichotomy), or any possible middle terms. Rather, my intent in using this dichotomy is to illustrate why criticisms against emotional involvement in moral decision-making only make sense in light of specific types of relationships. Once it is understood that criticisms of the partialist ethic made by the impartiality/justice side have power relative to the types of relationships considered (and vice/versa), I show that for close relationships these major criticisms are not strong, and actually cite reasons for emotional involvement.

The moral argument supporting emotional involvement proposed in what follows will focus on one specific type of relationship, a close relationship.

The Necessity of Acting in Accordance with Partialist Ethics in Close Relationships

Now, it is clear, I think, that impartiality is indeed a worthy moral ideal for a substantial section of the continuum on which our moral practices are arranged. The more impersonal the relationship is, the more impartial it ought to be. But, it seems to me, the corollary is also true. The more personal a relationship is the less role there is for impartiality. Indeed,

impartiality destroys intimate personal relationships.¹⁰
(emphasis mine)

Emotional involvement is morally required of those who interact with vulnerable others. By the nature of the harm possible to the vulnerable other, we owe them a certain amount of protection, as we would want the same were we similarly exposed. That is, there are moral responsibilities which result from choosing to relate with vulnerable individuals.

Arguments for the existence of moral responsibilities in relationships where vulnerabilities are exposed are made by Goodin in Protecting the Vulnerable. There, Goodin states that, "The central argument of this book is that we bear special responsibilities for protecting those who are particularly vulnerable to us."¹¹

Goodin cites the Oxford English Dictionary as defining something as vulnerable if it "may be wounded" or is "susceptible of injury." He then states that, "Conceptually, 'vulnerability' is essentially a matter of being under threat of harm; therefore, protecting the vulnerable is primarily a matter of forestalling threatened harms."¹² Of these threatened harms, he states that, ". . . the threatened harm must necessarily be to their 'welfare' or 'interests,' . . .",

¹⁰John Keekes, "Morality and Impartiality," American Philosophical Quarterly 18;4 (Oct 1981): 302.

¹¹Goodin, 109.

¹²Goodin, 110.

and that, ". . . interests must be understood to encompass more than narrowly material ones. . . the vulnerabilities in view clearly must extend to people's psychological as well as physical sensitivities."¹³

Vulnerabilities are ways in which one may be harmed, with harm being understood as including both psychological and physical destruction of one's interests and welfare. Vulnerabilities are defined both according to what the reasonable person would consider them to be in a situation, as well as in light of what unique individuals with their own interests and welfare would consider them to be in specific situations. Of course, the customary definition of a vulnerability will be based upon the reasonable person standard, although in some cases (e.g., medical patient) vulnerabilities will be rightly defined according to the unique individual involved.

As to the question of how we determine what we owe to the vulnerable other (in the form of moral action), Goodin provides a principle:

First Principle of Individual Responsibility: If A's interests are vulnerable to B's actions and choices, B has a special responsibility to protect A's interests; the strength of this responsibility depends strictly upon the degree to which B can affect A's interests.¹⁴

And also, he adds:

Vulnerability implies that there is some agent

¹³Goodin, 111.

¹⁴Goodin, 118.

(actual or metaphorical) capable of exercising some effective choice (actual or, as in the case of the dormant volcano, metaphorical) over whether to cause or to avert the threatened harm. . . . Similarly, references to vulnerability imply two other references. One is to what the persons or things are vulnerable. . . . The other is to whom the persons or things are vulnerable.¹⁵

Adopting a common sense view of our moral responsibilities to vulnerable others would have us hold that if we could avert a great danger to another with little personal effort, then we should help the other. The major considerations as to what we owe vulnerable others seem to include the harm involved and the effort required on our part to help. Furthermore, there are positive duties and negative duties to be considered. Goodin seems to be focusing here on what we need to avoid doing to others (negative duties), and not clearly indicating what we must actively do in adopting the others' concerns as our own (positive duties).

Given the lack of our choice to be in a relationship with the vulnerable other, we have primarily negative duties to him. The positive duties we owe at most include those interventions which demand little effort from us and would avert a great harm to the vulnerable other (e.g., throwing a life-preserver to a drowning swimmer).

This "first principle" offered by Goodin represents the duty which we owe to vulnerable others just by virtue of their being vulnerable. However, my focus is not on what duties we

¹⁵Goodin, 112.

owe to the vulnerable just by virtue of their being vulnerable. More relevant to the purposes of this dissertation, I consider the duties we owe to the vulnerable who we know to be vulnerable and with whom we choose to relate.

Relationships which are based upon positive duties to protect others with respect to their vulnerabilities are close relationships. To be more clear about what a close relationship is, consider Hugh LaFollette's rendering of the intimate encounter. He distinguishes between verbally and behaviorally intimate behavior.

An exchange is verbally intimate when one privately tells another something significant about herself or shares personal information she rarely shares with others. . . . An exchange is behaviorally intimate when one person acts with or allows herself to be seen by others in ways which reveal significant information about her. . . . Encounters are intimate inasmuch as one person reveals her personality or deeper-disposing traits to the other.¹⁶

Close relationships are distinguished from others (e.g., impartial relationships) by virtue of the emotional involvement reasonably expected in such a relationship. An individual exposes his vulnerabilities only on the (inherent) condition that the other does not exploit or mistreat them (negative duties), and also that the other express care and concern for that vulnerability (positive duties).

These latter, positive duties result from the choice of

¹⁶Hugh LaFollette, Personal Relationships. Love, Identity, and Morality (Cambridge: Blackwell, 1996), 108.

each individual to enter into a close relationship. The nature of close relationships is that the parties involved expose vulnerabilities. The expectation which goes along with involvement characteristic of close relationships is that the vulnerabilities will not be mistreated. As Friedman notes, "It seems indisputable that intimacy and close relationships require partiality, that is, require special attentiveness, responsiveness, and favoritism between or among those who are to be close."¹⁷

We recognize possibilities for close relationships, and choose to actualize some of these possibilities. Regardless of why we do so¹⁸, in so entering we commit ourselves morally to treat these others in certain ways. Close relationships involve partiality and demand attention to the uniqueness of the parties involved.

Consider an encounter between two people in which one is vulnerable and willing to share that vulnerability with another, while the other party responds in an impartial, emotionally detached way:

Dr. Check, an internist, is seeing Mike for the first time. Mike had scheduled this appointment with Dr. Check a

¹⁷Marilyn Friedman, "The Practice of Partiality," Ethics 101 (July 1991): 818.

¹⁸Participating in close relationships allows us to effectively receive emotional support with personal matters, matters which have us expose vulnerabilities to others in order to get that other's consideration of that vulnerability. Close relationships also allow us to enjoy a feeling of purpose and meaning in our lives.

couple of days ago, after briefly describing to him the sharp pain in his side from which he had been suffering for months. Dr. Check encouraged Mike to come in to his office so that he could have a better look.

As Dr. Check meets Mike in a room in the building in which Dr. Check works, Dr. Check closes the door, introduces himself and shakes Mike's hand. They sit facing each other and Dr. Check asks, "So, what seems to be the problem?"

It is important to understand that the partialist ethic is appropriate here just by virtue of Mike's vulnerability. Again, using a reasonable person standard to determine whether vulnerability exists, we could clearly argue that Mike is risking harm to his interests and well-being by revealing his medical problem to Dr. Check. His exposure could lead to his being harmed in all sorts of ways, depending upon how this information is treated (e.g., losing his job, altering the behavior of others close to him, feeling psychologically worse). When such vulnerabilities are exposed, the expectation is that they will be treated in appropriate ways. This is where the close relationship is born. With mere exposure to a stranger, however, we would primarily be considering negative duties. If Dr. Check had not chosen to be in this relationship, and Mike were to come up to him on a street corner and tell him about his pains, it is not clear that a close relationship would be born. Again, this would be the existence of vulnerability without any choice to relate to that vulnerability on the part of another, and would be

rightly considered using Goodin's "first principle."¹⁹ In this case, as Dr. Check has chosen to be in a relationship with a vulnerable other, he morally owes it to this other to emotionally invest himself in the relationship, using a partialist ethic.

The impartialist may counter this argument for the appropriateness of a partialist ethic in close relationships by arguing that impartiality is morally justified in such relationships. This impartialist can be imagined as arguing either that such treatment is in the best interests of his vulnerable patients as a whole (i.e., rule utilitarianism), or that such treatment is deserved by other rational beings, as it is the only way to treat them as an ends-in-themselves.²⁰

¹⁹Although Goodin himself would likely defend a moral requirement for caring for the ailing stranger.

²⁰Again, this is not to discount other versions of these two positions, ones which are proposed so that they can account for salencies and particulars of situations. See Alasdair MacIntyre, After Virtue, (Notre Dame, Ind.: Notre Dame University Press, 1981); and also Bernard Williams, Ethics and the Limits of Philosophy, (Cambridge, Mass.: Harvard University Press, 1985). J.B. Schneewind makes the following related point (see "Autonomy, obligation, and virtue: An overview of Kant's moral philosophy," in The Cambridge Companion to Kant. ed. Paul Guyer (Cambridge: Cambridge University Press, 1992), 309-341):

The categorical imperative clearly requires a kind of impartiality in our behavior. We are not permitted to make exceptions for ourselves, or to do what we would not rationally permit others to do. But it would be a mistake to suppose that Kantian morality allows for nothing but impartiality in personal relations. The maxim "If it is my child's birthday, give her a party, to show I love her" is thinkable and willable as a law of nature, as are some maxims of helping family members and friends rather than helping others. Of course our

The first argument, applied to Dr. Check and Mike, would be that by not emotionally involving himself in his interaction with Mike, Dr. Check could see more patients and do more overall good. If he used a partialist ethic and invested himself emotionally, then Dr. Check would likely take more time and effort with Mike (than he would in using an impartialist ethic). This time and effort is being considered as taken away from other patients. The second argument is one which considers emotional disengagement as a form of respect for Mike as a rational being, with emotional involvement considered as "presumptuous" and "clouding the judgment" of Dr. Check.

Although these arguments are strong in light of relationships with no exposed vulnerabilities, it is weak as applied to close relationships. The rule utilitarian argument fails because no matter what the consequences Dr. Check presumes to promote through his emotional detachment, the vulnerable patient who feels mistreated through impersonal treatment claims to be wronged. In other words, a lot of low quality treatment likely does not add up to much good overall, and is likely outweighed by a little bit of quality treatment.

The Kantian argument fails because the vulnerable individual expects that others similarly situated deserve to

actions for those we prefer must be within rationally allowable limits, but within those limits Kantian ethics has nothing to say against the working of human affection.

be treated according to a partialist ethic, not an impartialist one. Furthermore, the vulnerable individual can not be appreciated and understood without the emotional involvement of the other (epistemic value of emotional involvement).

Again, what is important to specify is what type of relationship is being considered. The impartialist ethic may view helping a vulnerable other as supererogatory and therefore not morally required. However, this view is intuitively wrong when the relationship being considered is one in which one (or both) of the parties involved has chosen to expose a vulnerability and there is an implicit trust between the two. And even though it may be argued that some versions of these absolute, impartialist ethics could be constructed to allow for emotional interactions and attention to specifics of situations, as long as the motive of such an action is "because it is my duty" instead of "because you are my friend," the former is omitting a crucial part of the moral experience.²¹

One final point is worth emphasizing about the choice to be in a close relationship. The vulnerable party has certain responsibilities to the other in a close relationship as well. Thus far I have primarily focused on the responsibilities

²¹Similar to Bernard Williams' case of the drowning wife and stranger, and the utilitarian who has one thought too many in his utilitarian consideration, instead of just saving his wife.

which are held by one who chooses to be in a relationship with a vulnerable other. However, once I choose to be in a relationship with a vulnerable other, I have agreed to expose myself to the vulnerability of the other, and will therefore likely be vulnerable myself. The vulnerable other must be willing to share information with me once I have so decided, allowing me a chance to understand that vulnerability so that I can better appreciate what that vulnerability entails.

Where the responsibility for discovering these peculiarities lies is another matter. I am generally inclined to say that the burden should fall upon the actor/chooser to discover who might be vulnerable to his actions and choices. But I am also inclined to say that he has discharged his responsibility if, knowing nothing more about them than that they're vulnerable to his actions and choices, he plans protections for them on the assumption they have perfectly ordinary sensitivities. The onus is on the vulnerable party to communicate any peculiar facts about himself.²²

Here Goodin points out that just because one is vulnerable does not mean that he can just passively exist in a close relationship. Instead, the vulnerable party must be trustworthy as well, specifically in informing the other who enters into a close relationship with him about any "peculiar vulnerabilities." This seems to include specific characteristics which would be missed even if he were open to the vulnerability of the other. With Dr. Check and Mike, Mike must be open and honest about his condition in order for Dr. Check to be properly respected.

²²Goodin, 123.

Impartialist Criticisms of a Morality Which Includes Emotional Involvement

Lawrence Blum nicely characterizes (and elsewhere himself criticizes) the view of emotional behavior as non-rational and unreliable:

Emotions and feelings are transitory, changeable, and capricious. They are weak, subject to variations in our mood and inclinations. They are controlled by and responsive to considerations other than moral or rational ones. Emotionally motivated conduct thus is likely to be unreliable, inconsistent, unprincipled, or even irrational.²³

The major criticism against emotional involvement in moral action is that such involvement seriously hampers our ability to act rationally, and may therefore have us act in a way that unjustly or unequally considers the interests of others.

Insofar as this criticism falsely assumes that emotional involvement is mutually exclusive with rationality, it is rejected. This is because such a way of defining emotional behavior excludes the evaluative and cognitive behaviors which are an integral part of such behaviors (e.g., the compassionate actor understands my suffering).

Consider these major criticisms against emotional involvement in moral action. Again, the main response used for each will be that the strength of these criticisms has everything to do with the type of relationship being

²³Lawrence Blum, Friendship, Altruism and Morality, (Boston: Routledge & Kegan Paul, 1980), 2.

considered.

1) Partiality

. . . the discriminative, partial nature of emotions has been perceived to be incompatible with the more egalitarian and impartial nature of moral principles.²⁴

The major assumption of this criticism is that moral relationships should be solely guided by general principles which have us consider impartially the interests of those involved. However, when considering the morally required actions in close relationships, we intuitively expect them to act partially towards us. Such interest seems incompatible with the general moral principles of impartiality. In other words, such partial action can be seen as my treating another as a means to my ends of personal satisfaction and as a feeling of closeness with this other.²⁵

Emotionally involving ourselves with others allows us to appreciate specific salient features of the situations that we could not appreciate without being involved emotionally. Such involvement allows us access to information about the situation which would likely not be available to the impartial observer. This information includes the current state of

²⁴Aaron Ben-Ze'ev, "Emotions and Morality," The Journal of Value Inquiry 31 (1997):197.

²⁵Again, contemporary impartialist accounts attempt to deal with this by making the modus operandi of the virtuous actor (specifically, his partiality) consistent with following general principles based in impartiality. However, it is not clear that any middle ground has been established.

those involved in the situation, as well as other information which those involved may only reveal to those who show that they are interested and trustworthy.

Emotions are partial in two basic senses: they are focused on a narrow area, as on one or very few objects; they, as well, express personal and interested perspectives. Emotions involve evaluations made by an interested agent from a specific and partial perspective. Emotions direct and color our attention: they limit what can attract and hold our attention; they make us preoccupied with some things and oblivious to others. . . they are not detached theoretical states; they address a practical concern, often personal, associated with readiness to act.²⁶

In addition to the instrumental value of allowing us to see the salient features involved in a situation, emotional involvement is also intrinsically valuable. (Vulnerable) Others are generally appreciative of those who are involved emotionally with them because it shows that they care. In close relationships, it is generally considered to be morally admirable to show (and to provide others such opportunity to show) genuine care.

2) Contingency

It has also commonly been argued that because of the accidental nature of emotional investment, we must be careful about so investing ourselves. Such contingent investments will guide us to act "against our better judgment." Because they are irrational, emotions are not impartial and

²⁶Ben-Ze'ev, 196.

egalitarian. As impartial and non-egalitarian, they are not moral and therefore should not be followed.

In response, first remember that emotional behaviors are not irrational behaviors. Even though there is contingency involved in what we emotionally invest ourselves, this does not mean that we are led to hold irrational beliefs and views. Rather, this contingency may mean that we have invested ourselves in certain goals and projects rather than other goals and projects. Again, emotional involvement does not exclude rational consideration, as emotional behaviors can be understood as including a cognitive consideration of the situation involved.

It is important to note that the virtuous actor should be considered as one who not only invests himself emotionally in situations, but also as one who knows the appropriate way in which to do so. Thus far, I have not qualified the moral requirement for emotional involvement in close relationships. This is because my main argument is in favor of such involvement in certain relationships, while the criticisms of such involvement seem to non-categorically criticize it (that is, criticize it as a part of any relationship). Although not discussed in detail in this dissertation, an inherent and clear next step for one convinced of the moral necessity of emotional involvement in at least certain relationships is to understand not merely when the partialist or impartialist ethic is appropriate, but also to understand the way and

degree to which one is to invest oneself emotionally (especially for all of the cases which are not clearly ones where either of these two ethics are appropriate).²⁷

Robert Solomon, in light of such contingency, does not argue that emotional involvement should be avoided, but argues that we must rationally examine our emotional investments and to learn how to choose them.

The task of reflection is to force our often clandestine choices of emotional strategies into the light, where they can be cross-examined and confronted with the evidence, compared to their alternatives, and ultimately, if they are acceptable to us, taken hold of as our own fully deliberative and gladly chosen commitments.²⁸

The contingency point, therefore, is one which should be taken seriously. It does not show that emotional involvement is to be avoided, but rather that certain types of emotional involvement, in certain situations, are to be re-considered and perhaps eliminated.

Secondly, and most important to this whole chapter, the assumption that we should hold an impartialist ethics in all

²⁷Very important to understanding the point of this dissertation is to understand that I am arguing that emotional involvement is morally required in at least close relationships. The further step, once this is granted, is arguing that certain ways of involving oneself emotionally are morally required. This step involves developing the appropriate disposition to be able to so act. I do not take this step in this dissertation. However, if the case for emotional involvement is made, this further step would be the next logical one to take.

²⁸Robert Solomon, The Passions (Notre Dame: University of Notre Dame Press, 1983), 420.

situations is not a defensible assumption. This is in light of the different sorts of relationships we participate in and the different moral expectations involved. Those who would morally require that we act in an impartial manner, even in close relationships, must provide a justification for that argument in light of the contrary expectations of parties to such relationships. It seems that we find ourselves in certain close relationships which we did not choose, such as most family relationships (e.g., our relationship to our parents). However, just because such a relationship is contingent does not mean that it is wrong to have such relationships, or that there is no justification for investing ourselves emotionally in these relationships.

3) Reliability

Some have also argued that emotional involvement makes our actions less reliable and less consistent. Oakley presents this reliability argument against emotional involvement in the following two ways.

First, Oakley states that reliability can be considered as related to summonability, or ". . . the extent to which we are capable of bringing it [moral consideration] before our mind."²⁹ Those who defend an impartialist ethic believe that we are able to act more consistently (and therefore more ethically) when motivated by duty than when we are motivated

²⁹Oakley, 94.

emotionally.

My response to such a claim again includes a criticism of the view of emotional behavior which is being used by such critics. These critics use an over-simplified rendering of an emotion (one which excludes the interpretation or cognitive element of emotions). Oakley makes the same point, calling the critic's view of emotional behavior an "unjustified generalization." He states that,

. . . this view of emotions as mere affects is an oversimplified picture of the nature of emotions, for emotions are complex phenomena involving cognitions and desires as well as a dimension of affectivity."³⁰

In light of the reliability of the behavior of those who emotionally interact with others, Oakley also says that,

Emotional capriciousness may not be a sign of the inadequacy of emotions themselves as moral motives, so much as an indication of a kind of moral failing in the particular person whose emotions are typically capricious.³¹

One seemingly unsupported assumption being made by the critics who raise this reliability problem is that the motive of duty is always available to the moral agent, or at least more so than motives of character or partiality are to the moral agent. This claim needs to be more clearly shown. Counter-arguments of those who are both involved emotionally and virtuously come to mind, such as the loyal and courageous

³⁰Oakley, 95.

³¹Ibid.

partner. Such a partner would hardly be considered unreliable, and would also be arguably more reliable than the impartial actor motivated by duty.

Oakley also asserts that reliability can be considered under the guise of efficacy. Here the critic argues that the motive of duty is always sufficient to outweigh the influence of inclinations away from the dutiful act. The argument here is that general principles are more efficient in having an individual act morally than is emotionally and partially involving oneself in moral decision-making.

In response, Oakley first cites cases in which contrary desires are strong enough to prevent the motive of duty issuing in action. Classic objections to any principle-based approaches to ethics are ones which show examples of duties in conflict. Second, Oakley argues that we can choose to ignore our duty. The defender of virtue ethics may argue that it is the character which is developed, not merely the understanding of one's duties or the general principles governing one's behavior, and that a strong character is the best predictor of efficacy in moral action. This becomes a strong argument for emotional involvement in moral action when one considers that the virtuous actor is one who is not merely acting reasonably, but is also engaging himself emotionally in situations to determine the appropriate actions to take. Oakley argues that, ". . . while motivation by emotion may sometimes suffer from vicissitudes in terms of reliability, this had better not

preclude emotions from being moral motives, since motivation by duty may itself be plagued by similar difficulties."³²

The basic response to the critic here is that emotional behaviors include a rational consideration of the situation. Emotional behaviors are rightly described as ways of interpreting situations. Considering them to be mere affects or feelings is to miss much of what is involved in an emotional experience.

Finally, consider that in virtue ethics, although commonly considered an alternative to a principle-based ethics which holds impartiality and egalitarianism to be the basis of moral decisions, practical reasoning plays a major part. Oakley states of practical reasoning that:

So, the rightness or wrongness of a particular emotional response is dependent on whether it is in fact aligned with an appropriate object, in the manner of a practically wise person.³³

And also,

. . . but phronesis is a capacity which integrates these perceptual, deliberative, affective, and practical faculties so that they operate well together.³⁴

Our moral judgments include our perceptions and affects in the situations we are considering. Furthermore, the actor involved emotionally is not necessarily acting unreasonably, as he may have developed the ability to invest himself

³²Oakley, 101.

³³Oakley, 81.

³⁴Ibid.

emotionally, an ability which includes the use of practical reason.

4) Vulnerability

The great personal involvement of an emotional relationship has not merely advantages, but risks as well. Those who are close to us can easily hurt us. . . . Telling our secrets to someone may establish a friendship relationship, but it also exposes our vulnerability. Some people actually avoid having friendships for this reason. . . .³⁵

Yet, this is precisely what our friends may value in our relationships with them—that we show willingness to be emotionally drawn, to be vulnerable to emotional losses and gains resulting from our close relationships with them.³⁶

Being involved emotionally with others leaves us vulnerable to them. They can hurt us by exploiting or mistreating our vulnerabilities. This criticism of emotional involvement in moral action seems more of a pragmatic one, one which would have us protect ourselves from such harm.

It does not seem to follow that just because we may be harmed by those with whom we are vulnerable, that we should not act in such a way. In addition to there being benefits in being vulnerable with others (forming bonds with these people and thereby developing valuable relationships with them), we may also be morally required to expose our vulnerabilities, just by the nature of the closeness of the relationship

³⁵Ben-Ze'ev, 202.

³⁶Ben-Ze'ev, 203.

involved.

Rita Manning specifically notes why intimate relationships are valuable to us:

Some of the commitments we have are to persons, and our relationships with some of these persons are intimate. . . such personal relations are, as Blustein argues, an indispensable element in a good human life. They help moral agents grow in self-knowledge and give meaning to their lives. Oakley agrees that "love and friendship are necessary to achieving a certain good kind of continuity, sense of purpose and knowledge in life."³⁷

The above criticisms of partiality, contingency, reliability, and vulnerability (especially when understood as being made by the impartialist against the partialist) are most effective as applied to business relationships or relationships with strangers.³⁸ However, these criticisms are weak when addressed to close relationships, where the ways of behaving being criticized are ironically expected and morally required.

The conclusion to be drawn is that emotional involvement is morally required (as a part of the partialist ethic) in close relationships. In addition to morally requiring emotional involvement, consider arguments citing instrumental and intrinsic values promoted by involving oneself emotionally in close relationships.

³⁷Rita C. Manning, "Toward a Thick Theory of Moral Agency," Social Theory and Practice 20;2 (Summer 1994): 209.

³⁸Although Goodin thinks his principle applies to strangers as well.

The Instrumental and Intrinsic Value of Emotional Involvement in Close Relationships

Reasons for fostering emotional involvement in moral relationships are presented by Aaron Ben-Ze'ev:

Indicating the importance of emotions in morality should show that the partial, discriminative perspective so typical of emotions is valuable in many moral circumstances. These circumstances can be divided into those in which the partial perspective has instrumental moral value as a means for achieving positive moral consequences, and those in which the partial perspective has intrinsic value as something valuable in itself.³⁹

I will use Ben-Ze'ev's general headings of intrinsic and instrumental value to similarly argue for the inclusion of emotional involvement in close relationships. It should be noted that arguments against emotional involvement in close relationships have been responded to above.

Instrumental Value of Emotional Involvement

"... they are a valuable means for leading a sensitive and moral life."⁴⁰

"Emotions enhance moral perception and provide a system of supportive motives which make adherence to the moral law easier."⁴¹

"To the extent that personal relationships are necessary for integrity and fulfillment in life, then, to that extent, partiality is instrumentally required as a means to achieving

³⁹Ben-Ze'ev, 203.

⁴⁰Ibid.

⁴¹Nancy Sherman, The Fabric of Character. Aristotle's Theory of Virtue (Oxford: Clarendon Press, 1989), 46. (hereafter FC)

those morally valuable ends."⁴²

The instrumental value of being involved emotionally with others can be divided into three functions: the epistemic role, the communicative role, and the motivating role. Each of these exemplifies how emotional involvement can promote the practical interests of those involved in a close relationship. It should become clearer after this section that emotional behaviors are ways that we use to show others what we want, how we are feeling, and what we want to know or avoid.

1) Epistemic Role

"Emotions express our sensitivity to what is going on around us."⁴³

Behaving in an emotional way opens us up to the morally salient features of situations in which we are involved. This ability to access the relevant moral features furthermore shows those with whom we interact that we are sensitive to the relevant features of the situation.

Salient features are discussed primarily by virtue ethicists. It is thought that by developing a morally virtuous character, one which has the individual engaged emotionally in various situations, that the actor will be better able to access the morally salient features of various situations and

⁴²Friedman, 820.

⁴³Ben-Ze'ev, 202.

thereby to act in a morally appropriate way. Without emotional investment in the situation, one limits the factors which can be appreciated in a situation.

Making a strong claim for the inclusion of emotional investment in moral action, Alisa Carse makes the following claim:

It appears, then, that we are not simply in need of an enriched normative vocabulary in terms of which to address those skills and capacities agents require in order effectively to apply general principles or rules of conduct to particular cases. We're also in need of an account of those skills and capacities agents need in order effectively to discern what morality demands, encourages, or recommends and, having done so, to conduct themselves in the proper manner, to express themselves effectively and appropriately.⁴⁴

This is a crucial point to be made in response to what is arguably the major criticism of virtue ethics and in general all ethical approaches which include emotional involvement. Such critics say that emotion-based ethics exclude or give a second-class status to a dispassionate, rational consideration of the factors which go into any decision. Given this point, they move to conclude that these emotionally-based actions are unreliable and biased, having the actor unreasonably acting, being led by his passions.

My response (consistent with Sherman) is primarily that such criticisms mistakenly assume that emotional behaviors are

⁴⁴Alisa L. Carse, "Facing Up to Moral Perils: The Virtues of Care in Bioethics," in Caregiving. Readings in Knowledge, Practice, Ethics, and Politics, ed. Suzanne Gordon, Patricia Benner, & Nel Noddings (Philadelphia: University of Pennsylvania Press, 1996), 93.

non-rational. Emotional behavior, again, presupposes a rational evaluation of the circumstances in which the emotional actor finds himself. Sherman, in speaking of what she calls "affective remembering," explicitly cites the power of emotional behaviors to reveal how situations are evaluated:

Once again, the epistemic advantage of emotion as medium seems to be its peculiar ability to make vividly present the objects of its evaluative focus. The evaluations are disclosed in a way that puts our nose right into the matter, in a focused and riveted way.⁴⁵

Further re-iterating this epistemic benefit of being involved emotionally while interacting with others, consider the following by Oakley:

. . . it seems that the unemotional person will, as such, have a narrow perception of various features of the world and will lack certain kinds of morally significant knowledge regarding others and the world in general. Several points can be made in support of this claim. First, as Blum and Wallace argue, a sympathetic, compassionate, or kind person is not only apt to perform beneficent acts, but also characteristically perceives more situations as warranting beneficent action when this is in fact the case, than would a person lacking in sympathy, compassion, or kindness. But further, when encountering someone in distress, having such emotions as sympathy and compassion for her often seems necessary in order to understand exactly what her distress involves and what her needs in that situation are.⁴⁶

The two major points here are that the person who is involved emotionally "characteristically perceives" situations as warranting morally valued actions, and also that when the

⁴⁵Nancy Sherman Making a Necessity of Virtue (Oxford: Clarendon Press), 48. (hereafter MNV)

⁴⁶Oakley, 50-51; See also Sherman, FC, 38.

emotionally involved individual is in a morally challenging situation, she is able to better understand the salencies of the situation.

As opposed to the ethic which puts a premium on impartiality and egalitarianism (e.g., some accounts of Kantian deontology), consider the following point made by Oakley: ". . . the unsympathetic or indifferent person. . . to the extent that they perceive the distress of others at all, will often be incapable of understanding the nature of that distress."⁴⁷ That is, the impartialist ethic (or any ethic which deters emotional involvement) does not allow the individual the same understanding of the situation. One following a general principle such as, "Help people in distress," while staying impartial and uninvolved emotionally, will not have the same understanding of the distress in a situation as the individual who is involved emotionally.

. . . the assistance offered by this person may be inappropriate because he has no emotional understanding of the nature of another's distress, nor of what needs to be done in order to help them.⁴⁸

Although investing oneself emotionally in the distress of another makes one vulnerable to that distress, without so experiencing the distress one cannot claim to understand it in the way that one may have to in order to alleviate it in a competent way.

⁴⁷Oakley, 51.

⁴⁸Oakley, 53.

Oakley makes this same point of the epistemic access which the individual who is invested emotionally has over the unemotional actor, stating that:

For the person motivated by certain emotions may sometimes be more likely to have true beliefs about the situation in which he acts than the person motivated by duty, and so the former may thereby have a better idea of when he is called upon to act dutifully and of what such action involves.⁴⁹

By being invested emotionally, the actor is given a more acute vision for the salient features of the situation at hand. Sherman speaks of this as the "evaluative focus" of the actor resulting from emotional investment:

Indeed, Aristotle is insistent that closely related emotions, such as contempt, spite, and insolence, are differentiated not by their "feels" but by their distinct evaluative focuses.⁵⁰

This epistemic value of emotional involvement is seen in the richness of interpretation made by those who are invested emotionally in a situation.

2) Motivating Role

Emotional behaviors also indicate that the actor is motivated to behave in certain ways. Without being involved emotionally, the motivations of the actor are not clear. In close relationships emotional behaviors help us to mobilize the resources needed for moral behavior, which is often not

⁴⁹Oakley, 103.

⁵⁰Sherman, MNV, 56.

the most convenient course of action.⁵¹ We can be seen as getting into the mood to act in the morally appropriate way, actively assuming the moral point of view instead of representing an immoral position. Oakley puts it as such:

. . . various emotions may be morally significant in so far as they play an integral part in the transformation of our values into action, or what we might call our having strength of will.⁵²

The mere impartial action in accordance to general rules or principles simply does not account for the motivation for so acting. Although impartialists may think that acting in such a way is morally appropriate, they will not allow their emotional behaviors to exist during such action. This is because they believe that emotional behaviors in general hinder moral behavior.

3) Communicative Role

Emotions have a communicative role of revealing our moral values to others and to ourselves. Since emotions express our profound values, emotional experiences can reveal these values. Taking care of another person with sympathy and compassion can reveal our evaluation of the person to ourselves and to the person himself. Sometimes we do not know how much we care for someone until emotions such as jealousy, fear, or compassion are

⁵¹It is not merely that the actor is involved emotionally, but also that the actor is emotionally involved in the right way. This "right way" or "appropriate way" is learned by the actor with experience (including example and precept). This experience teaches the actor both what sorts of emotional behaviors are appropriate for certain situations, and how strong the emotional response should be, given the salient features involved.

⁵²Oakley, 53.

generated.⁵³

Impersonal action is insufficient to show another what they mean to us, and specifically that we care about them. Such showing not only reassures them about how we feel, but also reassures ourselves about where we stand in relation to these others. As such, emotional involvement plays an integral part in our relationships with others.

In addition to their role in moral perception and discernment, the emotions play an important expressive role in moral response. As the example of respect illustrates, it is not just what we do, but also how we do what we do, that can make a moral difference in giving care. This is reflected in our gestures, the quality of our touch, our tone of voice, where and how we stand or move, how we listen- crucially, the emotions we do (or don't) express through our demeanor.⁵⁴

In short, we use emotional behaviors to display the way we think and feel, and what we want, and we use such behaviors of others to judge their wants. Emotions therefore play an invaluable role in interpersonal relationships where we love and care for others and need to understand what it is that they want so that we can help them live fulfilled lives.

Intrinsic Value of Emotional Involvement

"The nakedness of vulnerability is so frightening that we forget that intimacy-which is nothing less than willing vulnerability- is a great source of strength."⁵⁵

⁵³Ben-Ze'ev, 207.

⁵⁴Carse, 92.

⁵⁵Solomon, 390-391.

1) Affirmation of Self-Worth

We can discern a further connection between emotions and self-worth by looking at the emotions that others have towards us. In this regard, James Wallace argues that kindness and compassion from others tend to foster and support our self-esteem and sense of worth, because the benevolent concern for the other which is involved in such emotions is an affirmation that we matter.⁵⁶

For example, a sympathetic or compassionate person views the suffering of others with distress and is guided by a concern to help others, and his sense of self-worth may be grounded partly in what he sees as his capacity and ability to help others. So our emotions may be integral to our self-concept, and indeed, they may provide an important key to our identity, for many of our characterizations of particular people are often put in emotional terms.⁵⁷

Simply put, when we involve ourselves emotionally we experience ourselves as mattering. Such a feeling is valued for its own sake. By not investing oneself emotionally (and acting impersonally out of a sense of duty), one does not enjoy what one is doing and eventually will consider whether it is worth it to act in such a way or not, given that the value for so acting is not as apparent as it is for one who is emotionally involved.

2) Perceived as a Moral Exemplar

"For Aristotle, virtuous people have the kind of character that leads them to experience emotion in a proper way, as well as leading them to act in a proper way."⁵⁸

⁵⁶Oakley, 67.

⁵⁷Oakley, 64.

⁵⁸Ben-Ze'ev, 199.

Emotional involvement shows that one cares. When we are in a vulnerable situation, we need people who we can trust, reassuring us that we will not be hurt. Close relationships can be considered most basically as relationships in which we share things about ourselves that would not normally be shared. This is done voluntarily, and is seen as benefitting us in the instrumental and intrinsic ways as discussed in the previous section. Given that people do not usually find themselves in close relationships, but rather choose to invest themselves in close relationships, it is important to consider what moral responsibilities come along with so choosing.

I am not denying that we can have unemotional or 'cool' attachments to various things, but this is usually an indication that we regard such attachments as insignificant. . . We usually indicate the importance to us of the people we know or are acquainted with in terms of ever-expanding concentric circles of diminishing emotional concern and intimacy.⁵⁹

The vulnerable seem to have a need to expose their vulnerabilities, to let their guard down. This need to expose vulnerabilities is met by the existence of trust, characteristic of close relationships.

Once a person has shared his vulnerability with another, he expects that the other will treat that vulnerability with respect. Such respect includes an emotional acknowledgement of this vulnerability and a sincere appreciation of the importance of his vulnerability. Those who are able to involve

⁵⁹Oakley, 65.

themselves emotionally with vulnerable others are seen as "moral exemplars," and are praised by the vulnerable parties for protecting them in their time of need.

Conclusion

In other words, two people cannot have a relationship of love or friendship with each other, unless they each have certain emotions about the other, so a person without emotion could not have such relationships at all.⁶⁰

Those involved in close relationships expect that the others who voluntarily enter into such a relationship will be morally guided by more than merely deontological reasons, but also will be emotionally invested in the relationship, acting in accordance to the partialist ethic. Emotional investment allows one to appreciate and respect the vulnerability and particularities of the other and shows the other that one cares. Furthermore, emotionally investing oneself in close relationships also produces significant instrumental and intrinsic values to the parties involved.

⁶⁰Oakley, 57.

Chapter 2

Reasons to Practice Medicine in a Compassionate Way

. . . although a man possesses a knowledge of medicine, it does not follow that he practices; and this implies that there is something else apart from the knowledge which determines action in accordance with the knowledge.(433a)¹

In what follows, I will make the case for morally requiring health care workers to practice medicine in a compassionate way. This chapter should be understood as building upon the previous chapter. This moral requirement of health care workers follows from the closeness involved in health care relationships, specifically by virtue of the vulnerability of the patient and the choice of the health care worker to enter into such a relationship. I will further argue, as in the last chapter, that such emotional involvement promotes several significant instrumental and intrinsic values to the parties involved.

Partiality, Vulnerability, and the Art of Medicine

Given the reality of domination of patients by doctors, how can we construct an alternative practice? What would empowerment of patients mean and how does empathy contribute to the realization of its potential? Granted that patients themselves will be variously aware of and comfortable or uncomfortable with the traditional functioning of "power over" in the relationship, what

¹Aristotle. De Anima, Trans. R.D. Hicks, (Buffalo: Prometheus Books, 1991), 95. (433a)

does the practice of empowerment entail?²

Candib here cites the import of empowering patients. It is essential that health care workers and patients work together to both define the illness and generate treatment possibilities. Individuals live their illnesses, and their lives will significantly define the meaning of those illnesses. Without the health care worker's acknowledgement of what is valuable to the patient involved, she cannot expect to propose diagnoses and treatments which the patient will find meaningful. Instead, the health care worker will more likely present to the patient a picture of the illness which the patient may not be able to make sense of, given her unique story which she uses to define her illness. In such a case the patient will feel as if something has been done to her, but she will not understand what.

The moral requirement of health care workers to act compassionately rests on the following argument. First, in close relationships, emotional involvement is morally required. This is by virtue of choosing to enter such a relationship, and the vulnerability which must be respected by the medical practitioner. Second, the positive intrinsic and instrumental values far outweigh the negative aspects of being

²Lucy M. Candib, "Reconsidering Power in the Clinical Relationship" in The Empathic Practitioner. Empathy, Gender, and Medicine, ed. Ellen Singer More & Maureen A. Milligan (New Brunswick, N.J.: Rutgers University Press, 1994), 135-156.

emotionally involved in the care of one's patient. Third, a competent medical practitioner is an artist as well as a technician. As an artist, the medical practitioner must consider the values and goals of the patient. Without doing so, the practitioner is imposing assumed goals onto a particular patient, an imposition which is characteristic of a failure to act in an artistic way. As Lorraine Code warns,

Where there is a difference of power, knowledge, expertise, a claim to 'know just how you feel' can really expand into a claim that I will tell you how you feel, and I will be right, even though you might describe it differently, for your perceptions are ill-informed, and my greater expertise must override them.³

The health care worker, in applying his knowledge, can only use it to treat the illness or disease by going through the person who lives it. He can attempt to find it by poking and prodding. However, in this way, the person is being ignored and treated as a nuisance, literally getting in the way.

Benefits result from listening to and caring compassionately for a patient. For the health care worker, the rewards include a sense of making a difference in the life of another human being, the joy of living as an artist and finding his calling, and acting in a socially responsible way. The patient is offered a richer, more positive recovery

³Lorraine Code, "I Know Just How You Feel. Empathy and the Problem of Epistemic Authority," in The Empathic Practitioner. Empathy, Gender, and Medicine, ed. Ellen Singer More & Maureen A. Milligan (New Jersey: Rutgers University Press, 1994), 84.

process, a better sense of his own illness or disease and of his very self, and a feeling of power in a vulnerable situation.

In addition to being less instrumentally valuable to the discovery of the illness or disease, not attempting to acknowledge the patient's unique way of suffering is to do him a disservice. As an owner of the illness or disease being treated, the patient is entitled to have it treated as he sees fit.⁴ This entitlement at least minimally requires others to respect the patient's right to dictate how his illness or disease should be treated. Respect for this entitlement requires that one care compassionately for the patient-owner. Other types of treatment will likely sustain the power difference in the relationship, and therefore not foster respect for the vulnerability of the patient involved.

Compassion is not a simple feeling-state but a complex emotional attitude toward another, characteristically involving imaginative dwelling on the condition of the other person, an active regard for his good, a view of him as a fellow human being, and emotional responses of a certain degree of intensity.⁵

The physician's artistic ability includes a sensitivity to the particular characteristics of a situation. This sensitivity is developed through experiencing various

⁴Of course, his society will protect him if he poses a threat of harm to himself, and may restrain him if he poses a threat of harm to others.

⁵Lawrence Blum, Moral Perception and Particularity (Cambridge: Cambridge University Press, 1994), 175. (hereafter MPP)

situations which have him making numerous decisions in the lives of real people. The physician who develops his artistic ability comes to recognize that his diagnosis of an illness is being made not only by a medical doctor, but also by a person. In recognizing this, he may also come to recognize the power differential which exists in the health care relationship.

The health care worker, unlike the patient, is generally comfortable in the environment, has medical knowledge, and an ability to diagnose and treat. The patient is exposed and vulnerable, seeking the help of another in a confusing and highly specialized and technical arena. In a relationship with such a power inequality, only a shared concern can bring them together. Otherwise, they will be separate and will assume an impersonal relationship.

Close relationships play a different part in our lives from our impersonal business relationships. This difference can be understood through the distinctive moral expectations involved in each relationship. In the business relationship, the main values include impartiality and egalitarianism. However, in close relationships, the main values include partiality and genuine concern. Also, in the business relationship, emotional actions are seen as detrimental, "clouding one's judgment." However, in close relationships, emotional involvement with others and what is important to them is expected and morally required.

The question becomes: what type of relationship is found

in health care, impersonal relationships or close relationships? Granting this dichotomy, it is not immediately clear, given the proliferation of managed care and increasing specialization, that the health care relationship is not a business relationship. However, the reason that the health care relationship cannot correctly be considered a business relationship is because of the vulnerability experienced by the patient.

Daniel Sulmasy cites the vulnerability of the patient as one of four important reasons why the physician-patient relationship is not correctly considered a business transaction:

It is nearly a truism to state that the patient is an exceptionally vulnerable person in the hands of the physician. The patient entrusts his body, his dignity, his secrets, and frequently his life to the physician. The physical effects of being ill compound this vulnerability, affecting to variable degrees the patient's decision-making, communicative, and motor capacities in ways that always limit, even if minimally, the autonomous agency of the individual who is sick. . . . Because of their diminished autonomy and objectivity, lack of skills, and the physical incapacities brought on by illness, the sick have little choice but to ask the professional for assistance.⁶

Given this vulnerability of the patient which is inherent in a health care situation, the competent health care worker finds that she is in a relationship with a person who needs and expects more than mere scientific knowledge, but also compassionate treatment.

⁶Daniel P. Sulmasy, "What's So Special About Medicine?," Theoretical Medicine 14 (1993): 32.

A moral requirement of entering into a health care relationship is that one is willing to enter into close relationships with strangers. Given this basic requirement for practicing medicine, it does not matter what economic concerns or systemic problems are involved in the current state of affairs in health care. Once this vulnerability exists and a health care worker chooses to relate to the other regarding this vulnerability, a close relationship exists. Therefore the health care worker morally owes it to the patient to be partial and involved emotionally. With a recognition of the moral nature of close relationships, a health care worker can better recognize the necessity of developing her ability as an artist.

The Prima Facie Morally Requirement of Emotional Involvement in the Health Care Relationship

[Sick human beings] want, often desperately, to entrust themselves and their care to the physician, believing that his or her judgement about how to care for them is better than theirs, and caring little for the formalities of consent or the ideal of shared decision-making. Even when patients refuse recommended treatment, they do so usually not for elaborate reasons of religions or moral principle but most often because they have lost the trust essential for care, i.e., they do not believe the physician or the staff cares for them and they can no longer entrust their care to these persons.⁷

For the most part, we choose to be close to those with

⁷Richard Sherlock, "Reasonable Men and Sick Human Beings," American Journal of Medicine 80 (Jan. 1986): 3.

whom we can share our vulnerabilities.⁸ However, health care situations are unique situations. They involve the exposure of vulnerabilities of patients to health care workers, the former finding themselves in situations which are many times traumatic and inexplicable to them. However, to a health care worker who sees this type of thing every day, the exposed vulnerability may be just a part of the job. Considered as such, the patient's exposed vulnerability and expectations of closeness are simply dealt with according to policy. In this way, the vulnerability is being addressed using an impartialist ethic, one which is morally insufficient for relating to a vulnerable individual.

As we have moved from a consideration of close relationships in general to health care relationships specifically, one may question whether the health care relationship can be called "close" in the same way as those which we typically refer to as "close" (such as our relationships with a spouse, family member, friend, or other significant other).

⁸I say "for the most part" to account for exceptions to this, such as the parent-child relationship. Consider the child in this relationship. The child is not clearly choosing to be in an intimate relationship with his parents, but rather finds himself in one. However, it could still be argued that once the child becomes a rational, competent agent, one of "legal age" to make his own decisions as an adult, that he also chooses his close relationships, even with those who have been given to him, so to speak, before he had any choice. This would make sense of those family relationships where children, once grown up and independent agents, leave these relationships to pursue those (and only those) which have been chosen by them.

The health care relationship is a close one by virtue of the vulnerability of the patient, and the choice that the health care provider has made, just by selecting her line of work, to involve herself emotionally in the lives of vulnerable people. Although the expectations which the patient has of the health care worker differ in degree (and specifically, in the variety of positive duties expected) from the ones which she has of her family members and friends, they are similar in a most significant way. Namely, they too morally require a partialist ethic.

As an example of the unique type of closeness in the health care relationship, consider the following description of the relationship between specific physicians and a patient⁹:

(Interview 11, p. 4-5)

. . . And they were- and instead of just being my doctor, they are actually my doctor and my friend. You know, I could call them any time and he's one of the busiest guys I know- and I know I could call him any time and I know that he would take time out to sit down and talk with me about that. You know, whatever. About fly-fishing or whatever. So it's uh, above and beyond. It's definitely neat. And you know, you go in, and I hadn't been in for three to four years. Something like that. You know, enough time had gone to where you remember people but it's not like you see them everyday. And, uh, I went in and it was like everybody still remembered me, they were like, "Yeah. How's your brothers," and, "How's this?," and "How's that?" I mean they remembered things about you, but it's not in your charts. It's not there. It's like, uh, you know, talking to you as your friend. "How's this and how's that?" So I mean just- even that, just remembering you. A lot of doctors you go in and they say, "What is your name?"

⁹See appendix for Interview 11.

Here the health care relationship is compared to a friendship. This is a special type of friendship, but there is an intimacy and concern similar to that found in our other close relationships. However, this is "definitely neat" because the doctor in this case could simply assume a professional role-morality and therefore treat the patient as just another patient who is only significant because of the general physical problem he is having. Such a doctor would likely not remember the patient, especially after three to four years. This alternative would include the impartialist ethic, inappropriate for the close relationship freely entered by both parties involved.

Consider another example of the special type of closeness which exists in the health care relationship, and the appreciation expressed for health care workers who act in a way consistent with the moral expectations of close relationships.

(Interview 11, p. 3)

p- . . . it was like they really deep down care about it. I mean, you know, from a- they don't treat it just like a job- they don't act like a robot or a machine doing their job, you know, they care about you as a person. And you know that they have feelings, and you know- it's like if I'm hurtin', in a way they're kinda hurtin'. And you can tell. And it makes any of that a lot easier. You know. When you have to spend a lot of time in the hospital And doing all of this stuff, is painful as can be. And when you know there's people there helping you, like they do, and um there for you, and you can just tell that they genuinely care. Then it's- you know, it made my job as a patient, my recovery from physical therapy and everything- much easier and quicker, and uh, from, I guess, mental aspect, it kept me in much better spirits. All that kind of good stuff. . .

Here we can see that there are two different ways a health care worker can act: as another person who genuinely cares or as a robot or machine. The first is personal and partial, the second is impersonal and impartial. The closeness involved in health care relationships shares one important similarity to the closeness of other personal relationships (e.g., relationships with family and friends). It necessitates both parties to "let their guards down."

A likely result for the health care worker who so acts is that he will see the patient as "uncomfortable and scared and unsure." It is incredibly important to the patient (or vulnerable party of a relationship) that the health care worker acknowledge this fact. Without being vulnerable with the other, the other will likely feel alone and exposed, open to harm from others. Again, the epistemic benefit of emotional involvement is the vision which results for salencies in the situation.

Health care relationships vary in the level of vulnerability and therefore closeness involved. The health care relationship is a close one because it involves a patient who is exposing a vulnerability to a health care worker.¹⁰

¹⁰The exceptions to the closeness of the health care relationship arguably include those where the patient is more like an object than a competent subject, such as instances of traumatic accident or loss of consciousness. In these cases, it would seem that caring compassionately would not even be a question, as there is no suffering to experience with the patient (although it would seem non-controversial to claim that health care workers should practice with the best interests of the future selves of such patients in mind).

Because the health care relationship is generally close in nature, there is a prima facie duty to care compassionately for patients. I say "prima facie" to allow for exceptions to this rule, such as in especially traumatic cases or in cases of loss of consciousness, where it may be virtually impossible to care compassionately for patients.

The Intrinsic Value of Practicing Medicine in a Compassionate Way

Positive emotional expressiveness by physicians, such as friendliness, displaying interest and empathy, contributes to the 'social climate' of the medical examination. Numerous studies indicate that such a climate strongly predicts patients' satisfaction with medical care.¹¹

1) The Art of Practicing Medicine

Conflict then arises from the disparity between the patient's expectations of the role the doctor will undertake—expectations that are the basis of the trust he places in the doctor—and the doctor's own view of his role. The patient, that is, is probably seeking a **healer and comforter**, while the doctor, proud of his specialized technological expertise, consciously or unconsciously **scorns such a role** as anachronistic, unscientific, and too time-consuming for his busy schedule. To the patient, his anxieties about his future, however irrational, are part of his sickness; to the doctor, only physical, preferably observable, pathology is worthy of his attention. It's as if a person set out to hire a chamber orchestra and all he could get was Muzak.¹²

¹¹Patricia Baker, William C. Yoels, & Jeffrey M. Clair, "Emotional expression during medical encounters: social disease and the medical gaze," in Health and the Sociology of Emotions, ed. Veronica James & Jonathan Gabe, (Cambridge: Blackwell Publishing Co., 1996), 178.

¹²Louise Lander, Defective Medicine. Risk, Anger, and the Malpractice Crisis (New York: McGraw-Hill Pub. Co., 1978), 13-14.

The art of being a physician involves a vision for the expectations of the patient. Without a vision for such expectations, medicine becomes a "hit-or-miss" enterprise, with the physician doing what she thinks is appropriate in any particular situation by defining a patient as an instance of a general illness. In so acting, the interpersonal comforts which are so important to the effectiveness of health care are missing, as the patient's vulnerability and need for information are largely ignored.

The basic fact in health care is that treatment is to be delivered to the patient. However, delivery in the medical context involves more than the mere provision and administration of medical resources and technologies. As an artist as well as scientist, the health care worker must understand the patient to whom she is delivering any particular treatment. The skill involved in practicing medicine necessitates an appreciation for the particular lifestyle, values and goals of the patient on the receiving end of the delivery. Of course this is a skill which takes much experience and practice to develop. This skill cannot be learned as a particular rule or principle intellectually grasped. A.E. Taylor states:

It is this relativity of the just enough to the individual's personality and circumstances which makes it impossible to lay down precise rules of conduct applicable alike to everybody, and renders the practical

attainment of goodness so hard.¹³

The delivery should be something in which, given the circumstances of the particular illness and the relationship which the practitioner has with the patient, the artist and the patient are invested together. Many patients come to physicians for answers, and in effect refuse to own their illnesses. Regarding physicians who just go along with these patients, Arthur Frank points out that:

Such physicians then teach their patients that with respect to how they feel, the numbers, or diagnostic images, or cardiac tracings, are more reliable. Most of us, sooner or later, go to the doctor to find out how we feel, our distrust of subjective feelings being a form of dissociation.¹⁴

Considered in light of Sherlock's comment above¹⁵, that sick human beings want to entrust themselves in the care of others, what results is a desperate situation for patients who are treated by non-compassionate, overly technical physicians. In hearing a patient tell the story about her illness and what is troubling her, one gets a sense of where she is coming from and what that illness means to her. One also gets a better sense of why she is seeing the health care practitioner and what sorts of treatments or therapies are the most viable

¹³A.E. Taylor, Aristotle (N.Y.: Dover Publications, 1955), 95.

¹⁴Arthur Frank, The Wounded Storyteller (Chicago: University of Chicago Press, 1995), 34.

¹⁵see page 56.

options for this individual. By listening to the patient, the physician provides her the opportunity to share with another human being the suffering she is experiencing.

Treatments or therapies should be viewed as repairing damage or doing some sort of good for the patient. However, it should be recognized that the actual way in which the treatment or therapy is delivered is very important to the patient, and arguably has much to do with the success or failure of the treatment or therapy. In Chapter 3, where specific accounts of compassionate (and non-compassionate) action are considered, it will be clear that patients remember much about who treated them and how they were treated, not primarily what the treatment involved.

To be an artist and to understand the patient, the health care practitioner should most importantly attempt to understand the part that the illness is playing in the patient's life-story. As Frank powerfully states, "Disease happens in a life that already has a story, and this story goes on, changed by illness but also affecting how the illness story is formed."¹⁶ Physicians, to be compassionate, must have this sort of narrative competence, the ability not merely to acknowledge the presence of an illness or disease, but also to recognize how the illness or disease is being lived.

Frank also emphasizes the considerable impact that an illness can have for the sense of direction in a patient's

¹⁶Frank, 54.

life. "Stories have to repair the damage that illness has done to the ill person's sense of where she is in life, and where she may be going. Stories are a way of redrawing maps and finding new destinations."¹⁷

Health care providers are required to act compassionately towards their patients by virtue of the artistic nature of practicing medicine. The artist must appreciate in a compassionate way the specific situation of the suffering patient. Without compassionately acting, the health care provider may not understand the validity or meaning which any diagnosis or treatment will have for a particular patient (specifically, in light of the values and interests of that patient). Furthermore, the health care worker must practice compassionately in order to truly conform to the several common ethical principles of medical practice, including autonomy, beneficence, non-maleficence, and justice¹⁸:

Compassion influences the way decision makers would incorporate in decisions the three major principles that dominate medical ethics today: beneficence, justice, and autonomy. It make all of medical ethics subservient to one ordering principle: acting out of the very particularities of the individual situation.¹⁹

¹⁷Frank, 53.

¹⁸Again, this suggests that there is something to be gained from both the ethic of care and the ethic of justice. Here, for example, the ethic of care may be taken as indicating the way in which the ethical principles (e.g., beneficence) is to be met.

¹⁹David C. Thomasma and Thomasine Kushner, "A Dialogue on Compassion and Supererogation in Medicine," Cambridge Quarterly of Healthcare Ethics 4 (1990): 420.

2) Competent Treatment Provided

The problem for the patient is that his "illness, by its very nature, gives rise to the need for psychological support and pastoral or **compassionate** care, and the specialist, by the very nature of his 'limited' mandate, even though he has had the standard medical training of all physicians, is simply not ready nor perhaps equipped to provide that kind of care."²⁰

In providing compassionate care, the health care worker suffers with her patient, providing an environment for the patient to define her own illness in light of a life which includes certain values and goals for the future. Some have gone so far as to explicitly call compassion a "duty."

The strongest argument that compassion is a duty of all physicians lies in the connection of compassion to the duties generally admitted to be part of all physicians' professional responsibilities. Central among these duties are the fiduciary responsibility to put patient interests first, the duty of due care, and the duty to maintain confidentiality. Each has a significant relationship to compassion.²¹

The nature of health care simply includes the fact that patients will expect health care workers to care compassionately for them. These patients are typically in vulnerable situations, and expect that they will not be taken advantage of. They expect health care workers to be human beings in addition to providers of technology and therapy. As artists, the health care workers must acknowledge and attempt

²⁰Lander, 67.

²¹Charles J. Dougherty and Ruth Purtilo, "Physicians' Duty of Compassion," Cambridge Quarterly of Healthcare Ethics 4 (1995): 428.

to understand the way in which unique individuals are suffering their illnesses. If they do not so acknowledge, then they are simply not competently practicing medicine. The application of medical technology to unique individuals (the art) is a part of the job. At times, some have gone so far as to compare the understanding and treatment provided by the health care worker to that provided by a pastor or member of the clergy.²²

3) Practicing Medicine as a "Calling"

We are called upon, it often seems, for unreasonable requests at unsuitable times- times that we often later judge to be the finest hours of our days. We are chosen as witness or agent in some hidden drama: a flash of understanding, a cathartic explosion of tears, the tiniest turn toward reconciliation, a simple act of kindness that spills out at the close of a dead-run day. These are the times when doctors earn their credibility, which "grows out of compassion and trying to help, depending less on expertise than good intentions."²³

The "calling" is extremely important to those who take (or wish to take) pleasure in practicing medicine. The virtuous physician willingly performs his medical function, taking pleasure in so acting. Taking pleasure in the job in this way would seem to have a significant positive impact on the health care worker's resistance to burnout or to becoming

²²See Thomas Szaz, The Theology of Medicine (Baton Rouge: Louisiana State University Press, 1977).

²³David Loxterkamp, "Hearing Voices. How Should Doctors Respond to Their Calling?," NEJM 335:26 (Dec. 26, 1996): 1991-1993.

exhausted emotionally.

The physician who describes his medical work as part of his calling takes his job to be one which provides a service not to mere patients with certain types of ailments, but rather to fellow human beings. In fostering such relationships with his patients, he will likely define his job as one of serving suffering human beings who are benefitting from his care.

Health care workers are encouraged to see the financial implications of their practice. It is feared that soon the practice of medicine will be considered non-controversially a business. This is exemplified by the increasing attention being given in medical education to the economic implications of medical practice, and increasingly prevalent discussions concerning ways of reducing costs in the treatment provided.

It is morally wrong for a health care worker, as his patient's advocate, to consider benefitting a health care system by his own personal rationing at the expense of his patient's health. This is simply by virtue of the role we expect health care professionals to play. Sulmasy puts it as such:

The special nature of medical care makes the moral and social position of the physician more compatible with the metaphor of "Medicine is a calling" than the metaphor of "Medicine is a business." The ancient traditions of the profession support such a conception of medical care.²⁴

²⁴Sulmasy, 39.

Fostering of a compassionate disposition, thereby enabling health care workers to reflect upon their own values as well as the ethics of the medical situation, is the one major way in which we can combat such pressures. Such training will enable the health care worker to come to grips with some of the negative implications of the new health care situation without sacrificing their integrity in the process.

Through a consideration of her work as a calling, the health care worker is able to appreciate the relevance of her work in a way that has her acting as a human being for and with other human beings. Of course, a calling implies that one is being called from somewhere, as if from a higher power. It is important to understand that this "higher power" is not limited to a traditional, monotheistic notion of God. Such a calling can also be an expression of one's humility, her understanding that she is one human being among many on this earth at this time, subject to die some day just like the rest, without any apparent reason. The calling revolves around such humility, and it will be shown that the sense of calling brings with it a desire to act compassionately towards others.

In another sense, the health care worker is being called by those whom she treats and cares for. The calling, in this sense, may not be one which is primarily for the technical expertise of the health care worker, but rather a call to a fellow human being for compassionate care, whether in the form of reassurance or just presence in a surreal time of that

patient's life being redefined by an intrusive illness.

4) Satisfying Social Responsibilities

We feel drawn to the downtrodden, the ignorant, the disadvantaged. But not out of a sense of altruism or noblesse oblige, duty or guilt. Perhaps we still act, like the Good Samaritan, out of compassion and recognition of ourselves in those who suffer, and with a deep conviction that salvation is to be gained by sharing the load.²⁵

A compassionate disposition brings with it a better understanding of one's social responsibilities. Certain universal beliefs and values, as well as affective feelings for those whom he treats, have the health care worker willingly "suffering with" his patients. The compassionate disposition will have him reaching out to the poor and uninsured, doing so as a beneficent action for which he has been trained, and to which he has dedicated his life. Compassionate people desire to help their fellow suffers, and foster human relationships with them. The compassionate actor does what he can, measured against his own limitations.²⁶

²⁵Loxterkamp, 1992.

²⁶This is a key part of acting compassionately in delivering health care. Namely, being able to suffer with others and then to be able to assess what would be helpful to these others, keeping in mind that one also owes respect to oneself in helping others. This discussion, concerning the limits of compassionate care morally owed to patients, gets into another set of issues, and would therefore be better discussed at another time.

5) Individual Feeling of Accomplishment

According to Aristotle, the virtuous actor acts as he does because he finds it pleasurable to do so. People who take pleasure in their jobs are arguably the best at what they do. Furthermore, those who attain a humility of their existence are able to better deal with the realities of those with whom they work. Patients are better able to be vulnerable with health care workers who are vulnerable with them.

Forming a compassionate disposition will also help the health care worker deal with the problem of burnout. This is a problem which is associated with an inability to "deal with patients' suffering." Ramirez, et al., note that,

Three sources of stress were associated with both burnout and psychiatric morbidity; feeling overloaded, and its effect on home life; feeling poorly managed and resourced; and dealing with patients' suffering. Burnout was also associated with low satisfaction in three domains: relationships with patients, relatives and staff; professional status/esteem; intellectual stimulations.²⁷

Developing the ability to feel compassionately towards one's patients and co-workers promises to address several of these sources of burnout. As a result of developing such an ability, the health care worker will be better able to deal with negative emotional behaviors of his own as well as those

²⁷A.J. Ramirez, J. Graham, M.A. Richards, A. Cull, W.M. Gregory, "Mental health of hospital consultants: the effects of stress and satisfaction at work," Lancet 347;9003 (Mar 1996): 724-8.

with whom he works and the patients (and families) whom he heals.

The Instrumental Value of Practicing Medicine in a Compassionate Way

There are many reasons to include the interpersonal dimension in medical education. As Bugler (1987) states "confidence and trust in the physician is essential to the dimension of healing" (p.6). Flaherty (1983) states two essential reasons. First, that the types of problems patients bring to physicians are often private, sometimes frightening, embarrassing and anxiety producing, and even demoralizing and, therefore, demand a humane approach that allows the patient dignity. Also, there is the pragmatic reason, that good interpersonal skills may help improve patient health outcomes. . . The interpersonal relationship between physician and patient involves a highly charged affectual component (DiMatteo, 1979). As a result, "patient satisfaction with medical care, their compliance with treatment, and the outcome of treatment tend to be substantially related to their physician's ability to satisfy their socioemotional needs in the health care encounter" (DiMatteo, 1979, p.12).²⁸

1) Decreases Harm to the Patient

The Hippocratic principle of primum non nocere, therefore, must be expanded to encompass the patient's value system if it is to have genuine meaning. and 'Each patient has a slightly different definition of health.' and 'The physician must constantly guard against imposing his own values as the good to which all must subscribe if they desire to be treated by him.'²⁹

The right to autonomy of the patient relates to the basic and oft-cited principle of "do no harm." The notion of harm

²⁸Leesa M. DiBartola, Patient and Physician Perceptions of Physicians' Interpersonal Skills Dissertation, Doctor of Education, University of Pittsburgh, July 10, 1995, 63.

²⁹Pellegrino, 101.

must be broadly and inclusively understood as not merely including physical harms which may be done to the patient as a result of misdiagnosis or negligence, but also the more offensive potential harm done to the patient in imposing upon the patient one's own opinion as to what should be done in the patient's case. Again, this is because the patient should not be seen as a general instance of an illness but rather as a unique individual who is living an illness in a specific way. The decision-making process should be a shared endeavor between the health care provider, who is emotionally investing skills and time to understand the patient, and the patient, who will attempt to make sense of the illness with the help of the health care worker, and choose the treatment and the results which follow.

This normative principle of "do no harm," broadly defined, is based on the assumption that the practicing health care provider is by definition an artist, not merely a scientist. The ability to suffer with the patient in a compassionate way enables the health care provider to come to a better understanding of what the illness means and what the implications of various diagnoses and treatments would have for the life (including values and goals) of the patient (and patient's family). This requires that the health care provider be vulnerable along with the patient: listening to, feeling and sharing with the patient the illness which is being considered, developing the ability to be a fellow human

being with the patient, while at the same time using one's medically trained eyes in proposing diagnoses and treatments.

In light of the harm which results from a routine lack of compassion in relating with patients, consider also that over a period of choosing to treat the patient impersonally, ". . . the prescription, a thing, easily comes to substitute for the dialogue, the relationship, that might have made it unnecessary."³⁰ Harm also comes in the form of unnecessary treatment. This is not to be considered as implying that tests are unnecessary to diagnose an illness, but rather that by listening to the patient and considering compassionately her suffering, the health care worker may see that certain treatments, even though considered as of the standard for certain illnesses which the patient, as a chart, is taken to represent, are not, in fact, very useful for this patient when considered her unique goals and life-aspirations.

With all of the constraints on the health care worker in the technology-ridden, bureaucratic health care environment, the tendency may be to funnel the patient through one pathway or another, with confidence that whatever is wrong with that patient will be fixed somewhere along the line. Giving some prescription, procedure, or technology to the patient may make the health care provider feel as if she has done something for the patient, and make the patient feel that she has gotten something from the provider. However, upon reflection, the

³⁰Lander, 49.

underlying feeling of the provider in such cases is likely that she does not really know how the treatment will affect the life of the patient. Furthermore, the patient's feeling in light of such treatment may be that she has not really been listened to. What results is a general feeling of inauthenticity and distress on both sides. For the health care worker who comes to equate the technology and tests which she prescribes with competent treatment, questioning the appropriateness of any "indicated" treatment for patients because of their unique circumstances may be stressful. It is, in effect, to put herself and her profession in question. She comes to need a justification for inappropriate and/or ineffective treatments which are medically indicated procedures. This justification is found with the patient in need of someone who is ready, willing, and able to help her define her illness for herself. Purely technological (and therefore impersonal) delivery of health care may have such a patient feeling incompetent and unable to define her illness for herself.

Without practicing compassionately, the health care worker is likely neglecting some important values, needs, and goals of the patient. The result of this will likely be that the ethical principles which are espoused by the AMA and various other medical oaths will not be met. The harm which results from such treatment includes one of the patient's dignity, autonomy, and integrity.

2) Creates an Environment which Facilitates Patient Autonomy³¹

. . . the so-called health professions have an even deeper, culturally health-denying effect insofar as they destroy the potential of people to deal with their human weakness, vulnerability, and uniqueness in a personal and autonomous way. The patient in the grip of contemporary medicine is but one instance of mankind in the grip of its pernicious techniques. This cultural iatrogenesis. . . is the ultimate backlash of hygienic progress and consists in the paralysis of health responses to suffering, impairment, and death. It occurs when people accept health management designed on the **engineering model**, when they conspire in an attempt to produce, as if it were a commodity, something called "better health."³²

A patient's autonomy can be fostered by the information which is provided by the health care worker. The decision as to what information will be appropriate for any given patient will be determined through an examination of the patient. The examination is performed with the guidance of the patient and must, if it is to meet the ethical principles espoused by the AMA, consider the values and interests of the unique patient involved. If the health care provider does not give the patient the opportunity to express what the illness means for her, then the patient may feel that these concerns are not important. This feeling will likely result regardless of the reason for the health care provider's not considering compassionately the suffering of the patient during the

³¹see Edmund G. Howe, "Approaches (and Possible Contraindications) to Enhancing Patients' Autonomy," Journal of Clinical Ethics 5;3 (Fall 1994): 179-188.

³²Ivan Illich, Medical Nemesis. The Expropriation of Health (New York: Parthenon Books, 1976), 33.

examination (e.g. time constraints).³³

Consider the case in which the patient's lifestyle is not known and a treatment is provided based upon the barest of facts about the physical condition of the patient. On the basis of this incomplete information, the provider will necessarily diagnose the illness of the patient as a general malady, instead of a specific, lived illness. The general diagnosis, represented by the designated "pathway" or DRG code for that general illness, will be used to prescribe standard tests and procedures. By getting the patient on the appropriate pathway, the health care provider wrongly assumes that an application of technology by each provider of the pathway will eventually get to the bottom of the illness. The health care provider is, in this way, "passing the buck," having faith in this impersonal system as the best and most efficient way medicine can cure a patient.

However, consider the patient's experience of such treatment. The patient knows that she has not given all relevant information to the health care worker about the illness being considered. But she is being told to conform and

³³It may be that patients will become accustomed to a managed care environment. For those who have not experienced anything different than managed care, expectations of physicians will likely be different. These different expectations may have patients describing encounters with physicians previously considered non-compassionate as compassionate events. A discussion of developing more compassionate health care relationships within the managed care framework deserves more attention than I can give it here.

listen to the provider because she does not have the technical knowledge of the provider, and therefore does not have the requisite skills to define the illness for herself. Such a state of affairs in medicine, specifically the over-reliance on technology and science which omits a development of the artistic ability crucial to the competent practice of medicine, leaves the patient to either accept his role as an object to be treated by an impersonal technician, or to simply not comply to the regimen prescribed, thereby preserving her integrity and/or right to define her illness in her own terms, and deal with it accordingly.

Impersonal treatment severely limits the autonomy of the patient, as she is not encouraged in such a relationship to own her illness (specifically by understanding it in her own way, using her own words, according to her own lifestyle, values, and goals). Without caring compassionately, "suffering with" the patient in attempting to see the illness as the patient does, the health care provider fails to foster the autonomy of the patient.

3) Eliminates Cases of Noncompliance

Price indicates that "the chronic illness experience" is one which may include noncompliance to a medically prescribed treatment regimen. He indicates that, "The provision of skillful psychosocial care to patients suffering from chronic illnesses starts with an appreciation of what it is like to

live with a chronic condition."³⁴ Once a health care provider understands the patient's experience of her illness, he may also be able to understand her noncompliance. And this understanding of a single individual can lead to a better understanding of chronic illness in general. Price puts it as such: "Individuals' personal constructs may usefully then be used to explore the extent to which chronic illness sufferers share common problems and needs."³⁵

Compassionate relationships breed honesty and openness between human beings. Realistic goals, specifically in the form of treatment plans and definitions of illness for particular lives, result from a dialectal effort between patient and health care provider. These goals, unlike those which are imposed by an impersonal, technical representative of a system, are ones which parties are committed to, as they are shared.

In speaking on noncompliance for those who are prescribed antidepressants, Kaplan includes empathic behavior as a way of increasing compliance:

By spending time on patient education, providing reasons why patients should take every antidepressant dose, discussing alternative treatments, and conveying empathy, support for, and understanding of the patient, physicians may be able to minimize noncompliance and consequently decrease the likelihood that a patient may

³⁴B. Price, "Illness careers: the chronic illness experience," Journal of Advanced Nursing 24;2 (Aug 1996): 275-9.

³⁵Ibid.

experience discontinuation symptoms.³⁶

Quite simply put, the patient who feels that she has not been listened to will likely not trust that the health care worker really knows what is going on. The result is hardly surprising. The patient, who may only be reimbursed for seeing certain physicians in a certain order, as required by her HMO, may just go through the string of specialists until she gets to where she knew she needed to go all along. The basic underlying point is that anyone who feels unmotivated to pursue some avenue of treatment will likely not complete that treatment.

The decision as to whether and how to accept treatment is up to the patient. But it seems much more likely that patients will comply to treatments which are prescribed with a diagnosis which they understand and which are consistent with goals and values which they hold.

4) Decreases Cases of Malpractice

In a complex technological hospital, negligence becomes "random human error" or "system breakdown," callousness becomes "scientific detachment," and incompetence becomes "a lack of specialized equipment." The depersonalization of diagnosis and therapy has changed malpractice from an ethical into a technical problem.³⁷

³⁶E.M. Kaplan, "Antidepressant noncompliance as a factor in the discontinuation syndrome" Journal of Clinical Psychiatry 58 Suppl. 7 (1997): 31-5.

³⁷Illich, 30.

If patients and families relate to health care providers as impersonal parts of a machine or system, then they are more likely to demand miraculous cures which the people in the system are simply unable to deliver. Without compassionate care, miscommunication and ignorance of the goals of treatment are inevitable. The expectation of the impersonal machine is that it will magically make everything better, or make life like it was before the illness. The illness is not given to the patient to define and come to grips with herself, and what results is either a passive acceptance of treatments or a negative response to medical care experienced as a violation of the integrity of one's person. Either case may result in a legal claim against the health care representatives for not meeting the unspoken goals of treatment, goals which are largely met through caring compassionately for the suffering of patients.

Although it provides no guarantees in this arena, compassion certainly makes it more likely that a physician will act with due care as changing circumstances require. Indirect evidence for this claim can be found in the legal arena where law suits for malpractice (alleged violation of a standard of due care) seem more closely linked to failed relationships with patients than to inadequate technical skills.³⁸

Lander strongly states, in light of malpractice claims against health care providers, that:

What distinguishes the injuries that do not become malpractice claims from the injuries that do, and what even colors the patient's perception what constitutes an

³⁸Dougherty & Purtilo, 429.

injury, is the subjective element of patient anger; without anger, an act as hostile as a lawsuit, particularly against as well-established an authority figure as physician, is impossible to contemplate.³⁹

Anger seems to include the perception of another as offensive, as a threat to the individual, attempting to take something from the patient (e.g. integrity), or as having (negligently) already done so. By viewing the imposition of medical care upon oneself in such a way, the tendency to seek revenge understandably follows. Further, consider that law suits are intended to punish perceived offenders as well as to make the victim "whole" again. Law suits are actions, and malpractice claims can be seen as offensive strikes at others who are perceived as not treating patients in appropriate ways.

Finally, consider another powerful claim made by Lander in light of the health care system:

The reality is that the defects of the insurance and legal systems and the incompetence of individual practitioners, however real, have been used to mask the fundamental defect of a system of medical practice the increasingly creates new risks of injury while it simultaneously **denies the humanity** of those people who become its patients.⁴⁰

By feeling that he has been "put through the system," the patient will likely define his experience as impersonal and offensive. To impersonal treatment the patient will likely

³⁹Lander, 6.

⁴⁰Lander, ix.

respond in an impersonal way, denying the humanity of those who represent the health care system. Health care professionals become inhuman offenders who must be held accountable for the (perceived) harm done.

Conclusion

Pellegrino conveys a feeling of desperation for developing a focus on compassionate behavior in health care:

Potent influences in modern medicine and society now conspire to erode and even extinguish compassion. Among the most influential are: the fascination with technology, gadgets, and instruments; the inherent depersonalizing influences of our highly institutionalized social structures; the replacement of care by individual with care by the "team"; scientific medical education that focuses on man-the-object-of-study; and, finally, a medical education, fraught with rigidities, that does little to help the student develop his own humanity.⁴¹

I have argued that competent medical practice demands compassionate action. As is stressed here by Pellegrino, the current state of medicine depends on the scientific aspect of practice, while undervaluing the art. As a result, the practice is less rewarding to both health care workers and patients. However, we must first recognize what is that is specifically missing from the practice of medicine which is not compassionate, as well as what compassionate practice entails.

⁴¹Pellegrino, 158.

Chapter 3

A Thematic Description of the Compassionate Event

In what follows I present the results of a phenomenological study focused on the compassionate event. The study was undertaken with the goal of describing common ways in which people experience compassionate actions in health care situations. This study also was initiated with the intention of providing a description of the compassionate actor which can then be used in both parts of the present analysis.

The results of this study are proposed as further support for the argument that compassionate care is morally required of health care workers. Present results show that patients prefer compassionate care from health care workers, and describe a specific set of actions as compassionate ones. This description of compassionate behavior will be used to determine the basis for self-assessment and to establish the goal of the training program which I present.

In the present study, 8 male and 7 female adults served as participants in a series of phenomenological interviews.¹

¹A phenomenological interview is a dialogical process which has as a goal an elaboration of a specific experience or experiences (e.g., compassionate actions). Other (non-phenomenological) ways of describing specific human experiences which have the observer describing it from outside of the event are not used here. This is because such ways are not as able to validate the descriptions used with those who actually experienced the event being observed. (i.e., in the phenomenological interview, the descriptions are made by one person to another person, the latter attempting to understand

Participants included nine volunteer undergraduate students, three graduate students, a part-time auto mechanic, and two academic department secretaries. The average age was 28, and ranged from 21 to 55.

Each of the 15 participants met at a designated office for an audio-taped interview. Each also signed an informed consent form. All interviews began with my asking the following question:

"Could you tell me of a time in which a health care worker acted compassionately towards you?"

Most participants began the interview by describing a particular event in which a health care worker acted compassionately towards him or her. In three of the interviews, however, the participants began with an instance in which a health care worker did not act compassionately. All interviews consisted of the participant's description of various experiences of compassionate and non-compassionate behavior. Each interview was concluded when the participant reported having nothing further to say about the compassionate event (approximately 1-2 hours).

Upon finishing the interview, I derived themes from each

the description as the other does). Also, such ways will likely include biases of the observer which are not explicitly noticed (as they are in the bracketing interview of the phenomenological process). The major premise held by those who use the phenomenological method is that to understand a specific event or situation, one must understand that event or situation as do those in the event or situation.

of the individual protocols. This was done by citing those descriptive phrases and words that recurred through the interviews conducted. A follow-up mailing to each participant included a copy of the thematic summary of his or her interview and a request for comment on them. After receiving responses from 11 of the 15 participants, I read one interview in an interpretive group. Those of the group agreed with the themes that I had already identified. Following this, I prepared a thematic description of the compassionate event. This description included four major themes found throughout the interviews conducted.² These themes are presented with specific examples of each theme from several of the interviews, noting the specific words used by the participants themselves.

The thematic description presents the basic meaning of the compassionate event (as revealed through the 15 interviews completed). The themes represent the salient characteristics of a compassionate event and specifically what is involved in the action taken by the compassionate actor.

This experiment was done in accordance with the following schematic summary, shown in Figure 3.1:

²By "theme" I mean a part of the descriptions of each interview that can be recognized as recurring in the descriptions of those interviewed.

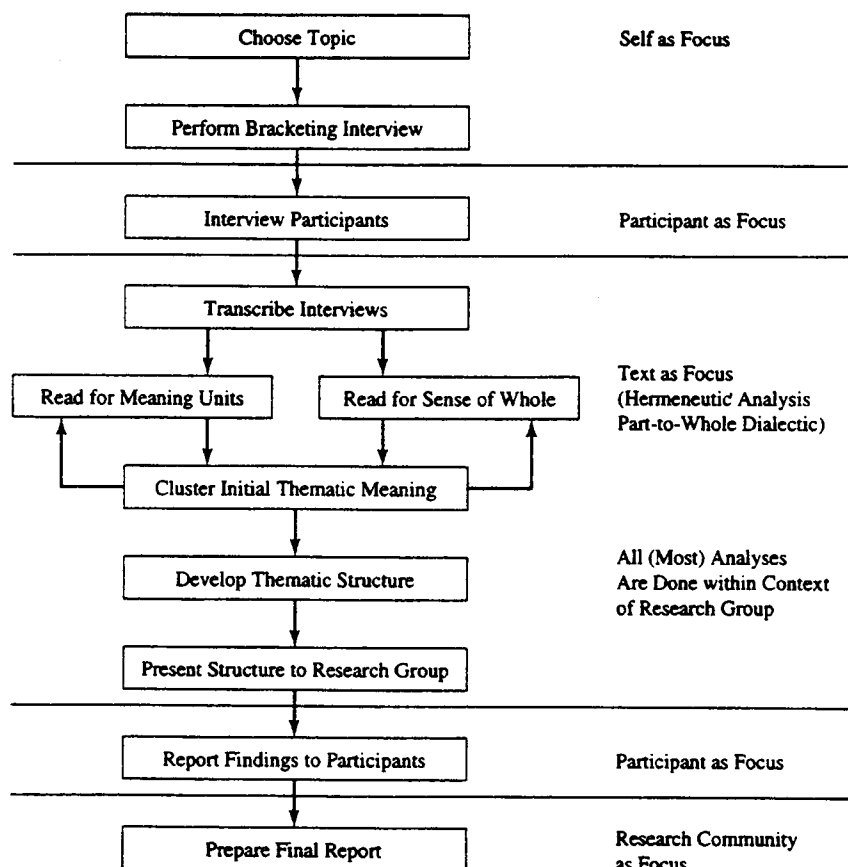


Figure 3.1³ Basic Steps of the Phenomenological Study

Themes Which Participants Used to Describe Compassionate Events

A clear type of relationship was described as existing between the parties involved in a compassionate event and those involved in a non-compassionate event. This may be seen

³Reprinted with permission; Howard R. Pollio, Tracy Henley, & Craig B. Thompson, The Phenomenology of Everyday Life (New York: Cambridge University Press, 1997), 60; Note that the "bracketing interview" involved my own description of a compassionate event. This interview is intended as a way of revealing the meaning of the compassionate event for the interviewer. This is done to make the interviewer more aware of his biases so that he can be aware of these in the interviews conducted.

in the words used to characterize the form of relationship identified with each:

non-compassionate relationships: Robot, Lab rat, shovelled in and out, a thing, on a lower level, a case (for the other)

compassionate relationships: emotionally involved, (treated like an) individual, real person, like a friend

Relationship

Compassionate Relationship

The following examples describe the type of relationship characterizing compassionate events.

it just didn't seem like I was just another patient in the appointment book. You know, I think that, that compassion came out that way, that they really knew who you were and they were honestly concerned that you did well. . .

One interviewee spoke of "high medical terms" as things which distinguished the relationship she had with her physician from the non-compassionate relationship:

just talking to me as a person instead of using all of these high medical terms

Those interviewed spoke of compassionate health care workers as they would of other intimates. Such characterization ranged from being treated as more than just patients, to being treated like friends, to being treated as if they were family members.

And when they were like pressing on your leg, he'd try to talk to you about other things- it hurts, and they weren't into the no pain, no gain sort of thing. But you still had to bend your leg around, get it working. And you got sort of a personal relationship and you really didn't mind going in.

Doing way more than they need to. I mean, going above and beyond their job. I mean, their job is to fix me up and to get me better and to get me back on my feet. And they took it to a more, uh, a much more personal level. And they were- and instead of just being my doctor, they are actually my doctor and my friend.

And there were two nurses A and T, and they basically just related to her as if she was their sister and not like she was just a patient.

And that he was concerned. And that I wasn't just another, quote, "patient." It seemed like, you know, it was um. . . not that it was a personal, any kind of a personal relationship, but he just, he was just concerned about me personally. . . It just seemed like he was- he was legitimately concerned about my well-being. Not just, "Well, I have another patient in the hospital. I'll have to check on them Monday when I do my rounds." He went out of his way. It just seemed that he was honestly concerned about how you were doing.

Those interviewed distinguished compassionate treatment from non-compassionate treatment using depictions of each actor. The health care worker who was described as a part of a compassionate relationship was described as similar to a friend or family member. The health care worker who was described as a part of a non-compassionate relationship was described as similar to a robot or machine. Here is one specific example of the difference:

Yeah, they really cared. You know, it was like they really deep down care about it. I mean, you know, from a- they don't treat it just like a job- they don't act like a robot or a machine doing their job, you know, they care about you as a person.

Non-Compassionate Relationship

The non-compassionate relationship was described as one in which there was a lack of care or concern by a health care

worker for the patient. In a non-compassionate relationship, one person was described as being treated as an object by the other:

It's ridiculous because it was like he didn't even care. He didn't even care. You know, he did it and I more or less went through the roof in pain. And he just kept doing it. It was ridiculous. He didn't care about it at all, and pretty much told me that there was nothing wrong with it. I was ready to hit him. But, I mean there's- it's my opinion that there's no place in the medical community for this guy. Somebody with an attitude like that. I mean it was ridiculous.

Well, the one girl that, um, when she went to put an i.v. in my hand. Um, they put it in right here, and she hit a nerve. And I kept telling her it hurt really bad. And she kept trying to put this iv in there. And my thumb started kinda jerking around, and I kept telling her, "That hurts! That hurts!" And as she kept trying to do it, I yelled at her, I said, "Look, that hurts!"

The non-compassionate relationship also was described by citing an experienced difference in status or level between the health care worker and patient involved. In these cases, the patient described him or herself as being uninvolved in what was going on, subject to a health care worker who was just there doing a job.

I really felt like I was no more involved in what was going on than, uh, oh. . . like a lab animal. . . And I felt like that's what I was in the situation- I was a source of data but I wasn't a patient. And, um, and he just really seemed irritated that this source of data was not just being quiet.

I mean it was just like, uh, he was just obviously, he just didn't care about the patient. So, uh, you know, it was like, he was using his position as a doctor, he thought of himself as a doctor as way above and beyond, you know, the person who he was actually working for and trying to help, and he just treated me like I was some lowly, don't know anything- like, "This is it, deal with it."

Because we had other doctors come in and they were business-like. You know, they came in, they'd check on her, and then they'd get out. You know, it seemed kind of rude. I mean, they'd come in, take the blood pressure, and they're out. It was like, you know, it's just a job to them. It really doesn't phase them to see somebody die.

And, uh, he kind of poked- it was in my abdomen- he kinda poked around, and every time he would ask, "Does it hurt here?" Um, it hurt all over, um, and he just kept saying, "No. That doesn't hurt."

Several participants also indicated that what made the health care workers non-compassionate was not only their not caring or being concerned, but also their lack of "apology" or demonstration that they understood the patient's situation:

I mean, because some of the questions were pretty personal, and, you know, kind of invasive to ask. And again, no kind of taking that back. No kind of apology. No kind of, "I'm sure you don't want to answer this question. But I need to know. . . ." Nothing like that.

And I really, really would have liked, it really would have been nice to hear, "I'm sorry this hurts." Or even, "I know this hurts."

Two participants described the experience of being given negative information about their physical condition. The health care workers providing them the information were described as lacking any concern for how this information would be received, and this was described as characteristic of the non-compassionate relationship:

. . . The uncompassionate doctor from STATE, I talked about very briefly about my knee before I went to CITY. He said, "This is what's wrong. We could take this chunk of bone that's broken out of your knee, let it heal, and you'll probably be in a walker or a wheelchair by the time you are 30." And he didn't have any problem saying that, no promise, not "I'm sorry and it's going to be

rough." So he didn't give a flip. Just like a robot. And, he's a real cocky individual, I don't know if that's got something to do with it. Maybe he actually felt bad and that's how he deals with himself. I wouldn't guess that's the case with this particular guy. But, you know, when somebody tells you that when you are 10 years old, that's got to be overwhelming. It's like somebody stabbing you.

. . . I have a prime example of somebody not being compassionate in health care (laugh), um, when I found out that was going to have to call the surgery, or have to have the surgery, I think because they thought that I wasn't going to care or something, I don't know what they thought. But the nurse called me and told me that I had this abnormal test, and she called me the day before Thanksgiving, here at the dorms, and then basically said, um, "You might have cancer, we're going to have to run more tests, but have a nice holiday." And I was pretty much distraught, as I didn't get past the, "you might have cancer" part. And then, it was such a hass- of course then I called my mom and my roommate didn't know what was going on. And I couldn't hardly tell her- couldn't tell my mother what was going on because- well of course she being in medicine wanted to know everything for herself. And then they wouldn't release my records to her. So I had to call back, all upset. It was just, it was just like, they just treated it like I was just another kid that they just told that might have cancer. You know, just something that she probably does do every day. . .

She continues:

. . . It kinda felt that she didn't understand what she was saying to me. Like she's just reading out of a book, saying, "You might have," you know, "the character might have cancer, and the character might die and the character might live." Instead of thinking, "Gosh, this is a real person. What if this was my daughter, and I'm calling her at a college dorm room, without her parents there, the day before Thanksgiving?" I would have even preferred for her to wait until after Thanksgiving. (laugh) You know, I could have waited one more day. There wasn't anything that I was going to do- there wasn't anything that I was going to do the next day about it.

Then she contrasted this person to a compassionate doctor:

. . . But then when the doctor actually took an interest

in who I was, and maybe address some of the fears that I had, and try to learn a little about me right before then, and, and uh, it meant a lot. Other than just, "Yeah, this surgery's fine." You know, "We have a high cure rate," or whatever. I mean, just spilling out facts. He just went another step further, and it really helped. When someone treats you that way, instead of just spilling out facts that may be important, but there could be another way of saying it, instead of just lining them up.

Consider the following distinction between "a" doctor and "my" doctor as exemplifying the distinction between the non-compassionate and compassionate type of relationship:

. . . but the thing was that, I didn't see him as this doctor in this white coat any more. It was kinda like he went from being just A doctor to MY doctor. And this was a doctor that I didn't even know. And who was just assigned to me because he was an urgent care doctor. And all of a sudden he became MY doctor. Somebody that he was worried about. He kinda gave me the same compassion that my family doctor, my pediatrician, has given me my whole life. So I think that that's how the relationship changed. We went from a doctor-patient to MY doctor. And, you know, they're totally different things.

Relationships Which are Neither Compassionate nor Non-Compassionate

In addition to depicting non-compassionate and compassionate relationships, there were two different types of relationship which were considered neither compassionate nor non-compassionate. First, consider the relationship which was described as worse than non-compassionate. Note that in such a relationship, the actor is described as "worse than a robot":

. . . and the doctor here was not very compassionate. He was just, he was just a jerk all together. And, uh, and he was, uh, he looked down on you and said like, "Aw, it can't be that bad." . . . he was worse than what you would think a robot would be. You know, he would just come over and feel your neck, to see if it was alright, and I'm telling him, "This is the most severe pain I've ever had in my life." You know, "Be careful." And he comes over, grabs my neck, and starts squeezing it around, like, I mean, you know, it was really hard not to flip out. And it hurt. I let out a little yell. And it was like no big deal. He kept doing it. I was like, you know- and he was like he didn't give two flips. And it was like, "No big deal. You'll be alright. Just go on with it- deal with it." And, uh, it was, it was- the guy was a total bum.

The second of the types of relationship which was regarded as neither compassionate nor non-compassionate was a so-called "friendly" relationship. This type of relationship was presented in only one of the fifteen interviews conducted. There a friendly practitioner was distinguished from both a compassionate actor and non-compassionate actor, described as "just nice." Consider the following comparison between the "other people" who were described as compassionate actors and the "just nice" people:

And they wouldn't go especially out of their way, like the other people did. But they were just nice. As far as their bedside manner goes.

And then compassionate, to me, is just that next step up of niceness, that people are just really going out of their way, and doing what they can for you.

You know, he was being nice, and he was nice, and that goes along with bedside manner, you know, some physicians have it, and some physicians don't. And I don't think anything of that, but. . . I think that he was just pretty much doing his job. Even though he was nice, you know, he was friendly in the way he did his job, I think he was just doing his job.

Consider now the three themes which were consistently used to distinguish the compassionate actor from the non-compassionate actor: Feeling/Understanding how the other feels and understands, caring genuinely and/or respecting the other, and going above and beyond what is required. (Figure 3.2)

Theme 1. Feeling and Understanding as the Other Feels and Understands

The person described as acting compassionately was described as understanding the experience of another, feeling what the other is feeling, and putting him or herself in the situation of the other:

Right. And realized that I had goals and dreams and ambitions and all those types of things. Where the rest of them were just like- just go under the knife, and deal with the rest of that later. And, he realized what it meant for me to have to drop out of school three quarters of the way through. And, um, so. . . I think that others were aware, but just didn't go that extra mile.

Feel/Understand Genuine Care (G) Go
as Other &/or Respect (R) Above and Beyond

15	X	G	X
14		G	X
13	X	G/R	X
12		R	X
11	X	G	X
10	X	G/R	X
9	X	G	X
8	X	G/R	
7	X	G	X
6	X	G	X
5	X	G/R	
4	X		X
3	X	G/R	
2		G	X
1	X	G	X

Participants

Figure 3.2. Terms used by Those Interviewed to Define the Compassionate Event

So, that's how I would define compassion. Especially in health care, is, um, any nurse or doctor who is able to put themselves in your position, or in the patient's position, and being able to feel the things that they must be feeling at the time.

. . . She did something extra that she didn't have to do. Why, why is that? Because there is something underlying. And that underlying thing is allowing themselves to be touched by the situation. To put themselves in the situation. To put themselves in my shoes. And, to treat me how they would want to be treated. A kinda golden rule kinda thing. . .

Compassionate actors who were described as able to feel as another felt were also described as "sensitive" and able to "let their guard down."

And I think that these people allow themselves to let their guard down in some way. Not that they became involved in my life, but that they allowed themselves to see an individual instead of another case. And that I was- they allowed themselves to see that I was uncomfortable and scared and unsure. And because they did that, um, that seemed compassionate to me.

But the internist's defenses aren't up, and he allows himself to be touched, and approached, and moved.

. . . to put herself in that situation, and to want to be treated as she wanted to be treated. I don't know. I think, that would be compassionate, because she understood, I think, a lot of the responsibilities and other things that I had on me, and on top of that I had this death in the family. And she thought, "Man, this must have been a really rough week on him." And so, I think that probably put herself in my situation.

. . . She's doing things that work to that end- of helping maintain G's dignity. And making sure that nails are right, and her face is done right, and her hair is right. Because, had G full command of her faculties, she would have these things for herself. She would present and project- and consider that what she was projecting

was a reflection on her husband and her household. So in effect it sort of flows through there. She's helping G do all of what G would want to do if she possessed her faculties, and all she would want to do would be to complement and highlight us.

. . . Because I still- I think that on some level she's judging her actions by what G would want if she possessed her faculties.

I can't really describe the one thing which makes them stick out more than anyone else, other than the fact that they truly cared about how she felt, and what she was feeling, and I think they always tried to project themselves in her position.

. . . it's like if I'm hurtin', in a way they're kinda hurtin'. And you can tell. And it makes any of that a lot easier.

Related to this sensitivity, and to the ability to let their guard down, compassionate health care workers were also described as indicating that they were listening by responding to what they heard:

Oh yeah, they listened to what you had to say, and uh, more importantly they will respond to it, instead of, you know, even if they- even if they like seem to listen to you, these people- because a lot of doctors will listen to you- these people, you know, they really take it to heart.

. . . and it was like she heard what I said, and you know, with this- instead of saying, "Here's this neck brace. Put it on. It will be the best thing for you." Instead, she said something to the effect of, "Well we could do this or we could do this. This will help you like this and what are your thoughts on it."

. . . They come in to listen to everything you say. And it's not like it just goes in one ear and out the other. They- you can tell they think about it- they respond to it, they try to help you, they're going to do whatever it takes to do what makes things right.

Theme 2. Above and Beyond

Participants distinguished between those tasks which were a part of the job of the health care worker and those which went above and beyond these job requirements. All compassionate events were described (in light of this theme) as involving an individual who was doing something that that individual "didn't have to do." This implies that the individual describing these events has certain expectations of the health care workers involved, and a sense of what specific actions are more than what is required of them. Consider the following descriptions of compassionate actions:

"She didn't have to"

. . . doing something out of the ordinary.

. . . somebody that you have a professional relationship with, I didn't expect that.

I think that's what the word compassion is, is treating others in the way that you want to be treated. And going above and beyond the call of duty.

. . . And that's my definition of compassion. When you, you know, take away from yourself and help others, even though it's not really necessary. You give part of yourself to somebody else. Unselfishly and not expecting anything in return.

And, even like after delivery, you know, some people could just go away and leave you alone but I remember the nurses always coming in and making sure, you know, "Are you feeling good?" "Do you need something?" "Can I help you?"

Just because I think that he was going out of his way just to call and, and to let you know that he was thinking about you. You know, and there's obviously so much other stuff going on. You know, there were other women who he had to see, I'm sure.

Further exemplifying this sense for what is required of a health care worker, consider the following distinction made between nurses and doctors:

Well, I don't think that it's the things that they do. But, you know, they obviously have different roles, so the doctor is going to come in and is going to say things to you. But he may say things to you in a more compassionate way than another doctor, maybe, but he is still not doing the same things that the nurse is doing. He has his own, his or her own role as being the doctor. And he can be compassionate in those ways. The nurses have their own roles, you know, being the nurses, and they can be compassionate in their own ways.

This interviewee then went on to distinguish doctors who go above and beyond from those who do not:

You know, like some of the doctors, a lot of them, would just admit the patient and wouldn't come in until the next day. But there are some doctors who would admit the patient and they would come as soon as the patient would come to the hospital, no matter what time it was. And those doctors are the ones that obviously the parents always loved, because they knew exactly what was going on and they felt that the doctor cared that their kid was in the hospital. And we always had complaints about the ones who admitted their patients from the doctor's office and wouldn't come in until the next day at six, or something, if that kid had been admitted the night before at six. So I think that just the little things like that too. Maybe a time thing with doctors.

And this interviewee also distinguished compassionate from non-compassionate nurses:

. . . a lot of the nurses there, the ones I would consider compassionate, would maybe, you know, if it was a slow day, we would go in there and watch a little tv with her, or play a game, or read to her, or, um, she loved to sing, and so just listen to her sing, you know, or something like that, just be in the room, spend a little extra time in there, because she was by herself all the time. Even though they have people at the hospital, you know, to come in and be there, and stuff

like that, just- because that, those are her friends, too, the people that work there, so I guess that's how I was distinguishing with, uh, --- who were her friends and who weren't her friends. The people who would come in and do a little bit extra and the people who would just do her meds and change her dressings and things like that.

Theme 3. Genuine Care and/or Respect

Genuine Care

A distinction was made between those who genuinely cared for the welfare of the other (compassionate actors), and those who were perceived as selfish or acting to achieve something other than the welfare of the patient (non-compassionate actors). The non-compassionate person was described as performing tasks because they were a required part of the job. The compassionate person was described as performing certain tasks because they "genuinely cared" about the patient for whom she was performing those tasks. Consider these examples of those who genuinely cared:

. . . they truly cared about how she felt, and what she was feeling, and I think they always tried to project themselves in her position. . .

. . . when I'm hurtin, she would be hurtin. . . and it's like they want to see you build and grow and get your leg bent another 5 degrees. And they are just really sincerely working towards it with you.

It just struck me that, that um, that they were just genuinely concerned . . .

It just seemed like he was- he was legitimately concerned about my well-being. Not just, "Well, I have another patient in the hospital. I'll have to check on them Monday when I do my rounds." He went out of his way. It just seemed that he was honestly concerned about how you were doing.

. . . honestly caring that I was- making sure that I understood that this was serious, and I needed to take care of myself, and he was going to do whatever it took to make sure that that was possible.

They do it happily and lovingly and openly, you know. And yet honestly.

Yeah, it's not, "This is just part of my job. I'm doing it, you know, because . . . " I think you pull that off for a little while, but you can't pull it off all the time if you genuinely don't feel that way. And I find the majority of the staff there genuinely do care about their patients. You know, how they're feeling, and what's going on in their lives, and whether anybody ever comes to see 'em, or whatever. . . I think to be compassionate, you have to genuinely feel that. I mean, it can't be, it can't be fake or superficial. It has to be something. . . Because if you don't genuinely feel that way, it's not going to come across that way. It's not going to come across as REAL compassion. You know, it comes across in a more fake, superficial way.

The compassionate actor was described as not merely meeting the needs of the patient, but also as showing a genuine interest in what the patient wanted or needed. The following examples are of the theme of genuine care and the theme of going above and beyond being given together:

I think that it's just the little things people do, just the little extra time that you might spend with each person, uh, to let them know that you really do care.

When you, you know, take away from yourself and help others, even though it's not really necessary. You give part of yourself to somebody else. Unselfishly and not expecting anything in return.

. . . they really sincerely want you to get better. They're not just, "Ok. Hurry up and get all of your leg-lifts done so I can get out of here." So, you know, they care, they want you to get better, they'll do anything to help you. Just like they actually care, instead of, just doing their job like a robot.

Selfishness; Self-Interest; Ulterior Motives⁴

Those who did not "genuinely care" for the patient were described as having other motivations for their actions. Present participants noted that it was important to know why someone was doing something. This was said to be because having selfish motives or doing something only because it was part of the job would make it wrong to call such actions compassionate ones.

. . . well, there's a self-serving interest, and if that self-serving interest becomes overriding, then that's the purpose of the action, it's not some other compassionate act. That's not done under the guise of being a compassionate act.

The following participant described an experience of emergency room personnel. The reason given for not describing them as compassionate was the possibility of their having a selfish motive:

Then again, as ER people, there's an immediate gratification that you get when people come in. . . "Hold this, do this, do this," you tell them what to do, you're in command, you're cool, you're cool under fire. That's instant gratification off of that. So, that, that, that doesn't necessary qualify as our necessary pragmatic compassion, necessarily, but it could. But not necessarily. Because there is that immediate gratification that you get. And, and there is something gratifying about being the cool head among others that are not.

This participant also described his decision to put his dog to sleep as an example of the distinction between acting

⁴These are the terms used by those interviewed to describe the non-compassionate individual.

for the best interests of the other and acting in one's own best interests:

Because I felt like, to- he had lymphoma- lymphatic cancer, and to keep him around beyond the point when he could service himself was only- I was only keepin' him around for my benefit anyway. So the selfish thing to do would be to keep him around until he dies. The compassionate thing to do was to end his suffering, cause his life quality had gotten below a point to where he could even service himself.

As an example of an ulterior motive, the participant spoke of the possibility of receiving compassionate treatment because of her mother's position as an administrator in the hospital:

And I don't know how much of it was because he knew my parents, or how much of it was just really him. Cause my mom is fairly high up in the hospital in NAME, she's the nursing administrator, so I know that a lot of people do know her, and kind of maybe treat us differently, my sister and I, than someone else.

In this example, a health care worker is described as not caring "one way or the other."

Well, I think that if the compassion is not genuine over a period of time, it would not come across as genuine. It would come across as, "Oh, well, they're just doing this because it's part of their job." It's not like they really care one way or the other whether you're cold. This is my job, I'm supposed to ask if you're cold. If you're cold, fine. If you're not, ok. It's not like it really makes any difference one way or the other whether the patient is comfortable or happy.

The following description is about a nursing home, and includes an elaboration upon the difference between one who genuinely cares about her patients and one who does not:

Because somebody who was not aware of the patient's emotional needs could see that they're clean, they're dry, they're fed, but as far as feeling comfortable with their surroundings- or whether they like peach pie or cherry pie, yeah they both sustain life, but maybe that patient doesn't like cherries! She prefers peach. My mother prefers chocolate ice cream. They see that she gets chocolate ice cream. You know, and if she wants more than one, and it's not against her diet, or whatever, she can have more than one. But those are the kinds of things, of letting them have things that they want. Those kinds of things I think fulfill the part of the emotional need, you know, knowing that somebody genuinely cares whether you get cherry pie or peach pie. And I think it takes a compassionate person. Because if you don't have any compassion, you know, what do you care? You know, whether they have cherry pie or peach pie. They got pie, what more do they want? You know, that type attitude.

And the same interviewee describes a nursing home in which her mother stayed and where people just did not care.

. . . And of course this is the second nursing home she's been in. Whereas the last one, the first one she was in, they almost let her die. You know, because it was like, "Oh yeah, her fever's broke." She'd almost died of pneumonia. She would have been dead in twenty-four hours. You know, "Oh. Her fever's broke, she's just sweatin'." You know, it's like, "We don't really care, she's just an old lady." And I'm goin', "I don't care if she's an old lady or a dog, she deserves a little bit of care, a little bit of concern."

Respect

Some interviewed spoke of respect instead of or in addition to genuine care. In citing respect, some described the experience of being on a "level" relative to the health care worker:

Everybody has their own lifestyle, and so, you know, you're still my friend, you know, I'll still help you . . . And I think that you have to talk to people, like really have conversations with them, to get to that

level.

This respect also includes a certain type of treatment in light of the vulnerable position of the other. Here a home health care nurse is described as respecting an elderly woman with advanced Parkinson's disease:

. . . she seems to just give up her emotions, she really cares what G thinks, and takes the extra time to not be patronizing. But when she's held up in a tic, she might be--her mind might be somewhere that makes total sense, and P seems to go to great lengths to afford her the dignity that she would want if she possessed all of her faculties. . .

Consider this account from a man who remembers back to when he was a child, and his mother's oncologist speaking with him about his mother's condition:

. . . because he actually respected me as a person. In terms of, you know, he knew that some kids didn't know exactly what was going on. He actually took the time. He took time to show me and my sister what was going on. What happened, what the disease was, and so forth.

Relating "respect" to the theme of going "above and beyond" rational expectations or requirements, here the same participant continues his description of the oncologist:

Most of the time it seems like the doctor talks to the husband, or takes the parents aside. You know, they're the ones who talk about it. But it, I guess it was that he actually made a point to talk to us. You know, he could have just said, "Oh, by the way, tell your children." Which may or may not have happened. But he knew the point to actually bring us in and tell us what was going on.

You can "Just Tell" who Genuinely Cares

When speaking of those who acted compassionately and those who did not, participants indicated that they could "just tell" who was genuinely concerned and who was not.

The following is an example of being able to "just tell" from a student-nurse who worked in a children's hospital.

I think that they just take more time talking to the people, or reassuring them that things are going to be ok, you know, maybe answering the question over and over again, and not getting huffy with them, you know, saying, "I've already told you this eight times." You know. Just those kinds of things. Just little things, but just their whole demeanor makes that different. Or if they don't go in there rushed every time they hit the door- if they're just in that room, and not thinking about, maybe, the six other patients that they have. Just, um, focusing on who's there at that time. I would say that's the big thing in between nurses, because some of them just go in, they come in for their twelve hour shift and they want to go. And that's it. And then some of them you can tell, they're there, but they're really there. They care about each room they go into. They may like some more than others, but they care what happens ultimately to each one.

You know. When you have to spend a lot of time in the hospital and doing all of this stuff, is painful as can be. And when you know there's people there helping you, like they do, and um there for you, and you can just tell that they genuinely care. Then it's- you know, it made my job as a patient, my recovery from physical therapy and everything- much easier and quicker, and uh, from, I guess, mental aspect, it kept me in much better spirits.

And the patients know whether you really mean what you are saying or you're doing it as a part of your job.

Conclusion

A compassionate event was described in a way similar to the way in which all close relationships are described. Specifically, the actor involved is described as going above

and beyond what is expected by the person who is describing the action, feeling and understanding what the patient feels and understands, and genuinely caring and/or respecting the patient. These results will be used in Part 2, where the proposal to teach medical students to care compassionately for their patients reflects these three themes and specifically the appropriate behaviors involved.

PART TWO

DEVELOPING AN EXPLICIT METHODOLOGY FOR TRAINING
MEDICAL STUDENTS TO CARE COMPASSIONATELY

Chapter 4

Medical Education and the Attention Given to the Ability to Compassionately Care

"What is the moral status of this action (or policy for action)?," . . . "What traits and capacities ought I to develop and express as a physician, nurse, bioethicist, or teacher who must engage with and care for others?" These questions introduce the need for a rich moral vocabulary, of the ability to address issues of character and virtue as well as right action. They also suggest that bioethical education and focus would, at its best, be aimed at developing and exploring not only intellectual skills and moral theoretical knowledge but the whole character of the health professional.¹

Given that the argument I made in Chapter Two is sound (concluding that medical practitioners should be able to act compassionately towards their patients), the ability of medical students to practice compassionately should be targeted by admissions criteria and explicitly developed in medical training. In this chapter I consider admissions criteria and methods of training used in medical schools and post-graduate years. I argue that the admissions process for entering medical school is focused almost exclusively on the technological and scientific ability of those who apply, virtually to the exclusion of the compassionate ability of the candidates. I next consider clinical training and the "hidden curriculum" held to be primarily responsible for the development of medical students' interpersonal skills. This hidden curriculum is a poor substitute for explicit and intentional character training, as it is contingent on many

¹Carse, 101.

different variables and includes no explicit measurement.

I conclude that it is not the intention of clinical training programs to instill in medical students the ability to treat patients in a compassionate way. Instead, there is a socialization of the medical student which includes learning how to detach herself emotionally from the suffering of others, even though such learning is not morally justified or explicitly considered in light of the character of the medical student which is being fostered.

The Recruitment Process.

Are The "Moral Compasses" of Applicants to Medical School Checked?

The admissions criteria for medical school largely focus on intellectual capacity as measured through test scores and grade point averages of the candidates. This criteria omits an explicit focus on their interpersonal, practical or artistic ability.

With the exception of the personal interview, the basis for admission has little to do with anything other than test scores and grades reflective of the intellectual processing of highly technical sciences.²

At most there will be a brief meeting between the candidate and representatives of the medical school. However, given that the applicant will likely present herself in a way that will reflect what she thinks the admissions committee is looking for, it is not clear whether one can get an accurate

²DiBartola, 27.

idea of the moral character of the applicant in such a way.³

Nowhere in the admission process is there a basis for evaluating one's level of compassion, integrity, respect for the rights of others, creativity, caring or empathy (Downie, 1992). In an analysis of the selection and training of medical students, Coombs (1991) states that traditional medical education has been skewed by a selection process that narrowly selects medical students from among those who, because of a single-minded pursuit of admission, may lack the breadth of interests and the social experiences necessary for the development of a socially sensitive and emotionally mature personality. The typical recruitment process favors applicants who are emotionally inexpressive, grade-conscious, competitive and narrowly specialized in science (Coombs, 1991). They are intellectual rather than broadly experienced, and trust in a hard science quantifying approach that disregards less readily measurable psychosocial factors such as feelings (Coombs, 1991).⁴

This narrow focus on the theoretical ability of applicants implies that medical schools are looking for those

³Hafferty and Franks note: "Applicants craft an admission biography that includes appropriate justifications for their decision to enter medicine and an acceptable vocabulary of motives."

(Frederic W. Hafferty & Ronald Franks, "The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education" Academic Medicine 69;11 (Nov 1994): 865).

It is important to note here that the interview process can vary quite a lot, depending upon who interviews the candidates and what criteria are used in evaluating the candidates. To eliminate biases of health care workers doing the interviewing, professional interviewers should be considered.

The recent President's Address of the AAMC includes a suggestion that incorporation of a consideration of the character of the applicant promises to be done efficiently by first screening the candidates who do not meet the academic and MCAT requirements, and then focus on the character of applicants to make choices from there (see Cohen, 1997).

⁴Ibid.

with the potential to be scientists, not those with the potential to be compassionate medical practitioners. If the latter were the goal, one would expect to find in the admissions criteria an intentional, explicit, and rigorous method of focusing on the character of the individual applying to medical school. A focus on the moral character of the candidate would be one designed specifically to expose the personality or disposition of the candidate.

As an example of such explicit and intentional criteria, Rezler and Flaherty propose the following guidelines to be used in testing the interpersonal ability of applicants:

1. Delineation of qualities which contribute to clinical performance;
2. Definition of concrete behaviors which reflect the presence of each quality;
3. Definition of selection standards based on these behaviors;
4. Selection of methods best suited to assess these behaviors;
5. Sorting applicants into three groups based on predefined standards: (a) superior, (b) average, and (c) least desirable.⁵

Interest inventories and personality tests also promise to provide helpful ways of evaluating the interpersonal

⁵Agnes G. Rezler & Joseph A. Flaherty, The Interpersonal Dimension in Medical Education (New York: Springer Publishing Company, 1985), 7-9.

disposition of applicants.⁶ Measures of compassionate and empathic ability should be considered in their own right and as a basis on which to develop new methods of selection regarding such interpersonal skills.⁷

The admissions process is one possible place to increase the number of compassionate health care workers. Further, for those who consider the ability to act morally and compassionately as either something with which we are born or which can not be changed once it is instilled (as a product of early childhood learning and experience), the application and admissions process may be the only place to ensure that medical students have the ability to practice compassionately. Hafferty and Franks state that this belief (the second of four they consider) is one commonly held by those who represent medical education:

The second belief, well entrenched in the culture of medicine. . . is that. . . one's moral character basically is established prior to entry into medical school and that course materials or even an entire curriculum will not decisively reshape a student's personality or ensure ethical conduct in the future.⁸

⁶ In light of the critics of such approaches, Rezler and Flaherty point out that:

In view of the very low acceptability of personality tests, their widespread use in selection to medical school is unlikely. Nevertheless, it may be useful to review information from research studies regarding their potential contribution to selection. (Rezler and Flaherty, 18)

⁷see Hogan, (1969); Elstein & Teitelbaum, (1974).

⁸Hafferty & Franks, 862.

Rezler similarly reflects this belief: "Applicants to medical school who don't have such interests (in people's problems) and don't possess interpersonal skills rarely develop them in medical school."⁹ Of course, this is quite understandable, given the rigorous course-load taken by the medical student.

The import of considering the interpersonal skill of applicants to medical school was emphasized in the recently delivered President's Address of the AAMC (Oct 31-Nov 6, 1997):

. . . we can minimize the risks of having to deal with students who have hopelessly deviant moral compasses in the first place, and, just as important, we can maximize the chances of having to deal only with those whose moral compasses require little further adjustment. We can do so by establishing among our admission criteria an absolute requirement that matriculants to our schools evidence the moral and ethical grounding prerequisite to achieving our high standards of professionalism.¹⁰

If it is believed that moral character is fully developed before entering medical school, then changing the admissions process seems the only realistic way to increase the number of compassionate health care workers.¹¹ Regardless of whether

⁹Agnes G. Rezler, "Personal Qualities and Admission," in The Interpersonal Dimension in Medical Education, ed. Agnes Rezler and Joseph A. Flaherty, (New York: Springer Publishing Company, 1985), 2.

¹⁰Cohen, 136.

¹¹This view about the origins of our disposition should not be viewed as necessary in order for one to be in favor of focusing on the character of applicants in the admissions process. Those who believe that we continually learn how to behave in different ways after childhood and throughout life

this view is accepted or not, consider that there are also several practical benefits for developing an explicit component of the admissions process which focuses on the moral character of an applicant.

First, such a focus promises to increase the number of those who intend to pursue general or family practice, and who are also suited to such practice by virtue of their strong moral characters. Such students should be encouraged to continue developing their strong interpersonal skills and tendency to focus on the suffering of human beings in learning how to practice medicine in these and other fields where interpersonal skill especially enables the clinician.

A second benefit of admitting students for their moral strength of character is that such students will help to create an environment in which they both teach as well as learn from those medical students who are more theoretically and technologically inclined. That is, the distinction between the art and science of practicing medicine will be more apparent with the students who are skilled interpersonally and will likely promote discussion concerning clinical style. The overall student and resident consciousness on the art of practicing medicine (as well as that of current health care workers), and general awareness of (and specific utilization of) the power of a strong

may still agree that the disposition with which applicants enter medical school is a good predictor of the character which can reasonably be expected to be instilled.

interpersonal ability to alleviate suffering, will likely be beneficial to the understanding of the medical profession.

Thirdly, it seems that such students may be able to bridge many of the power-gaps which exist in the hierarchy of medicine. Instead of becoming more and more technical and scientific, thus separating each specialty farther and farther apart, the compassionate actor promises to utilize each of the different specialties (e.g., nursing, social work, clergy) in light of the goal of healing, and not merely treating, patients. Bridging gaps in this way will ultimately provide better and more comprehensive care for the patient, and a better understanding by health care workers of the various resources available.

Criticisms of and Responses to Revising the Admissions Process of Medical School

Although I've mentioned several benefits of changing the admissions process to include an explicit focus on the moral character of applicants, there are several criticisms of instituting such an admissions criterion.

First, the hypothesis which holds that the number of compassionate health care workers can be increased by instituting such an admissions criterion is difficult to prove. Such a claim will require a measurement device to determine who is compassionate and who is not, both upon beginning and completing medical school. The AAMC points out, in listing admissions requirements of medical schools, that:

The personal and social traits that medical school admission committees seek in prospective students are difficult to measure. Each school has its own standards and recognizes that the student who would be happy and productive in one school setting would not necessarily be so in another. Nonintellectual characteristics are usually evaluated by means of reports from undergraduate colleges, interviews, application forms, and autobiographical sketches. Few schools employ interest and personality inventories.¹²

For this critic, then, it will have to be shown that such a measurement device exists and that the device is reliable.

Second, candidates who are admitted for their moral character instead of their scientific ability may not be able to satisfy the scientific part of the curriculum. This scientific competency is thought to distinguish those who practice medicine as physicians from those who are healers of another sort.¹³ Once these character-candidates are in

¹²Association of American Medical Colleges. Medical School Admission Requirements. 1995-1996. (45th ed.) Washington, D.C.: AAMC, 27.

¹³see Gomez, et al., on clinical skills assessment:

"There was a lack of correlation between clinical skills scores and academic grades."

(J.M. Gomez, L. Priety, R. Pujol, T. Arbizu, L. Vilar, F. Pi, F. Borrell, J. Roma, J.M Martinez-Carretero, "Clinical skills assessment with standardized patients," Medical Education 31;2 (Mar 1997): 94.)

And also Jansen, et al., who show that those who may score well on written tests which demonstrate a medical understanding don't necessarily perform as well:

"However, correlations between scores on the written test and on the performance-based test were low for all skills."

(J.J. Jansen, A.J. Scherpbier, J.C. Metz, R.P. Grol, C.P. van-

medical school and unable to satisfy the scientific requirements of the curriculum, the issue for administrators will involve the decision of whether to weaken the technological and scientific parts of the curriculum so that these character-candidates can pass, or to simply fail those who can not make the grades (and, perhaps, whether to make the interpersonal component of training required, such that some of the students who are competent technologically would fail these courses). Weakening the scientific requirements would be a direct challenge to the integrity of medical school and a serious threat to those treated by medical practitioners who passed (certain) scientific and technological courses only because of weakened requirements. Failing these candidates, however, would likely be criticized by those who see moral value in caring compassionately for patients and in the changes in the medical school curriculum which reflect a seriousness about interpersonal ability. These critics would argue that those who formulate medical school criteria are not serious about training competent health care workers, workers who are interpersonally skilled as well as scientists.

A third criticism cites a slippery-slope problem which is likely to result from the new admissions criterion. This is that these character-candidates may find it harder to learn under the guise of the available role models, specifically the

der-Vleuten, J.J. Rethans, "Performance-based assessment in continuing medical education for general practitioners: construct validity" Medical Education 30;5 (Sept 1996): 339.)

attending physicians, who find the new admissions process a direct challenge to their competency in training residents in the practice of medicine. It may be argued that changing the admissions process is not enough. Given the terrific import of having the appropriate role-models for programs of disposition training, the training process will have to be changed after including interpersonal skill in the admissions criteria. It is argued that such a change in the admissions process would be the first step to a reformulation of medical school curricula. In light of such large-scale reformulation which would be initiated after the proposed change in the admissions process, it is argued by this critic that we must be sure that it is worth the effort.

In response to these criticisms, consider first that there are many ways in which to measure the interpersonal ability of applicants (including interest and personality inventories). Admittedly, there are not proven as "sure fire" ways to define the character of an applicant. However, this is to be expected, as such measurements have not thus far been disproved as to their effectiveness, and also because the character of an individual is an extremely complex thing to measure! Cohen urges those who admit applicants to medical school to judge character traits. . .

. . . not by vague impressions gathered through a brief interview, but by documented evidence of prior public service, of leadership, of experiences with volunteerism, of a penchant for self-sacrifice in the interest of others. How about garnering peer evaluations from college classmates and others who can comment from

personal experience about the applicant's suitability as a person for becoming a personal physician?¹⁴

Further, it seems common knowledge that students who excel in the first two years of medical school may not do so in the next two clinical years, and vice-versa. Rezler and Flaherty consider admissions processes which do not account for the possibility of students being good clinicians instead of good scientists as "discriminatory":

. . . medical faculty know from experience that students may get high grades in basic science courses and do poorly later, during the clinical years. The opposite may also occur. Both in fact were documented by Rhoads and colleagues (1974), who found that about half of the students excelled either during the first two or the last two years, but did not perform consistently throughout. If admission practices are validated only against grades in the basic sciences, this discriminates against students whose best performance occurs later.¹⁵

We do not know whether a modified admissions process would effectively produce more compassionate health care practitioners. This is for future research to show. However, those who are not convinced that such a change is necessary should consider seriously the many and highly significant values which will result potentially from health care workers who are trained to care compassionately for their patients. Furthermore, if this ability is necessary to the competent practice of medicine, then the question is not a matter of

¹⁴J.J. Cohen, "Leadership for medicine's promising future" Academic Medicine 73;2 (Feb 1998): 136.

¹⁵Rezler & Flaherty, 3-4.

whether or not admissions criteria should include more explicit attention to the moral character of candidates, but rather how it should do so.

In response to the second criticism, consider that "lowering" of standards in medical school admissions criteria is a derogatory way of characterizing such a change. Alternatives to such a characterization include "changing," "improving," "renovating," and "modifying." The skill of caring compassionately for patients is required for the competent practice of medicine. For that fact alone, a test for such skill should be incorporated into the criteria of medical school admissions.

Finally, in response to the slippery slope criticism, again note that once it is granted that the compassionate practice of medicine is morally required and a condition of clinical competence, the question becomes not one of whether we should change the admissions criteria, but rather how are we going to do so.

From Admissions to Training:
If it Isn't Initially Tested For, Then it Must Be Taught

By not paying much explicit attention to the moral character of the applicant to medical school, one may be led to conclude that medical educators believe one of three things:

i) practicing in a compassionate way is not important to the competency of health care practitioners

or

ii) compassionate ability can not be reliably detected in an admissions process

or

iii) compassionate behaviors are taught in medical school and in residency training

The first belief I have shown to be false, given the instrumental and intrinsic values promoted by so acting, what is involved in the art of practicing medicine, and the moral argument for practicing in a compassionate way (in Chapter Two). Some may argue that compassionate behavior, by the very rendering of it through the themes produced by my phenomenological interviews, is to go "above and beyond" or "over and above" what is required. By this argument, compassionate action is supererogatory, more than is morally required of the health care worker. Therefore, a competent physician does not necessarily behave compassionately towards his patients.

In response, note again that the primarily alternative to the compassionate relationship was the non-compassionate relationship. In this alternative relationship, the patient was not merely deprived of those values which are a part of the compassionate relationship, but was also harmed as a result of being treated non-compassionately. So in addition to the patient not receiving what he expects (given his vulnerability) in a non-compassionate relationship, the instrumental and intrinsic values promoted through emotional involvement are lost. Further emphasizing this duality between compassionate and non-compassionate health care

workers, note that participants who spoke of genuine care also said that they could "just tell" who cared genuinely and who did not. Those who did not care genuinely were at best described as "just doing their jobs," at worst "selfish" and "just not caring." Although this evidence is by no means absolute, there does seem to be a general dichotomy between health care workers who care compassionately for their patients and those who "care" in a non-compassionate way (thereby excluding a larger "grey area" between the two).

Interview 11, p.4

And would do anything for me. It's just incredible how different it is. Especially such a clear cut line, I mean I'm sure there's a lot of- I don't think anything in this world is just black and white. But from my experiences what sticks out- there's definitely a line. There definitely is a line. There definitely is one. That just sticks out in my mind from all the experiences I've had of doctors. And it's just amazing how, you know, how some of them care so much, and how some of them care so little.

The second belief seems to be unproven because of the number of viable ways available to detect interpersonal skill and specifically compassionate ability which can be used (as listed above). More research needs to be done before this statement can be adequately defended.

The third possible position is that the artistic ability is, in fact, being taught in medical schools and residency programs. Let us assume that medical schools do not give much consideration to the moral character of applicants because it is believed that students will be trained to be compassionate practitioners in medical school and post-graduate residency

programs. If it can be shown that these programs do, in fact, strengthen the moral character of students and residents, then the lack of focus on moral character in the admissions process will be (more) justifiable (although not thereby justified). However, if it is shown that medical training programs do not adequately equip trainees with the ability to care compassionately for their patients, then we will conclude that medical educators consider the ability to practice compassionately as either unimportant to the competency of a medical student or not reliably detected.

Clinical Training: Emotional Detachment and the "Hidden Curriculum" Used to Socialize Medical Students

As a general way of understanding the different skills ideally learned in medical education, consider the model of Coombs, which breaks the major areas of learning how to be a clinician into three basic concepts: the head, the hands, and the heart.

In addressing impaired affect as a result of medical education and training, Coombs (1991) presents a conceptual model of healthy professional development symbolized by three overlapping circles, each representing an interdependent competence vital to professional and personal effectiveness: "(1) mental discipline, the cognitive know-how for accurate diagnosis and appropriate interventions the head; (2) the manual skills necessary for clinical tests and procedures the hands; (3) the affective aspects of interpersonal care the heart" (p.540). Whereas complete physicians are competent in all three, impaired physicians are underdeveloped in one or more, typically the affect (Coombs, 1991). Traditional medical training emphasizes the head and hands and neglects the heart. A medical student's lifestyle can become imbalanced by the pursuit of excellence, and the constant effort to impress

colleagues. He states that the medical student is chronically overworked and preoccupied with work related matters and becomes physically and emotionally exhausted.¹⁶

Coombs points out that medical training is typically underdeveloped in affective aspects of interpersonal care and that medical students are exhausted emotionally. This "impaired affect" is, in part, the learned emotional detachment which is a major part of the hidden curriculum of medical school. Medical students have themselves expressed such concerns with the quality of the education they are receiving. Consider the following:

In July 1992, the Robert Wood Johnson Foundation published the results of a two-year study conducted in response to the mounting evidence of dissatisfaction with medical education reported in a 1989 Harris survey. The Foundation Commission on Medical Education summarized by noting that there are three primary reasons to validate major change in the medical education system. First is in regard to the process of learning. In the traditional system, students spend two years memorizing and then reproducing facts for written examinations. Aside from being demoralizing and counterproductive, most students report that they forget what they did learn shortly after the examination. Second, the clinical years are often spent in a mode of teaching by humiliation and abuse as medical interns spend countless hours, often three to four consecutive days and nights without sleep while they cover hospital rotations. And third, is the development of new realities that dictate for change in the process of medical education.¹⁷

Current programs of medical education do not explicitly

¹⁶DiBartola, 34; see R.H. Coombs, "Non-cognitive components in the selection and training of medical students," Medical Education 25;6 (Nov 1991): 539-541.

¹⁷DiBartola, 23-24.

train students to practice medicine compassionately. Nelson and Traub note that, "Although there is general agreement that the teaching of clinical procedures needs vast improvement, little appears to have been done to achieve this goal, particularly with regard to medical students."¹⁸

Medical students are taught what is and is not important to understand and be able to do primarily through what the medical school curriculum requires of them. Hafferty also points out that in the medical school environment there are at least. . .

. . . three interrelated spheres of influence: (1) the stated, intended, and formally offered and endorsed curriculum (e.g., the "this is what we do" curriculum); (2) an unscripted, predominantly ad hoc, and highly interpersonal form of teaching and learning that takes place among and between faculty and students (the informal curriculum); and (3) a set of influences that function at the level of organizational structure and culture (the hidden curriculum).¹⁹

As with the admissions criteria, so also in post-graduate training, required skills are largely technological and scientific, while what is considered as elective includes training to care compassionately for patients. Again, the message is that it is intellectual know-how and diagnostic ability which is essence of the practice of medicine.

¹⁸M.S. Nelson & S. Traub, "Clinical skills training of U.S. medical students," Academic Medicine 68;12 (Dec 1993): 926-8.

¹⁹Frederic W. Hafferty, "Beyond Curriculum Reform: Confronting Medicine's Hidden Curriculum," Academic Medicine 73;4 (Apr 1998): 404.

While clinical medicine is thought to have its own logic and set of skills, it continues to be modeled on biological science, and this model is rigorously inculcated in medical school and residency training (Rosenhan, 1970; Scriven, 1979, Sober, 1979). Though it is sometimes admitted that clinical judgment includes something like 'artistry', and that a "clinician may be 'scientific' only at certain moments" (Clouser, 1977, p.3), the view that clinical practice must be scientific is clearly dominant.²⁰

What is considered most important in medical training is apparent from the measures used to pass and fail medical students.²¹ The message is that an intellectual and diagnostic grasp is enough, even with mediocre interpersonal skills. Regarding the development of interpersonal skills, and specifically how to involve oneself emotionally in the care of her patients, consider that:

In regard to medical students' training, studies all point towards one continually documented theme: how medical school socializes students to view emotions- both their own and patients'- as obstacles to the practice of medicine.²²

Medical educators recognize that the medical student goes through a significant socialization process. An important part of this socialization process is the acquisition of values which enable the clinical student to become a

²⁰Richard M. Zaner, "Medicine and Dialogue," The Journal of Medicine and Philosophy 15 (1990): 305.

²¹One question which represents the import of the character of medical students and residents: Have there been medical students or residents who have been suspended or expelled from programs because of their moral failings?

²²Baker, et al. (1996), 174.

successful health care worker. The values of the health care worker seem primarily learned through their interactions with others who are also training to be health care workers (or are practicing health care workers who pose as models for the medical students).

For example, in a recent national study, medical school deans cited "role models" (by 82% of the responding deans), coursework (66%), and freshman orientation (59%) as the three major influences on their students' development of high professional standards.²³

The results of this study indicate that there is no explicit method of training medical students to develop their ability to care compassionately for their patients. It is questionable that role models can consistently train medical students to practice in a compassionate way, given the variation of their own philosophies of medicine as well as there being no explicit tests of the moral character of these medical students. Regardless, role models are a major purveyor of values to the medical student.²⁴ And relevant to learning how to care compassionately for patients, a major part of the interpersonal disposition taught in medical

²³Hafferty & Franks, 863.
[from J. Bickel, Promoting Medical Students' Ethical Development: A Resource Guide, (Washington, D.C.: Association of American Medical Colleges, 1993).]

²⁴Consider the following criticism: "Although the virtue of imparting ethical principles at the bedside and via role models is almost universally acclaimed, most advocates direct only a passing glance at the issue of how "objectively busy" clinicians can be counted on to adequately cover the important moral issues that appear omnipresent in clinical settings." (Hafferty and Franks, 867)

training is not to involve oneself emotionally and act compassionately in treating patients, but rather to become "unresponsive" and "increasingly detached."

The learned attributes of detached concern and emotional detachment referenced in the work of Hafferty (1991) as a learned survival skill for the physicians, often leads to a lack of compassion and empathy when interacting with patients. Bulger (1989), Lloyd and Gately (1991), refer to the depersonalization of medical education, medical practice, and patients, prevent the physician from communicating with compassion and empathy, as they lose sight of the person and focus on the disease or process.²⁵ In developing such a disposition, the tendency to perceive and compassionately respond to the suffering of a patient are seen as not necessary to, and perhaps even interfering with, the appropriate diagnosis and treatment of a patient.

Baker, et al. note:

What is critical here is that early in their careers medical students are taught to overcome or master their emotions rather than talk about or examine them in detail as important aspects of medical practice. Efforts to appear knowledgeable and in control may also carry over later into their actual practices when physicians exhibit an emotional stance of 'detached concern' (Fox 1963) in dealing with patients.²⁶

Many medical residents speak of losing their ability to act compassionately in treating their patients ("having it drummed out of them"). This loss is accepted as if it were simply a part of the secondary socialization of medical training. Consider the medical student cited here by DiBartola as exemplifying this attitude:

In the regular column A Piece of My Mind featured in The Journal of the American Medical Association, a third

²⁵DiBartola, 80-81.

²⁶Baker, et al. (1996), 175.

year medical student writes an article titled Self Defense. In the column she describes her dilemma, which she says is universal to all current clinical students, of remaining empathetic. She describes how her response to a dying man who no longer looked human due to the blood oozing from lesions all over his body, went from an initial care, concern and empathy, to becoming unresponsive to his incessant cries. She states that the patient's plea for understanding and compassion drew her increasingly detached and inexpressive because she felt she had no hope to offer him, and thought she had to withdraw in order to deal with his pain and impending death.²⁷

Instead of learning how to help patients with their suffering, medical students are taught how to protect themselves from such suffering. This seems to relate also to how they learn to appear knowledgeable to those evaluating them as well as to their patients.

Developing a 'cloak of competence' is perhaps the key task facing medical students. . . appearing knowledgeable is paramount, even if one does not really know the answer to the question being posed. They adopt a strategy to 'mask their uncertainty and anxiety with an image of self-confidence. Image making becomes recognized as being as important as technical competence.'²⁸

Once in school, they learn to value detachment, cope with uncertainty, develop strategies and rationales for ameliorating ambiguity, and structure issues of clinical responsibility.²⁹

Those who claim to have their ability to care compassionately "drummed out of them" may not actually be victims of such a loss. Childhood socialization is quite

²⁷DiBartola, 32-33.

²⁸Baker, et al. (1996), 174.

²⁹Hafferty & Franks, 865.

strong and not easily overcome through a secondary socialization (e.g., medical school training). The strength of the initial socialization has both positive and negative consequences for medical education: positive, in that compassionate medical practice promises to be increased significantly with a focus in admissions on those who have displayed a virtuous disposition; negative, in that those who are currently recruited as adept theoretically and lacking interpersonally do not have a strong empathetic or compassionate ability to begin with.

In medical training, if the student was being taught how to foster compassionate relationships with her patients, then she would be required to experience the suffering of her patients. Such experience must be understood as necessary to the art of medicine.

Above, the medical school deans surveyed about medical education and medical students' learning of "high professional standards," cited (in addition to role models) coursework. Some medical programs have recognized the import of teaching medical students the art of practicing medicine. As a result, they have developed courses (many of them electives) for interested students to take. However, what results from not requiring the development of specific interpersonal skills (e.g., a sensitivity for ethically salient features of health care situations) is that such development is not considered necessary to practicing medicine. Consider the second-class

status which such courses are seen as having through such incorporation into medical school curricula:

While many appear to recognize (although perhaps only rhetorically so) that moral considerations are as much a part of medical decisions as technical considerations, most medical schools (and faculty) appear satisfied to locate the content and teaching of medical ethics as a second-order priority relegated to odd hours in the formal curriculum. It therefore should not be surprising to encounter both medical students and faculty who come to view ethics as a "clinical tool" composed largely of discrete pieces of technical information and/or skills.³⁰

And also,

. . . ethics becomes "just another course," usually offered for the wrong reasons and usually at a time when it is least likely to interfere with other, "more important" subjects. If left to this fate, ethics becomes a peripheral curiosity. . . Rather than guiding the study and practice of medicine, ethics can become a tool for the furtherance of goals and policies that ultimately are structured without reference to ethical precepts.³¹

Learning how to behave in an ethical way, like learning how to care compassionately for patients, requires more than a mere elective course or seminar, but rather an on-going evaluation and reflection upon specific behaviors taken in health care situations throughout medical training. It requires that medical students learn how to care compassionately for their patients. Learning how to practice in such a way requires more than mere intellectual learning. It also requires the cultivation of a moral character through

³⁰Hafferty & Franks, 867.

³¹Hafferty & Franks, 866.

actual practice. Given the type of training which is required to develop the ability to practice compassionately (and morally), incorporating ethics-courses into medical school curricula which are limited to a theoretical understanding only reinforces the misleading view that ethics is a type of knowledge.

In spite of the wide-spread attention accorded matters of ethics and medicine in recent calls for educational reform, the prevailing sentiment, at least within the basic science faculty of medical schools, is a rather limited and task-oriented view of ethics, a view in which ethics exists as a tool and therefore as something external to the core of medical practice and the physician's identity.³²

And also,

. . . medical training involves considerably more than the acquisition of a new knowledge base. It also involves learning new rules about feelings and about mistakes and the management of failure.³³

Fostering a compassionate disposition requires an environment in which the student can actually try to take suffering seriously. The strict demand for this ability has to be conveyed to the student from the start in the admissions process, and something developed as a part of a life-long practice.

The desire to offer hope to another human being is not fostered as an important part of medical practice. What results are serious negative effects for the health care

³²Hafferty & Franks, 864.

³³Hafferty & Franks, 865.

relationships subsequently formed:

We argue that this distanced "professional" stance also undermines physicians' ability to be fair, fitting, and optimally effective in their practice. We are unconvinced by claims that adopting a stance of neutrality or "objectivity" toward patients will minimize diagnostic and therapeutic errors or the prejudicial effects of race, gender, and social class. More often, such "objectivity" obscures recognition of the patient as person and hides the effects of prejudice (whether about gender, class, race, or ethnicity). In the long run, attempts to bridge such distances and differences make for better medicine than retreating to a distanced objectivity. Overcoming these distances also provides the sense of connection with patients that is typically a source of deep satisfaction and fulfillment for most physicians.³⁴

Medical educators who do not encourage emotional involvement as an integral part of developing students' clinical skills may defend this way of training on the following grounds (assuming that they do believe that the ability to practice in a compassionate way can be taught):

- i) There is no better way of preparing medical practitioners to treat the massive number of patients to which they will likely be subject.
- ii) This type of training will best prepare them for employment in a managed care health care environment.
- iii) This method of treating has been efficient and effective in the past.

The first and second grounds seem to be rational and responsible points in light of the stark reality of the

³⁴Code, 5.

current health care situation in the U.S. A utilitarian justification for not instilling in medical students and residents the ability to care compassionately is the following. Even though training medical students and residents to practice in a non-compassionate practice may strike us intuitively wrong, we can allow for such a "wrong" if performing it can help us avoid a greater wrong which we would suffer if we did not so perform. The greater wrong is the number of individuals who would go untreated as a result of caring compassionately for every patient who was treated.

In response, I again pose the question of whether students and residents who are not trained to practice in a compassionate way are competent as medical practitioners, artists as well as scientists? If not, then such training must be provided.³⁵ Also, it is not clear that we **are** avoiding a greater wrong by practicing in a non-compassionate way. As was argued in earlier chapters, patients who are not treated compassionately will be less likely to comply and may not seek medical attention until late in the illness process, while those who are treated in a compassionate way are more likely to comply and in the future seek medical attention in the early stages of a disease. Such programs, designed to train health care workers to meet a greater number of patients, may ironically result in an even larger number of

³⁵see Nicole Lurie, "Preparing Physicians for Practice in Managed Care Environments," Academic Medicine 71;10 (Oct 1996): 1044-1049.

unsatisfied, noncompliant, and unhealthy patients.

The final ground for defending the current medical training program is the argument that it is the traditional way of training. Admittedly tradition and becoming a part of a guild larger than oneself is an empowering experience. Health care workers are involved with patients who have illness and diseases which threaten the continued enjoyment of their chosen lifestyles. In such situations, patients may view health care workers as more than mortal, able to preserve life. As more than mortal, it may be argued that the physician is to impose diagnoses and treatments upon patients, as it is in the patients' best interest. In assuming this paternalistic position, there seems no place for the ability to care compassionately for patients.

In response, consider that patients need to trust their health care providers. However, the state of medicine is becoming one in which there are more and more pressure to contain costs. This pressure can easily lead to forming impersonal relationships between patients and physicians. The assumption of paternalistic power by the physician brings with it the potential for many serious abuses in light of the pressure to contain costs. The negative effects of these abuses outweigh the positive effects of paternalistic practice by the physician. Furthermore, although the patient likely desires to be cured and healed, many will not satisfy this desire by submitting to a paternalistic physician. Many

patients seek a close relationship to share her vulnerabilities and in which to get medical help. Such a relationship is antithetical to the impersonal relationship of the paternalistic physician in which the patient is only a means to the end of satisfying their economically-conscious employer and to have a job themselves. Finally, regardless of the possible benefits of practicing paternalistically, the competent practice of medicine requires caring compassionately for the suffering of patients. Therefore, such practice can not be condoned for this reason alone.

Given the change in the way in which medicine is practiced, and the continuing emotional needs of vulnerable patients, it will be even harder for health care practitioners to invest themselves emotionally in the lives of their patients. It is up to medical education programs to train health care workers in their technological ability as well as their clinical skill. Medical schools must institute explicit curricula indicating how students and residents will be trained to be artists.

Power in Medical Practice: Language, Hierarchy, and Policy

As an example of a study designed to access the patient's experience, consider the "The Experience of Care Project" conducted at Penn State University Hospital. In this project, participant observers "accompanied patients and their families during hospital stays, in an effort to better understand the

experiences and perspectives of patients and families and to provide a collection of computerized narratives that (could) be used to examine problems in patient care."³⁶ As a result of this project, three types of patient dilemma were highlighted: "problems with (1) information flow, (2) false expectations, and (3) scheduling."³⁷ These all can be traced back to a general lack of compassionate care on the part of health care workers.

Consider the clinical event as a meeting of two people who speak different languages. People who speak different languages usually have a difficult time communicating with one another. Medical students learn a new language, a new way of defining events in the world. In learning a different language, they are separating themselves from their patients, as the latter use different words and ways of describing the same phenomenon. Without attention to the moral character and the import of caring compassionately for patients, it will be more easy to impose this language upon patients. The medical language and its precise nature, the strong tradition of granting those who are competent in using it both epistemic priority and paternalistic power regarding others' health, and the price that the public is willing to pay for its administration, may be seen as better than the lay-person's at

³⁶James McClenon, "The Experience of Care Project: Students as Participant Observers in the Hospital Setting," Academic Medicine 71:8 (Aug, 1996): 923-929.

³⁷McClenon, 925.

describing an illness or disease. Such an assumption has serious consequences for the way in which the practitioner will treat the patient in the clinical event.

To practice in a compassionate way, the medical practitioner must relinquish his absolute power to define the illness or disease according to medical language alone. The illness is, if anyone's, the patient's to define. If the medical curriculum is teaching the medical language without acknowledging that it is a language, not **the** language, to describe the physical condition, then the curriculum is producing health care workers who are imposing their words and technologies on vulnerable patients, people who may neither understand nor appreciate the implications of such labeling and treatment, and such treatment may pose a serious threat to their future self-sufficiency.

Consider the non-controversial assumption that students who gain admission to a program of medical education want to do well. Further, consider that in medical education doing well is largely measured by the satisfaction of teachers with whom the student is working. This brings to light another major potential hinderance of developing the ability to care compassionately: the hierarchy which exists in medical practice, and the impact which this hierarchy will have on the students who will be submitted to it during clinical training.

The attending physicians represent the top of the hierarchy, routinely leading flocks of residents through

morning rounds, testing the residents in their ability to categorize various patients, positively reinforcing those who get to the essence of the patients' ailments, all while ordering social service workers, nurses, and rehabilitation workers to perform different services for these patients.³⁸ As such physicians are obviously considered to be in control, it is not difficult to conclude that if they categorize patients impersonally, as nothing more than objects to be fixed and rotated back out into the world, that it is quite likely that residents will also practice in this way.³⁹ This can become a serious problem in the case where such a role-model gains a significant following of students.⁴⁰ There seems little doubt to the onlooker of this process that it is the physicians who have the power, as the rest of the health care workers perform their services only after receiving their orders from the physician in charge. Even if a health care worker "lower on the medical totem pole" is able to influence or prompt the judgment of the attending physician, the point

³⁸Whether the hospital administrator or insurance company is actually the top of the hierarchy will not be discussed here, although the prospects for so arguing are acknowledged.

³⁹The significance of role models for learning how to practice medicine in a compassionate way will be further discussed in Chapter 6.

⁴⁰In medical school, Wright, et al., have noted that, "Exposure to role models in a particular clinical field is strongly associated with medical students' choice of clinical field for residency training." (S. Wright, A. Wong, & C. Newill, "The impact of role models on medical students," Journal of General Internal Medicine 12;1 (Jan 1997): 53-6.)

remains- the attending physician has the power and responsibility for the care of patients.

The mere existence of such a hierarchy invites impersonal and dehumanizing treatment (regardless of the positive benefits cited for its existence). In such a hierarchy, people are apt to be characterized according to their roles or job titles, and these job titles dictate the amount of respect any given individual deserves in the medical arena. Treatment of others according to their role and status can also have implications for the treatment of patients. Such treatment has a negative effect on providing an environment in which patients are treated routinely in a compassionate way.

In addition to the negative effect which a physician's practice can have on the habits developed by residents, there is a major indirect effect of his practicing in a non-compassionate way. If physicians who are adept theoretically but lacking in compassionate ability are making all of the orders, then the impact of those health care workers who are compassionate and attentive to the suffering of patients will be minimized, as i) their compassionate services will not be regularly utilized, as such physicians do not recognize the important part which fostering compassionate relationships plays (to address the suffering of patients- that is, the art of medicine), and therefore do not regularly consider the suffering of patients, ii) those health care workers who are able to practice compassionately may, in doing what

compassionate care deems appropriate, act in opposition to the physician's orders.

Acting in a way which is not consistent with policy is itself grounds for suspension or dismissal. The implicit message is that hospital employees must follow the policies at all times, even if a specific human being will be harmed by that policy. A compassionate health care worker can not operate under such a system. Treating competently these unique individuals calls for caring compassionately for them, regardless of whether such treatment breaks policy. And although it may not be right for compassionate health care workers to simply break hospital policy as they see fit, the point is that there must be some explicit consideration of such situations and how they are handled, in light of the best interests of patients and their having compassionate health care.

Being faced with the brute reality of hierarchy in medical practice is crucial in the interpersonal development of the health care worker. In situations where acting compassionately would break hospital policy, the health care worker can either accept the morality of impersonal practice and follow policy in an absolute way, or do what he thinks is the right thing to do, even when this breaks the policy. There are no clear answers here, but rather a serious moral dilemma. This dilemma should be explicitly considered by those who are being trained to be health care workers.

Conclusion

The major problem of allowing depersonalized practice is that practicing medicine with such emotional detachment puts into question the nature of the practice itself. If the practice of medicine is an art which includes a consideration of the specific values and goals of the people being treated, then practicing in an emotionally detached way would seem to severely limit the artistic ability of the practitioner. The individual who is emotionally detached is arguably no longer practicing medicine, but rather attempting to "fix" the patient.

The above consideration of medical education supports the need for more attention in medical education to developing the ability of students to care compassionately care for patients (what Coombs here refers to as "the heart").

. . . if doctors do not have high standards of professionalism--altruism, respect, compassion, honesty, integrity, and others--medicine's very survival is threatened. Medical educators must insist that their graduates demonstrate these attributes, through more careful admission criteria, more attention to medical professionalism in the curriculum and in the evaluation of students, more community service for students, and improved role modeling by faculty.⁴¹

The next two chapters, in response to the lack of adequate training methods in clinical skills, especially with regards to compassionately caring for patients, propose a two-stage program of developing the artistic and compassionate ability of students who are learning how to practice medicine.

⁴¹Cohen, 132.

Chapter 5

Examining a Health Care Worker's Ability to Care Compassionately: A Program of Self-Assessment Based on Emotional Experience

There is now widespread recognition of a shifting health paradigm. This has resulted in demand for a more comprehensive and better integrated approach to medical education, with corresponding avoidance of a curriculum driven by factual content and dominated by departmental rivalries over core knowledge. Instead, the emphasis is likely to be placed increasingly on the encouragement of a spirit of enquiry, guided by recognition of the importance of evidence both from basic medical sciences and social sciences relevant to health practice.¹

Because physicians use themselves as instruments of diagnosis and therapy, personal awareness can help them to "calibrate their instruments," using themselves more effectively in these capacities.²

By virtue of the lack of focus on the moral character of the medical school applicant, and the lack of explicit focus in clinical training on the development of the student's moral character and ability to practice compassionately, I propose a two-level training program. This program is one which is intended to instill in medical students the ability to care compassionately for their patients. It includes the student's reflection on and characterization of medical practice, an understanding of emotional behavior and the integral moral place of emotional interaction, and the instrumental and intrinsic value of caring compassionately for patients.

¹S.M. MacLeod, & H.N. McCullouch, "Social Science Education as a Component of Medical Training," Social Science and Medicine, 39;9 (1994): 1371.

²Novack et al., 502.

Acquiring an Appreciation for the Art of Medical Practice

. . . educators routinely acknowledge that the overall process of education is a form of socialization and that all socialization involves a moral dimension. . . The basic issue is not one of ridding the environment of "contaminating" values or elements but rather one of recognizing their presence and working with them--including taking steps to counter whatever elements are deemed (at the time) to be unwarranted or undesirable.³

Learning how to care compassionately for patients must be an on-going development in the training of the medical students. Medical practitioners should be required to develop the interpersonal skills necessary to practice medicine in a competent way. Such development is rightly considered as an inseparable part of the clinical training process, rightly evaluated and developed at the bedside.

The student must understand his unique characteristics and style. Some in the medical community have recognized the importance of attending to students' own self-conceptions and ability to evaluate their own clinical style. Nairn, et al., propose a method which they call the "Behaviour Change Project," which involves medical students "changing a self-identified aspect of their own behaviour." The authors indicate that "most students. . . found (the project) helpful in some way, particularly in learning about their own behaviour and the processes of behaviour change."⁴ However,

³Hafferty & Franks, 863.

⁴R.G. Nairn, J.H. Coverdale, & G.S. Elkind, "Teaching the principles of behaviour change to medical students: evaluation of a programme," Medical Education 29;6 (Nov 1995): 443-8. see also J. Bligh, "The clinical skills unit," Postgraduate

the overall lack in programs to specifically assess and train the moral and compassionate character of clinical students may be a result of the perceived lack of effective methods for evaluating moral character.

In relation to the effects of education on attitudes and affect, Gonnellar and Zeleznik (1983) state that the affective domain is probably the most difficult area to address in medical education, even though "inappropriate attitudes may represent the greatest source of professional incompetence and poor performance."⁵

Devising a specific way of measuring the interpersonal ability of medical students poses a serious challenge to those who consider such ability as necessary to the competent practice of medicine. In light of this problem, consider the following:

Empathy has been revered as the human quality of being able to identify with another person and understand their feelings. Most would agree that this is a quality that would be of paramount importance in the field of medicine; however, as stated by Evans, Stanley and Burrows (1993) "two facets of medical education limit students' development of empathy: the traditional format of intervening training; and the social ethos of medical training that stress clinical detachment" (p.121). . . . To counter this problem, training courses for medical students have been developed with the goal to improve their empathy. Though there is debate as to whether empathy can be taught or effectively measured, Evans and others (1993) conducted a study that measured students' empathy skills before and after participation in training workshops. The results of their study indicated there was no difference of scores before and after the workshops. The authors reported that "the cognitive, affective and behavioral dimensions of empathy may be such that a single empathy test cannot measure changes in students' understanding, motivation and behavior"

Medical Journal 71;842 (Dec 1995): 730-2.

⁵DiBartola, 35.

(Evans and others, 1993, p.131).⁶

Other research done on development of medical students' interpersonal skills similarly points to a difficulty in measuring the ability to care compassionately. Noel, et al., proposed the use of a structured form and videotape of patient workups to evaluate the clinical skills of the participants. One major finding is that "participants disagreed markedly about the residents' overall clinical competence."⁷ These researchers concluded that, "A structured form improved the accuracy of observations of clinical skills, but faculty still disagreed in their assessments of clinical competence."⁸ Others have found that there is not a strong correlation between the academic grades of students and their clinical training scores.⁹

This inability to test for clinical and interpersonal skill should be expected, given that such testing in the medical school context is rather novel. I share in Hafferty's optimism about the initiation of such programs:

The current move to structure evaluation efforts

⁶B.J. Evans, R.O. Stanley, & G.D. Burrows, "Measuring medical students' empathy skills," British Journal of Medical Psychology 66 (1993): 121-133.

⁷G.L. Noel, J.E. Herbers Jr., M.P. Caplow, G.S. Cooper, L.N. Pangaro, & J. Harvey. "How Well Do Internal Medicine Faculty Members Evaluate the Clinical Skills of Residents?," Annals of Internal Medicine 117;9 (Nov 1 1992): 764.

⁸Ibid.

⁹see Rezler & Flaherty, 3-4.

around competencies ("what we produce") rather than around courses and coursework ("what we do") is an extremely positive step.¹⁰

It is not clear that a system which trains and tests the student's interpersonal skills has been adequately tested to support an argument against their predictability and reliability. However, a possible way of distinguishing the interpersonally competent from the incompetent is suggested by the phenomenological interviews conducted in Chapter 3. Remember that those interviewed spoke of being able to "just tell" who cared genuinely. Further, the clear line between those health care workers who were considered to be compassionate and those who were not indicates not only that patient satisfaction may be a neglected yet effective way of evaluating clinical (and interpersonal) skill¹¹, but also that there may be some potentially reliable way of "just telling" who would be artistically able as a medical practitioner (and who would not).

In a section titled, Relation of Ethics and Human Values to the Sciences of Medical Practice, of the Robert Wood Johnston Foundation Report, Medical Education in Transition, the importance of focusing on interpersonal ability in medical

¹⁰Hafferty, 407.

¹¹Considering the use of patients as evaluators of clinical skill, see:
F.J. Medio & S.J. Morewitz, "Four approaches to using patients to teach and evaluate clinical skills of residents, interns, and students," J Am Osteopath Assoc 92;11 (Nov 1992): 1433-6.

training is emphasized through four levels. Consider these levels in light of the general interpersonal ability I have been suggesting:

- Level 1: Personal integrity and the attitudes and traits of character that are compatible with being a physician. These include: honesty, dependability, truthfulness in acknowledging limitations, taking responsibility for mistakes and loyalty to the patient's best interest.
- Level 2: Empathetic and compassionate patient care. Compassion involves knowledge and insight into the personal experience of illness and the patient's social, psychological and spiritual resources; an awareness of strengths and hazards of using the physician's own person as a therapeutic agent; and personal and cultural understanding about death.
- Level 3: Value laden issues in the patient-doctor relationship and in the social, economic, and political contexts of medical care.
- Level 4: The medical profession's stance toward the broad social conditions that affect the public's health and access to health care.¹²

The following proposal has each individual medical student or resident (depending on when the program is initiated in the education process) participate in self-assessment exercises based upon their own clinical experiences. Training exercises designed to improve their ability to care compassionately for the suffering of their patients will require each student involve herself emotionally in treating her patients and in meeting the clinical skills requirement.

¹²DiBartola, 64.

Overview of the Self-Assessment Program

In assessing the abilities of medical students and residents, they are not merely asked how to perform different tasks. Rather, they are given the clinical opportunity to prove their competency. Similarly, in order to assess the **ability** of health care workers to act compassionately, real-life interactions with others must be made and considered. Basically, the way to show what sort of actor one is by taking actions.¹³ Evaluating emotions experienced in health care situations is intended to help students and residents better understand such experiences, specifically what they show about the actor and what effects emotions have on others in specific situations. These exercises, to be taken seriously, must be made a part of the required curriculum of medical school and the post-graduate years.

Self-assessment exercises can be conducted in many different formats, from one-on-one and small groups to a seminar format with various discussion leaders. In any case, such exercises seem to necessitate the incorporation into the medical curriculum of individuals trained to instruct in and

¹³Patient reports on how they experienced the care they received from health care workers may be excellent tools to use in testing the ability of health care workers to act compassionately. For example, the patient will be asked what behaviors or actions were compassionate, and which ones were non-compassionate. This may help the health care worker come to a better self-understanding, and better come to act compassionately.

guide such a course.¹⁴ It may be that such individuals who are responsible for the self-assessment exercises would be available continually, possibly assigned to certain students and residents to discuss emotional health care experiences. Given the nature of this training, maximum benefits would likely result from the format which had self-assessment exercises performed in small groups of students in residency training who share the same specialty. Such groups will enable students to learning about themselves both from sharing and evaluating their own clinical experiences, but also by hearing how others experience clinical encounters.

The discussions in these groups are be descriptive, considering at length how the situation was in fact experienced emotionally.¹⁵ In Chapter 1, emotions were argued to be instrumentally valuable, playing a communicative, epistemic, and motivating role in our relationships with others. The complexity of emotions will become evident in this self-assessment phase. Self-assessments will clearly

¹⁴The appropriate training of such "facilitators" would seem to vary, as the bare minimum would require an understanding of emotional behaviors, an appreciation of the values of caring compassionately for patients, the ability to effectively teach these skills to a medical school population, and the nerve to persist in the face of those who defend the value of emotional detachment and who also undermine this whole project.

¹⁵Leading to the next stage of training, in which certain types of emotional behaviors (e.g., compassionate ones) are fostered, discussions also include some prescriptive elements, and in this way medical ethics will be taught in light of the experiences discussed in the group.

indicate the values held by the emotional individual, especially given the interpretations inherent in emotional behaviors. These interpretations will be shown to have significant implications for the emotions experienced in health care practice. By focusing on the emotions of health care workers, we are able to access the background and biases of the health care worker which are coming into play in the interpretations being made in caring for various patients.

The basic modus operandi of self-assessment exercises is the consideration of emotional experiences in health care situations. To give such a course the best chance possible, it should be initiated at the earliest possible time in the medical student's training. To start, the emotional experiences discussed should be those which students remember from their own lives, including of their own family members and especially any which they consider as motivating them to attend medical school. Once students begin their clinical encounters, they should be required to continue evaluating their emotional experiences.

There are some standard cases which health care workers all experience in learning their art. These standard cases are concisely illustrated in the "core curriculum" recently proposed by Novack, et al. Many of these factors can be imagined as being related to significant socializing experiences of the medical student.

A Core Curriculum for Physician Personal Awareness
Physicians' beliefs and attitudes

- Core beliefs/personal philosophy
- Family of origin influences
- Gender issues
- Sociocultural influences
- Physicians' feelings and emotional responses in patient care
 - Love, caring, attraction, and boundary setting in medical care
 - Conflict/anger
- Challenging clinical situations
 - "Difficult patients"
 - Caring for dying patients
 - Medical mistakes
 - Physician self-care
- Balancing personal and professional lives
 - Preventing and managing stress/burnout/impairment¹⁶

Medical education programs which take seriously attending to the moral character of medical students and residents will provide students with ample opportunity to reflect upon cases representative of these issues pointed out by Novack, et. al.¹⁷ These defining events play an important part in the implicit character training of medical students in their clinical experience.

Physicians' and students' stories are often "critical incidents" that were meaningful because of a sense of connection with patients, because they substantially changed their interactions with patients, or changed their perceptions of their caregiving roles.¹⁸

¹⁶Novack, et al., 503.

¹⁷This would require some staff member or members who had a flexible enough schedule to be able to discuss these issues as they occurred. This likely will require a process by which students discuss these cases as they happen, as they will eventually happen for each of them. Through such a requirement, health care training programs will show a seriousness about the ultimate goal of producing compassionate health care workers.

¹⁸Novack et al., 506.

Hafferty and Franks emphasize the same point (in light of teaching ethics):

. . . we propose that the teaching of ethics should parallel ethical issues as they arise during the training experience, beginning in the basic science years and continuing into clinical training.¹⁹

Without discussing these events, students may not recognize the values which they have are inseparable from the their feelings in situations. The significant negative result of such a lack of recognition is the development of bad habits based upon inappropriate values during their clinical training. The self-assessment exercises will provide a way to evaluate such experiences. These exercises enable the medical student to gain a better appreciation of what such experience indicates about the nature of medical practice and about her own personal style and values. These exercises will generate ways of considering problems which he may otherwise experience over and over throughout his medical career. Focusing on such experiences will equip the student with a method of dealing with other problematic experiences in the future. He will be able to reflect upon his emotional behaviors involved in such experiences and what these behaviors indicate about how he is interpreting situations.

It is important, too, to appreciate that the growth of experience requires not only that beliefs (or memories) be accumulated and consolidated, but that on occasion they be jolted-that certain connections be broken and reassessed in the light of anomalies. For the

¹⁹Hafferty & Franks, 867.

youth, this involves encounters with exceptions. These often mark a moment of puzzlement about how to proceed or understand, given past experience.²⁰

Learning how to involve oneself emotionally is a skill. Consider the example of transference/counter-transference between patient and care giver as exemplifying the import of learning about how to involve oneself emotionally in the health care relationship:

Also, patients may misinterpret appropriate caring and empathy. Because physician-patient relationships often engender a special intimacy, there is potential for powerful feelings of attraction to be aroused in both caregiver and patient. These feelings may induce physicians to become overly distant, engendering patient and physician dissatisfaction, or to become overly involved emotionally or even sexually, which will have serious psychological and clinical consequences. Personal awareness and understanding of emotional reactions to patients allows physicians to appropriately set effective boundaries that allow for both objectivity and connectedness with patients.²¹

Novack et al., here note the importance of being aware of one's own emotional reactions and of having the appropriate distance with patients. This appropriateness has much to do with the expectations of suffering (vulnerable) human beings. Because of this, the major way of accessing this appropriateness is to access the point of view of the patient.²²

²⁰Sherman, FC, 192.

²¹Novack, et. al., 504.

²²Again, this is the next step in training, from seeing the value of emotional involvement, to understanding how to appropriately involve oneself emotionally.

Instead of being considered as negative events to be dreaded and feared, these events can be viewed as positive opportunities for individual growth, and a way to make oneself more compassionate and therefore a more competent health care worker.

Specific Steps of the Self-Assessment Program

As an example of what a self-assessment exercise may look like, consider the following case:

As a first year resident, Jan was interested in doing an oncology rotation, and possibly moving on to become an oncologist. She had considered doing so ever since her mother died of breast cancer 15 years ago. This has been her motivation for becoming an oncologist throughout medical school. In the second week of the rotation, Mike, a 55 year-old black man with end-stage lymphoma asked Jan what his chances were. Jan replied that his chances of leaving the hospital were not good, as the cancer had spread through his lymph-nodes and that the radiation treatment he had received had not been effective in stopping (or even slowing) the metastasis of the cancer. Two days later Mike died.

This was the first patient whose death Jan had experienced. Jan's emotions included a deep sorrow for this man and his family (wife, 2 kids who were age 7 and 9, and 49 year-old sister). She also experienced a renewed consideration of questions she asked when her mother died, the major one being, "Why this guy and not someone else?" Finally, she contemplated her duty to herself and to other patients in light of her feeling burned out as a result of her emotional involvement in caring for this patients.

In the self-assessment exercise, it is most important for

Jan to share and elaborate upon her emotions. We are interested in understanding how Jan feels, how she interprets, and what she desires in the situation. Again, the assessment will serve the dual role of dealing with the particular situation at hand, as well as coming to better understand the importance of emotional involvement in practicing medicine. Some of the major instrumental benefits of emotional involvement which may be considered during assessments will include these (as cited by Sherman):

. . . emotions are sensitivities that (1) help us to attend to and record what we care about (in both a positive and negative sense). (2) They are modes of conveying and expressing values. (3) As a part of these last two capacities, they can reveal values we were previously unaware of (i.e., record and convey them). They are modes of disclosing values. (4) In some cases, they help to establish what we value or detest, rather than merely track or reveal antecedent valuing. They are modes of establishing values. (5) Additionally, emotions can be valued for their own sake, simply as important ways of living a full, human life. They are intrinsically valued. (6) Finally, emotions motivate action. They provide impetus for action. They are motives for action.²³

In light of Jan's example, these each may each be elaborated upon in order to better understand the complexity of the emotional involvement in a health care situation.

(1) Emotions help us to attend to and record what we care about (in both a positive and negative sense).

In this case, Jan will explicitly consider her own way of describing this situation, and will be able to see her focus

²³Sherman, MNV, 50.

in the situation. She can also share some of her questions about cancer, in light of Mike's life, and in light of her life.

(2) They are modes of conveying and expressing values.

What happened in this case? How does Jan feel about the situation? What does she think about it? What does she desire to do? The answers to these questions promise to lead us to Jan's values. What is it that is morally required of her in this situation? What sorts of requests could have been made by the patient of her? What is her moral responsibility to such a patient? A discussion of such questions can lead to a clarification of Jan's values, and can lead to more open and compassionate care with future patients in similar situations.

(3) As a part of these last two capacities, they can reveal values we were previously unaware of (i.e., record and convey them). They are modes of disclosing values.

Similar to the last, the emotional behaviors may surprise one, especially when made explicit and seriously considered. A consideration of the emotional behaviors taken in the care of a patient can help a practitioner better understand her own values and thoughts about different situations.

(4) In some cases, they help to establish what we value or detest, rather than merely track or reveal antecedent valuing. They are modes of establishing values.

What was learned from this case? Given that health care workers learn from their clinical experiences, they are apt to form generalizations about certain sorts of patients. Is this useful? Will this affect the care given to patients who are

treated in the future with similar symptoms? Should they be?

(5) Additionally, emotions can be valued for their own sake, simply as important ways of living a full, human life. They are intrinsically valued.

Is it simply good to be in an emotional relationship with the patient? Does the patient appreciate your openness with him? Do certain relationships become close ones, and does this mean that emotional interaction becomes a moral necessity?

(6) Finally, emotions motivate action. They provide impetus for action. They are motives for action.

How did Jan's emotional behavior affect what she did? What did she feel like doing, and what did she do?

These exercises should be considered as a way of accessing not only the emotional behaviors of the clinician, but also the emotional experiences of patients (and specifically the experience of vulnerability). Such open feelings seem to be just the thing to help counter the very real tendency of medical students and interns to depersonalize their practice and leave the "heart" out of their routine treatment of patients.

Sherman states that they are "modes of conveying and expressing values." Emotional behaviors, in other words, show (Sherman's "reveal") how we are interpreting situations. In Jan's case, we can see that cancer means certain things to her based upon her past experience of it. Those without personal experience with cancer may have less empathy for the family and patient. Some involved in treating Mike may feel partly

responsible for his death. Others may feel and act upon the desire not to delve into the deep existential implications of the situation, removing themselves from such concerns by explicitly stating that "death is simply a part of life which we must all learn to deal with." It is not an important part of the self-assessment exercises to get to the right answer as to how a situation should have been handled, and to why certain views of the members of the group are right/wrong, better/worse. Rather, the goal is to describe how, in fact, the situations are being experienced. Solomon relevantly states that:

The task of reflection is to force our often clandestine choices of emotional strategies into the light, where they can be cross-examined and confronted with the evidence, compared to their alternatives, and ultimately, if they are acceptable to us, taken hold of as our own fully deliberative and gladly chosen commitments.²⁴

No one involved can be wrong in such exercises, as "wrong" is not a word which has any meaning for that which is reported by the group-members. However, sharing the ways in which we interpret situations with others may help us better appreciate our own tendencies, tendencies which we may not accept in others and be unaware of in ourselves.

Again, Sherman emphasizes the import of emotions, encouraging us to . . . "think of them as modes of attention enabling us to notice what is morally salient, important, or

²⁴Solomon, 420.

urgent in ourselves and our surroundings."²⁵ In considering how health care workers interpret situations (especially during training), it is extremely important and just plain pragmatic to scrutinize situations in light of the emotions involved. Such scrutiny can take the form of a specific consideration of the feelings, thoughts, and desires which are involved.

Through self-assessment exercises, it is hoped that the health care worker will come to consider habitually her emotional experiences, and recognize the import of her emotions in showing the type of character she has. Note that the self-assessment exercises revolve around students' sharing descriptions of situations in which they had emotional experiences. The medical student who is sharing such experiences should be encouraged to recount his feelings. After doing so, the next step will be to describe the emotional behavior (complex) in terms of the desire or interpretation involved. One standard approach will be taking each term of the complex in kind. However, an alternative approach is to allow those various descriptions to come up as they seem relevant to the student who is sharing his experience. The role of the facilitator of this discussion will be to guide the discussion in conformity to the different parts of the emotional behavior being considered.

In Jan's case, she may begin by describing the feelings

²⁵Sherman, MNV, 39.

she experienced, and then go into the desires she had in the situation (e.g., to avoid it or to do something). If she does, then the facilitator may just let her go in her recounting and elaboration on the experience. If Jan instead recounts the feelings and then waits for further guidance, then the facilitator of the self-assessment exercise may ask about the desires, perceptions, interpretations, or reflections which were experienced with the feelings.

Assume that Jan's re-counting of her feelings led her into a consideration of what she desired in the situation. Here it will be important to consider only the type of desires experienced and the way in which the actor dealt with these desires. The facilitator with an understanding of emotional behaviors would want to know how Jan felt and thought about her desires. This will be extremely relevant to using the self-assessment exercises in the training which will follow.

Jan may say that she wanted to help the family understand the situation and to help them understand how to deal with their pain, but also that at the same time she wanted to stay out of the way and to allow the family to grieve while celebrating Mike's last days with them. In the self-assessment group, Jan's desire can be focused upon and considered by the group. The others in the group may share their similar experiences and specific desires in the situations which Jan is considering, as this will further help both those in the group as well as the individual who is

sharing her experience (in this case, Jan) better understand how their desire helps them or hinders them in acting how they think they should. However, it is important to keep in mind that the facilitator must be able to focus on Jan's experience, and not to let the group get too far off track of the main focus of the session, which is to elaborate upon each part of the specific emotional experience (complex) which is being shared.

The impersonal, purely scientific approach to patients is one which is being renovated through this training program. The (non-rational) desires are what make us human, and are what will have a profound effect on the level of compassion felt for the suffering human beings who are cared for by the health care worker. The real desires (non-rational appetites) which are experienced in situations are what health care workers will learn to deal with and inhibit. Health care workers able to expose and explicitly consider the specific desires which they experience will be better able to appreciate the import in their interpersonal skill and their ability to better practice the art of medicine. Furthermore, when the self-assessment exercises are used in the virtue training, the practitioner will better understand the important role that their emotional involvement (and specifically, compassionate behavior) has in competently practicing medicine and providing care with which the patient is satisfied.

In considering the interpretations of the situation being considered in the self-assessment exercise, the instructor may focus on specifics of the participant's description. Perceptions play a major part of emotional behaviors, seemingly inseparable from interpretations of the situation considered. The perceptions shared by the health care worker will expose the vision which the health care worker has. The perceptions of the health care worker will importantly expose her past experiences, experiences which will have a strong influence on how she analyzes situations and therefore ones of which she will want to be aware in the future.

A group of students would be especially helpful in considering how these attributes form a meaning of the patient's situation as well as what alternative attributes haven't been considered. Again, it will not be necessary to say which attributes are right and which ones are wrong. Such normative terms won't be used. The group will attempt to stay on a descriptive level. It will become apparent to the students involved that a perception of alternative attributes will create a different interpretation of the situation (in the training section, it is shown that certain perceptions foster a compassionate relationship with the patient). If alternative perceptions are proposed, then the exercise should be one in which the students in the group attempt to experience such perceptions. Whatever the result of such an exercise, each student will learn something about himself

through attempting it. Again, the focus of self-assessment is to better appreciate the interpretations being made by the student who is sharing an experience. However, many different thought exercises can be used in light of the perceptions shared. One example is to ask what the perceptions involved imply for a health care worker's treatment of patients who are perceived in such a way.²⁶

It is not necessary for health care workers to sacrifice their own core beliefs and attitudes, but it does seem necessary, in order to provide compassionate care for their patients, for health care workers to be aware of their own core beliefs and attitudes.

Where we are unable or unwilling to express our emotions, talking about them may well be the best possible strategy for handling them. Once again, its purpose need not be to get rid of them but might just as well consist of a renewed effort to intensify them.²⁷

Again, beliefs and attitudes reveal themselves in emotional responses experienced in certain situations. For the purposes of the self-assessment currently being considered, it is important to become more aware of one's core beliefs and attitudes, and the implications of these for the

²⁶For example, some health care workers, given their values, prefer not to participate in abortions. Such workers would find it a threat to their integrity to provide the service being requested by these patients. Compassionate care would include an appreciation of the suffering of the woman involved in such a decision. However, compassionate care does not require that the health care worker give the patient whatever the patient wants.

²⁷Solomon, 426.

treatment of any particular patient.

The self-assessment exercises help one better understand oneself through the consideration of one's emotions. They also provide a forum for introducing questions about the art of practicing medicine and how the practitioner should act towards specific patients. However, these exercises are rightly considered as just the beginning of developing the student's artistic ability. As Finocchio, et al., state:

Medical education reforms cannot be targeted at the undergraduate level alone. The knowledge, competencies, and attitudes for successful practice are developed and refined during graduate training and throughout the professional career in continuing medical education.²⁸

The information gleaned from these exercises will allow the student entering the training seminar to focus on what he individually could do to improve his ability to provide compassionate care for her patients. The training program will provide him with the opportunity to develop his ability as an artist. Solomon here similarly states that reflection is only the first step, and sometimes an insufficient one, for developing certain types of disposition:

Mere recognition is only sometimes sufficient for self-overcoming. Usually, it is only a first step. We have too much invested in our irrationality to be divested of it so easily. Self-overcoming requires something more than insight. It, too, like the emotions,

²⁸Leonard J. Finocchio, Paul J. Bailiff, Richard W. Grant & Edward H. O'Neil, "Professional Competencies in the Changing Health Care System: Physicians' Views on the Importance and Adequacy of Formal Training in Medical School," Academic Medicine 70;11 (Nov 1995): 1028.

requires an ideology, a commitment to action.²⁹

From the recognition which is the basis of this first step, we now move to a consideration of ways of forming the compassionate disposition.

²⁹Solomon, 422.

Chapter 6Training Health Care Workers to Practice Medicine
Compassionately

It is best argued by Aristotle, if anyone, that emotions are educable, that affective capacities can be cultivated to yield dispositions that are enduring and responsive to appropriate objects and values¹. . . To have this sort of grasp, Aristotle suggest in the lines that follow (1143b8-15), depends upon experience and time of life (not literally chronological age, except in the sense in which age is meant to be a rough indicator of experience). For experience gives us the eyes (omma) to see the particular requirements of ends correctly (1143b15).²

I now propose several ways of cultivating the ability of clinical students to treat patients compassionately. These methods are primarily intended to foster a vision for how patients are suffering. These training methods should be used with those who have already completed the self-assessment course, as the medical student must have a sense of his own style and tendencies before he begins to modify them (otherwise, there will be no clear way of knowing how he should change or whether he is improving as a clinician).

The goal of this training is for medical students to develop the ability to involve themselves emotionally with the patients with whom they interact. Such involvement will be based on the belief, similar to Aristotle's, that experience is the ultimate teacher of character and a vision for the

¹Sherman, FC, 47.

²Sherman, FC, 43.

proper emotional involvement. The training methods which follow will primarily propose different ways of considering the same experiences which those in clinical training have always had.

Retaining the Human Part of the Health Care Relationship

But now that I have been a patient, I know that you can't really understand unless you have been there yourself. I thought that I was good, but now I know that I wasn't good enough. Today I would be better.³

The major way in which to practice medicine more compassionately is through assuming the patient's perspective. In a program (similar to the training program which I am presenting here) which attempts to have medical students see from the patient's perspective, Suzanne Poirier states that the exercise "forces them to think about things as a patient does. . . because in the stress of learning the incredible amount [medical students] have to learn, the human part gets lost."⁴ The challenge to health care workers is to understand the suffering of their patients as the patients are suffering it, and what the implications of this suffering is for the lives of the patients, while continuing to use their medical skills to make diagnoses and suggestions for treatment. Zaner emphasizes that,

³Edward E. Rosenbaum (The Doctor New York: Ivy Books, 1988), 134.

⁴Edward E. Rosenbaum. The Doctor (New York: Ivy Books, 1988), 39.

To 'put yourself in my shoes,' rather, is to see things as the patient experiences them while yet remaining oneself. To be compassionate is not to obliterate the always crucial distinction between doctor and patient.⁵

Medical education programs which aim to foster compassionate actions should focus on these for both evaluation of dispositions as well as training students to develop a sensitivity and way of caring compassionately for the suffering of patients. However, this training does not require that the medical practitioner forfeit his medical knowledge in order to act in a compassionate way. On the contrary, it requires that the practitioner learn how to continually "reinsert" himself into the patient's position while using his medical knowledge:

. . . health professionals learn as part of their socialization that to be professional requires stepping back from becoming too involved with patients. This is surely taught: from the initial concern, one must objectify the complaint to be truly professional and offer help. What is not taught, however, is the art of reinserting oneself into the patient's life as a human fellow sufferer once the therapy has been initiated. This is no easy task in any event, but it is severely hampered by a lack of theory about compassion and our expectations for physicians and the whole process of healing attendant on this lack.⁶

⁵Zaner, 316.

⁶Special Section: Compassion: What Does It Really Mean? Cambridge Quarterly of Healthcare Ethics (editors) 4 (1995), 410.

Methods of Training Health Care Workers to Provide Compassionate Care

The ideal end state is a state of transformed and schooled emotions, such that emotions have been cultivated to support the judgments of practical wisdom.⁷

The method of assessment and training which promises to be most effective in developing a compassionate disposition is one which is based upon the specific lived, emotional experiences of health care workers.⁸ This training is intended to develop the character of the student. Therefore, it will be most effective if it has the student practicing. Aristotle recognized the import of training character through actual practice:

Excellences of intelligence, he says, are largely acquired by teaching; excellences of character, being nonrational, cannot be taught but are acquired by training (the translations often say 'by habituation', but excellence of character is not a mere matter of habit, such as putting on one sock before another when dressing).⁹

In considering emotional behaviors as experienced in specific situations, we gain access to the interpretations,

⁷Sherman, FC, 7.

⁸see Megan Boler, "Disciplined Emotions: Philosophies of Educated Feelings," Education Theory 47;2 (Spr 1997): 203-227; also Victor L. Worsfold, "Israel Scheffler's Ethics: Theory and Practice," Studies in Philosophical Education 16;1-2 (Ja-Apr 1997): 189-200; also Yeuk Yi Pang & Elizabeth Wojciechowicz, "Coordinating the Emotional and Rational in Moral Education," Eidos 10;1 (June-July 1991): 21-46.

⁹J.O. Urmson, Aristotle's Ethics (New York: Basil Blackwell, 1988), 25.

assumptions, perceptions, biases, and values which are being made or held by specific actors, as well as the desires which the human being who is working as a health care worker is experiencing in those situations.

Why was it hard for me to learn compassion as a third-year medical student? I think because, although I was seeing patients and given some responsibility for their care, I was still in medical student mode, fearing failure, knowing that to continue I had to succeed, outdo the others competing for the few places available.¹⁰

Toteson (1990) offers the following recommendation as a method to encourage the students to assume responsibility for their own learning, which he believes is central to reform. This recommendation compliments training program proposed below.

(1) Medical education should require student participation. Since the principal task of learning is deciding what and how to learn, medical schools should provide opportunities for making such decisions with the help of supportive tutors.

(2) Use of small group sessions rather than large didactic lectures. Center the education on the student rather than the faculty.

(3) Incorporate problem based learning. The need to learn usually comes to the physician in the form of problems to be understood and solved rather than assignments to master a defined body of knowledge.

(4) Integrate the basic sciences and the clinical study. The study of science and clinical medicine should be interwoven throughout the curriculum so students can learn how to act scientifically as they practice medicine.

¹⁰Michael Chunchi Lu, "Why It Was Hard for Me to Learn Compassion as a Third-Year Medical Student," Cambridge Quarterly of Healthcare Ethics 4 (1995): 457.

(5) General medical education should provide the opportunity to study subjects of special interest. Approximately 60% of the coursework should be required and 40% selected by each student according to their interests, optimally with some in other schools within the university.¹¹

I will consider each of these parts in turn, as they each highlight specific skills important for a compassion-training program for medical practitioners. This training program is based on the premise that those who act compassionately in what they do have come to acquire a vision for the suffering of those with whom they practice their art.¹² The goal is to develop in them a vision which enables them to respond compassionately to such suffering as if from a "second nature." Sherman, using an Aristotelian account, makes a statement which nicely highlights what needs to happen in order for health care workers to develop a disposition to routinely practice in a compassionate way:

Perception informed by ethical considerations is the product of experience and habituation. Through such an education, the individual comes to recognize and care about the objects of ethical consideration. Human distress becomes labeled a possible moment for generosity and unwarranted harm as an occasion for anger towards the aggressor. In this way certain facts are described evaluatively and become occasions for evaluative beliefs. Such beliefs about one's situation in turn yield reasons for action which fall within the motivational structure of specific virtues. They become specific intents to act

¹¹DiBartola, 50-51.

¹²It is in this sense that several of those interviewed (in Chapter Three) stated that "everyone is compassionate," in that every individual has suffered in some condition and is therefore able to suffer with others who also suffer or have suffered in the same condition.

(prohaireseis) upon deliberation concerning how and in what way one should respond.¹³

Consider now the five general headings listed by Toteson, and my elaboration upon each in light of training clinical students to practice medicine compassionately.

1) Medical education should require student participation

I have heard it said that to be a doctor, you must first be a patient. In my own case, I practiced medicine for fifty years before I became a patient. It wasn't until then that I learned that the physician and the patient are not on the same track. The view is entirely different when you are standing at the side of the bed from when you are lying in it. If I could go back, I would do things in my own practice very differently than I did. Unfortunately, life doesn't give one that chance. All I can do is to tell you what happened to me and hope that we both can learn from it.¹⁴

This section provided a discussion of what student participation could mean, in light of an explicit goal of training clinical students to develop the ability to care compassionately for their patients. I suggest that personal experience, acting classes, role models and mentors, literary examples, and standardized patients be used to teach medical students what it feels like to be a patient. Patient satisfaction and evaluation of video-recorded interviews with patients are two other methods of evaluating and training students in their ability to care compassionately for their

¹³Sherman, FC, 31.

¹⁴Rosenbaum, vi.

patients.

I will broadly define the "student participation" that Toteson cites. The focus of this section will be on the experience of the patient. Student participation will have the student considering varied implications of illness and disease. Evaluation of the student, in light of the interpersonal, artistic ability, will include the patient's measurement. A program which includes such patient participation is intended to encourage students to have emotional experiences with their patients.

To be educated about an illness or disease as it is lived, to know as one's patients know it, one must understand what the illness or disease means for the patient. Without such understanding, the clinician may be imagining certain meanings. An effective way to understand in this deep way how patients experience specific diseases and illnesses is for health care workers to have the same experiences of the same diseases and illnesses themselves. Every other way of approximating the experience of patients (literary accounts, narratives, interviews, acting classes) are by definition approximations of the lived experience.¹⁵

¹⁵There are limitations, of course. It is clear that many diseases and illnesses will not be ones which can be directly experienced by health care workers. However, they must always keep in mind that everything other than actual experience is an approximation, and will therefore include imagination (and therefore the assumption of certain attributes of the illness or disease which may not be included in the illness or disease as actually lived).

The following comments were made by a doctor who was changed as a result of the diagnosis and treatment of a malignant tumor in his own throat (from the story originally titled, "A Taste of My Own Medicine"):

Never before have I realized how agonizing the wait is for the patient. . . I never knew what it was like to sit and wait and wonder; now I do.¹⁶

Then Dr. Reed enters the room. He doesn't say a word to me. He feels my neck, looks at the X rays and says, "Okay." Then he walks out. I am stupefied by his behavior.¹⁷

As I drive home, I mull over the impersonal way the girls discussed my anatomy: "thick neck, shoulders too wide." All this said as if I weren't there. It's a bad medical habit I'm familiar with, though I've never thought about it before. All my life I have heard the phrases "a senile old man, a little old lady, the crock in room 411."¹⁸

These are only a couple of reflections of one patient, a patient who is also a physician. The point seems to be, again, without first-hand experience, health care workers are likely to be unable to appreciate what the patient is suffering (and therefore care compassionately for the patient). Sometimes they will be unable to appreciate the suffering involved in specific treatments, even though they have for many years prescribed those very treatments!

Today I will start X-ray therapy. After so many years as a doctor, one would think I would understand and know what to expect, but I really don't. I've referred

¹⁶Rosenbaum, 57.

¹⁷Rosenbaum, 59.

¹⁸Rosenbaum, 60.

many patients for radiation treatment, but prescribing is different from receiving.¹⁹

As another example of one who recognized that he had been operating with "preconceived ideas" in treating his patients, consider Dr. Roger Bone. Dr. Bone was a physician who described himself as attaining a vision for the suffering of his patients only after suffering as they suffered. This vision changed radically his idea of what the practice of medicine should be like:

Q You've been a critical-care doctor for 25 years. Having experienced cancer yourself now, is there anything you would have changed about the care you gave your patients?

A I wish I'd had a more personal relationship with them. I'm not a touchy-feely person, so I didn't touch the patient's hand. I wish I'd treated them as more than just patients. I never tried to be their friend because of the risk to me- to spare myself grief. I was their doctor, I brought the residents by, I pronounced the treatment plan, and I left. I was good to them, but I let their families deal with their concerns about dying. I think they instinctively knew I wasn't prepared to deal with that, so they found someone else to talk to. But I have no problems initiating those conversations now. When I talk to terminal patients, I feel they're helping me as much as I'm helping them.²⁰

Many of the conditions which are treated in health care can be simulated, and should be simulated, so that the health care worker can better understand the "little things" which are salient in the situation. As the medical student

¹⁹Rosenbaum, 57.

²⁰Anita J. Slomski, "Giving terminal patients peace of mind," Medical Economics (Dec 9, 1996): 114-127.

experiences seriously ill patients for the first time, he should be encouraged to attempt to understand their suffering.

Bone thinks that his cancer patients "instinctively knew I wasn't prepared to deal with" the concerns they had about their disease. Again, patients seem confident in their ability to "just tell" who really cares and who does not. In light of this ability, and the preference of patients for close relationships with health care practitioners, the envisioned ideal of a disinterested, objective view of patients seems detrimental to the ability of the health care worker to competently treat her patients.

Think of these heavenly doctors trying to come up with an account of health and the healthy life, independently of any experience they may have of the desires and ways of life of the creatures they are going to treat. They do concede that to apply these norms to a group of patients, they will need to know something about their current state. For they cannot treat a disease without recognizing its symptoms and measuring these against their paradigm account of health. What they deny, however, is that the norm of health itself derives in any way from the condition, or the wishes, of the patient. It is "out there" to be discovered and then applied to their case.²¹

Without appreciating the patient's own definition of health and the appropriate way to live, the physician will be likely experienced as acting like a robot, mechanically telling her what she needs to do to get healthy and how she needs to define and deal with her illness.

Recognize also that not having a vision for the

²¹Nussbaum, 19.

experiences of the patient may have health care workers mistakenly act like they understand what they are treating.

It is not merely that the novice cannot reliably discriminate the objects of due sympathy, etc., but that even if he could, his response would most likely lack a depth and insight which comes only from having lived and suffered.²²

Without understanding the suffering of the patient, treatment may be experienced as offensive by the patient, imposed on them by others who wrongly assume that they "know what's going on." As a result, patients are left unsatisfied and frustrated. Consider as an example the harm resulting from the imagining (and imposition) of false attributes upon the suffering of another the case of battered women:

Even if medical providers were not perceived as judgmental, many women felt as though the providers did not have a sufficient understanding of the complex circumstances that battered women typically face. The women felt that many providers had preconceived ideas about battered women. These misunderstanding were often perceived as responsible for the lack of concern and compassion on the part of the medical provider.²³

This "lack of concern and compassion" is rooted in a lack of a vision for what these women are going through. We can also consider the desire to treat quickly and efficiently each patient as playing a part in this non-compassionate care. However, the health care workers here simply lack the ability

²²Sherman, FC, 48-9.

²³Heidi M. Bauer & Michael A. Rodriguez, "Letting Compassion Open the Door: Battered Women's Disclosure to Medical Providers," Cambridge Quarterly of Healthcare Ethics 4 (1995): 462.

to perceive the salient features of this sort of situation, a vision which is (primarily) acquired by those who have been through the same thing. The self-assessment and training are meant to give health care workers the ability to have patients who they do not understand tell them about their experience and why they have entered the health care arena for help.

Any measurement of the quality of the care which health care workers provide should include the satisfaction of the patients being cared for in the patient's own words. Such a consideration will reinforce the primacy of the patient's role in the clinical encounter, an important part of developing the health care worker's ability to practice the art of medicine. Considering patient satisfaction will likely reveal "preconceived ideas," of both the effectiveness and ineffectiveness of the care provided as well as the thoughts and feelings of the patient.

A character trait of the compassionate clinician is humility, a recognition of shared humanness with patients (" . . . but for the grace of God" I would suffer as my patient is now suffering). This is an integral characteristic of the clinician who understands the import of suffering for his patients. An appreciation of the patient's experience should also include an understanding of how they as health care workers are perceived. Such an understanding further facilitates the health care worker's understanding of patients and what the patient expects from health care workers. By

considering these latter expectations, the health care worker may be quite surprised to find that she is experienced commonly as one who is expected **primarily** to care compassionately for the suffering of the patient.

Although the best way to learn how to act compassionately is by experiencing illness or disease for oneself, there are alternative ways which promise to be effective. As such, these ways should also be considered for inclusion in the training program. They include:

Acting Class

And the learner's mimetic enactment of them (through performance) is a way of coming to feel from the inside the relevant qualities of character and emotion. It is an emulative and empathetic kind of identification.²⁴

One way of experiencing the suffering of a patient is to act it out. Acting requires research and should be motivated by a sincere interest on the part of a clinician to better understand the specific illness being considered.²⁵ Such an interest may give the clinician the opportunity to choose an illness or disease, research it, and actually talk to some people who have the illness or disease, considering how these patients experience it. This exposure may show that patients

²⁴Sherman, FC, 182.

²⁵Its occurrence in the personal life of the clinical student gives him the access which is to be discussed in these acting classes. Therefore, personal experiences are considered especially good examples to use in such exercises.

are willing to just talk about what their illnesses are like, and to expose the suffering involved in the illness which defines the illness for them.

Moore-West, et al., cite the value of these exercises:

The simulations can be done by faculty (Bishop 1988), fellow students, or paid actors. The value of simulations is the opportunity for students to come to appreciate psychosocial information with respect to patients as well as an opportunity for patients to provide specific feedback to students regarding their interviewing style and manner of questioning. At the University of Arizona, patient instructors (people with chronic illness who play their illness) are able to provide specific feedback to students, not only about their interviewing style but also concerning the appropriateness of their physical exam and their diagnostic findings. Not only are such student/patient interactions highly reliable in terms of student assessment, they also underscore the value of listening to patients' interests and concerns. To learn from a patient how one's style of interviewing affects them has a powerful impact on developing respect and sensitivity to the patient.²⁶

Role Models

The most effective instruments of character formation are the professionals who teach in medical and law schools and seminaries. But they must be able to demonstrate that competence and character are inseparable, and that fidelity to trust and self-effacement can be, and must be, indispensable traits of the authentic profession. Unfortunately, not enough professional school faculty members are convinced of this or are morally equipped to serve as models of virtue.²⁷

²⁶Maggie Moore-West, Martha Regan-Smith, Allen Dietrich, & Donald O. Kollisch, "Innovations in Medical Education," in Educating Competent and Humane Physicians, ed. Hugh C. Hendrie and Camille Lloyd (Bloomington: Indiana University Press, 1990), 137.

²⁷Edmund D. Pellegrino & David C. Thomasma, The Virtues in Medical Practice (New York: Oxford Univ. Press, 1993), 158.

Another way of training individuals to be more compassionate is by modeling such behaviors for them. This is an effective way of teaching students to practice medicine in a certain way. Modeling also promises to be an effective way of motivating students to practice specifically in a compassionate way.

Role models are commonly considered responsible for teaching clinical students how to practice compassionately. Gregory Pence, in his article, "Can compassion be taught?", asks the reader to . . .

. . . consider now the most popular view of teaching compassion: the role-modelling view. According to it, medical students become compassionate by observing senior physicians who treat patients with compassion. If compassion is to be taught, such physicians must 'model' compassion.²⁸

However, as a rare criticism of this way of teaching medical students (e.g., how to practice compassionately), Pence argues that,

Merely imitating compassionate behaviour is not compassion because real compassion stems from deeper, internal attitudes and emotions. Where compassionate behaviour is imitated in this way, it may be done as much to please and identify with the senior physician as much as because the suffering of the patient really matters.²⁹

He then goes on to make another criticism:

Second, like the two previous views, the putative 'transfer' between senior physician and student is very

²⁸Gregory E. Pence, "Can compassion be taught?", Journal of Medical Ethics 9 (1983): 189-191.

²⁹Pence, 190.

murky and vague. Unless there is active and important discussion of why and how compassionate attitudes are expressed, the role-modelling view is in danger of degenerating into the previous view [that compassion is naturally 'picked up' by students].³⁰

Pence invites us to challenge the belief that role modeling is effective in medical training. Consider what a "role model" is.³¹ A role model is someone who is considered as a representative of a certain social position, a position which the observer of the role model is likely using to learn how to satisfy the requirements of that social position. The role model is "looked up to," as if they are behaving in a way that others aspire to emulate.

In training clinical students, the physician is a role model in that he is playing a role (attending physician in a hospital, e.g.) to which the clinical student aspires. The role is theoretically how to practice medicine, although "clinical," as "in the clinic," today seems as much administrative and bureaucratic as it is patient-centered. Pence is warning that we not assume that role models will effectively teach medical students.³² He means one of two things: that role models do not actually teach anything, or

³⁰Ibid.

³¹A major consideration of current professional athletes is not merely what a role model is, but what moral responsibilities a role model has to his fans and those who "look up to him."

³²see Chapter 4 discussion of the "hidden curriculum" and medical school socialization.

that role models (or administrators) do not teach what they think they are teaching.

The first reading, that role models do not teach anything, seems counter-intuitive. Medical students are being introduced into the health care setting, aspiring to the role of the one who is evaluating them. They learn how to get around in this environment from those who have been there longer-the role models. The medical student is subject to the routine and guidance of attending physicians and senior residents, as well as to the curriculum and goals of the school and administration of the program they have chosen. As education involves, by definition, the shaping and molding of students, those who represent the education process are effective in showing the student how to do the job.

That role models are not effective in teaching students how to practice compassionately seems the stronger criticism being raised by Pence. His challenge is that mere imitation is not evidence of one's learning, focusing on compassionate behavior in particular. I agree with Pence that there should be explicit and intentional methods of training and measuring the student's ability to practice compassionately. We should not assume that such an ability is being taught³³. However, I do not agree with his estimation of the power of

³³In light of, for example, the strong accounts of the "robot," non-compassionate health care worker noted in the thematic description of compassionate behavior of the third chapter.

"imitation."

When we consider the compassionate practice of medicine, we are speaking about an art. The most effective way to train artists is to have them practice their art. The most effective way to test the skills of an artist is to have her practice her art. Imitation is the best way to learn the art of medicine. Pence's point is that we need to be able to distinguish those who can practice from those who are faking it. This is where patient satisfaction comes in. As I've emphasized throughout, the evaluation of interpersonal skills must include feedback from the patient. Patients seem very aware, and have a sense for those who "really care" and those who are "just doing their job."³⁴

Pence is right to challenge the common assumption that role models are effective in teaching clinical students how to practice compassionately. However, he is wrong in his assertion that imitation is not strong evidence of having certain skills. On the contrary, as far as practicing an art is concerned (e.g., medicine), imitation is the best evidence of the ability of the students involved.

Role models are most important to the development of the ability of clinical students to care compassionately. Administrators and those who design the clinical training environment must also play a major part in developing the

³⁴Again, this was exemplified in the thematic description of Chapter 3, where participants said that they could "just tell" who genuinely cared and who did not.

artistic ability of clinical students. Explicit consideration of the art of practicing medicine should be involved, and those who are role models should have the ability to practice medicine compassionately. If they do not, then a major way of teaching medical students will be misused.

Recognizing the powerful influence which role models have on the way in which medical students and residents practice, some have recently proposed the development of "mentoring programs." For example, Ricer, et al., propose such programs with the specific intent of increasing student interest in primary care.³⁵ They also emphasize that the mentor position would be different from other role model positions, including the exclusion of formal evaluation by the mentor.

Casuistry

There is a significant literature on the case-based approach, or casuistry, in biomedical ethics. In this way of training, individual cases are considered and differentiated according to specific features which are important. It is argued by those who use such an approach that this is how we learn to distinguish between right and wrong, as opposed to learning general principles or rules to apply. They further argue that principles or rules represent appropriate ways of acting in many cases already experienced. The casuist

³⁵R.E. Ricer, B.C. Fox, K.E. Miller, "Mentoring for medical students interested in family practice," Family Medicine 27;6 (June 1995): 360-5.

approach will help the student make such case-by-case distinctions, and will have the student appreciate the usefulness of learning from unique cases. Finally, this approach would seem to be one which can be easily incorporated into the current medical curriculum.

Using specific cases is an excellent way of drawing fine distinctions relevant to dictating different courses of action. Included in such cases are not only unique situations, but also stressful situations, violations of policy or code, errors and mistakes, and any other anomalies. For example, weekly (or monthly) "morbidity and mortality" meetings are currently used in teaching hospitals. These are an example of how unique cases should be used to learn from. However, at these meetings, it has been my personal experience that the questions and responses involved are of a scientific nature, and rarely tap into the most relevant questions concerning how these errors were dealt with in light of the patient and family involved, as well as for the student personally. Perhaps such discussions actually take place in a more informal way, but it should be made more clear that these are very important parts of the art of practicing medicine, no less important than the scientific or technological decisions involved.

One way in which the casuist method could be applied is exemplified by using "standardized patients." Chalabian and Dunnington describe how "standardized patients can be an

effective means to teach or assess a physician's competence in clinical skills, such as history taking, physical examination, and patient-physician interaction skills."³⁶ Others have recently considered the use of such patients and have found them to be effective and reliable measures in clinical training.³⁷

Finally, Hoffman and Vu recently (December 1997) discussed virtual reality as possibly being the "teaching tool of the twenty-first century."³⁸ It is hoped that the implications of this technology will not be limited to honing the clinician's scientific and technological skills, but will also include putting the clinician in ethical dilemmas as well.

Literary Approach

The skill of reading fiction is to be close enough to the subject of the fiction to feel an emotional identification and to experience, not just know about, what is happening, and at the same time to be just far enough away so as to be able to reflect on that experience with some degree of critical detachment.³⁹

³⁶J. Chalabian & G. Dunnington, "Standardized patients: a new method to assess the clinical skills of physicians," Best Pract Benchmarking Healthcare 2;4 (Jul-Aug 1997): 174-7.

³⁷see Pangaro, et al.; Gomez, et al.; Stillman, et al.

³⁸H. Hoffman, & D. Vu, "Virtual reality: teaching tool of the twenty-first century?," Academic Medicine 72;12 (Dec 1997): 1076-1081.

³⁹Howard Brody The Healer's Power (New Haven: Yale Univ. Press, 1992), 265.

This approach is closely related to casuistry, where specific characters and how they experience illness or disease is considered as they consider it. This approach promises to be effective in having one better understand the suffering of another.⁴⁰ However, the major reason this approach is inferior to the case experienced personally is that the latter is more vivid and better retained than the former.

Lynn Epstein has designed a course which uses literature to teach premed students that. . .

. . . understanding patients' concerns and fears is as important as treating diseases. Convinced that literature can nurture humility and compassion in future physicians, Epstein takes her charges on a semester-long journey- from scripture through centuries of classics, including Moliere, Shaw, Tolstoy, and Faulkner. Before they ever treat a patient, pre-med students will have read compelling tales of doctors good and evil, of wrenching choices made by physician and patient, of medical accomplishment and failure, sensitivity and arrogance.⁴¹

And also (in the article focused on Epstein's literature-based course) relevant to teaching compassion, Goldstein asks:

Do such courses succeed in injecting more empathy into doctor-patient relationships? According to a 1995 article in the Annals of Internal Medicine, literature does indeed improve student understanding of patient experiences and enhances the ability to resolve ethical problems. Although their precise contributions to the

⁴⁰see Paisley Livingston, Alfred R. Mele, "Evaluating Emotional Responses to Fiction," Derek Matravers, "The Paradox of Fiction: The Report Versus the Perceptual Model," and Gregory Currie, "The Paradox of Caring: Fiction and the Philosophy of Mind," in Emotion and the Arts, ed. Mette Hjort, (New York: Oxford University Press, 1997).

⁴¹Goldstein, 36.

practice of medicine may defy measurement, the article concludes, such classes encourage future physicians "to recognize the human dimensions of all the experiences that occur within their gaze."

Literary examples can be used to better understand the suffering involved in illness and disease, and specifically to better understand illness and disease as lived. However, as clinicians, the actual situations will, as reflected upon, arguably have a much stronger and long-lasting impact on the student who is learning how to act in a virtuous way.

Videotaping Clinical Encounters

I did a rotation of my M.A. Medical Ethics Practicum at the University of Pittsburgh's Western Psychiatric Institute. There the residents doing rotations performed intake interviews to assess people who would possibly be committed for a brief period of time for further assessment. In training of the residents, their intake interviews were videotaped and evaluated. This was especially important for them, as they were expected to make a decision as to whether or not an individual would be committed in about 15 minutes. This required a detailed understanding of the DSM-IV⁴² criteria for various disorders. These videotaped interviews seemed to be excellent ways of critiquing the clinical skills of the students, given that there was a specific time, place, and general routine of reviewing them.

⁴²DSM-V was not published at that time.

Holmwood notes that:

Direct observation and review of videorecordings of registrars in practice are valuable for learning clinical skills. They also engender an atmosphere of disclosure and professional honesty within the discipline of general practice.⁴³

Furthermore, Edelstein and Ruder videotaped complete medical interviews and physical exams using "The Northwestern Evaluation and Training System" (NETS). They concluded that the "NETS can be used for educational feedback to the individual students and or quality assurance feedback to training programs regarding the effectiveness of their instruction in interview and physical evaluation skills."⁴⁴

2) Use of small group sessions rather than large didactic lectures

. . . the project of self-knowledge requires (external) dialogue and audience. We need 'to live together with friends and share in argument and thought' in order to be fully conscious of the sorts of lives we are leading.⁴⁵

This quote nicely summarizes the import of small group sessions in order to develop the ability of health care workers to act compassionately. Simply put, we learn about

⁴³C. Holmwood, "Direct observation. A primer for supervisors of doctors in training," Aust Fam Physician 27;1-2 (Jan-Feb 1998): 48-51.

⁴⁴D.R. Edelstein & H.J. Ruder, "Assessment of clinical skills using videotapes of the complete medical interview and physical examination," Medical Teaching 12;2 (1990): 155-162.

⁴⁵Sherman, FC, 27.

ourselves by observing ourselves in action and by rationally considering the choices we make. Small groups of students who meet and consider real-life situations in which they have made choices and responded emotionally in making these choices are ideal for this type of group. Emotional behaviors allow us access to our interpretations of situations, including what characteristics we are attributing to objects and individuals and what features are salient to us. It is the vision which we are interested in, a vision which is the basis of the virtuous actor.

Training groups would function much like those of the self-assessment phase. However, instead of merely being descriptive in giving accounts of emotional health care experiences, those of the group will also be prescriptive. They will consider what should be perceived (in order to be compassionate in practicing medicine in specific situations), how desires should be dealt with/inhibited.

Small groups allow for more discussion and detailed consideration of the cases involved. As with the student participation section above, students should be encouraged to voice their concerns for the suffering and people involved. The art of medicine rightly includes such groups, and emotional interactions and value-laden suggestions should be evaluated in light of the group's view of the proper role of the health care worker. Through dialogue about these issues, students will develop a better appreciation for their art and

for dealing with the emotional interactions of their practice. Hearing about others experiencing similar thoughts and feelings will likely enable one to be more open about one's experiences and the ways in which one deals with similar experiences and issues.

3) Incorporate problem based learning

The orthos logos of Aristotle's phronimos, that is, the reasoning by which one hits the mean (to meson) in action and feeling, is not constrained by an implicit method which theory lays bare. . . the orthos logos remains always much closer to the particulars: a way of 'improvising' and 'conjecturing' (stochazomai) given experience and what is now at hand.⁴⁶

It does not seem controversial (especially in light of the socialization considered in Chapter 4) to claim that clinical students learn to treat patients according to a certain model. This model is called the "curative model" by Ellen Fox in a recent article in JAMA. She notes that there is no clear definition of this model, and she therefore offers that the curative model as "the approach to clinical medicine that narrowly focuses on the goal of cure."⁴⁷ Characterizing this standard paradigm of medical treatment, Fox states:

Elaborating on this theoretical construct, the curative model is characterized by an inherent set of assumptions, attitudes, and values. For example, its way of thinking is distinctly analytic and rationalistic.

⁴⁶Sherman, FC, 25.

⁴⁷Ellen Fox, "Predominance of the Curative Model of Medical Care. A Residual Problem," JAMA 278:9 (Sept.3, 1997): 761-763.

Clinical concerns are approached as puzzles to be solved; clinical encounters are treated as occasions for scientific inquiry. Because the object of analysis is the disease process and not the patient, symptoms are treated as clues to diagnosis, instead of as phenomena that are themselves worthy of treatment. As Christakis and Feudtner put it, patients' revelations are valued "chiefly if they lead to a diagnosis or an effective treatment plan, as when important intimate details . . . 'crack' the case." (emphasis added)⁴⁸

Having an inherent set of assumptions is not what makes this model problematic, although this seems to be suggested by Fox. Every model will have such assumptions, and it seems impossible for any individual who leads a life to have experiences in which she makes specific attributions and makes sense of situations of which she is a part without some model. Instead, the major criticism posed by Fox is that the model which health care practitioners are currently using is the wrong one. It is wrong "because the object of analysis is the disease process and not the patient, symptoms are treated as clues to diagnosis, instead of as phenomena that are themselves worthy of treatment."

As an alternative to the curative model in the practice of medicine, Fox proposes the "palliative care model." The palliative care model will be considered as one used not merely for hospice patients, but in treating the suffering of all patients. The major difference between these two models is in the goal held by each. The curative model requires that

⁴⁸Fox, 761.

health care workers interpret patients as representing certain ailments or diseases, and focusing on certain standard ways of eliminating these ailments or diseases. The palliative care model, on the other hand, "supports a variety of goals, including relief of suffering, control of symptoms, and restoration of functional capacity."⁴⁹ Note that the palliative care model, unlike the curative model, involves a consideration of the ailment or disease as it is defined by the patient, instead of merely imposing a name onto the ailment or disease which the patient has.⁵⁰

Another difference between these two models is in what qualifies as "relevant information" in each. Fox states that,

. . . in palliative care, the management plan is tailored specifically to each patient, according to the patient's personal values and preferences. This approach contrasts with the curative model, in which the appropriate treatment is considered a scientific question that is best decided by the physician.⁵¹

The major problem of the curative model, in light of including the necessity of caring compassionately for patients in delivering competent medical care, is that it imposes care onto patients, instead of "artistically" working with patients. In light of this problem, consider the following suggestion from a third-year medical student:

⁴⁹Ibid.

⁵⁰see also as an example of this sort of paradigm shift the "generalism" spoken about by Cassell (1995).

⁵¹Ibid.

I think the first step is to teach medical students to pay attention to suffering: not just pain (although we do not even pay enough attention to that), but to suffering; not just what condition the patient has, but what the patient is going through; not just what makes the student feel good, but what makes the patient suffer.⁵²

It is of the suffering, in how the patient is experiencing that which ails him, that health care workers must be explicitly aware in order to accurately diagnose illness on the palliative care model. To simply approach the individual as an organism which is not functioning according to the paradigm of health represented by the curative model may make quicker the diagnosis and treatment of patients. However, the cost of the curative method is that the practitioner who uses this method may not be fully aware of how his patient prefers to function, and how this preference affects the diagnosis and proposed treatment for any illness or disease. With the palliative care model, it is easier to see that some illnesses may be better off left alone, as the symptoms involved are of little concern to the patient, or are better left alone in light of the alternative side-effects which will be a part of their lives as a result of the treatment to be recommended using the curative model.

In light of this distinction between the curative and palliative care models, another popular suggestion made in light of the limitations of the curative model is "problem-

⁵²Lu, 457.

based learning." Such learning seems potentially incorporated into either model. DiBartola summarizes the place of problem-based learning in relation to the curative model as follows:

Problem based learning, as the forefront component in the call for reform, has evolved from merely an answer to the question of the separation of the sciences and clinical study, to a process of learning that combines elements of mutual respect for colleagues, inner motivation, self-direction, professional responsibility and personal accountability, and the joy of discovery. This socialization process associated with problem based learning lends to its credibility not only in the realm of the intellect, but in respect to the outcomes associated with medical education and the resultant professional and personal qualities of the physician.⁵³

And more clearly presenting the problem-based approach as the basis for a paradigm shift in medical education, consider the following⁵⁴:

The call for reform, as physicians and patients recognize the need for movement into a mode of education that allows for the interpersonal dimension, is made clear in the literature as various authors state their reasons that relate to individual personal needs and the global needs of society. This movement emphasizes formal and informal components that lend themselves to greater student interaction, mutual respect, and a joy of learning that fosters a positive personal and professional attitude. The major components of reform, the incorporation of problem based learning and the integration of the interpersonal dimension in medical education, both provide formal and informal processes that encourage empathy and compassion, interpersonal interaction, and a more holistic view of the patient, health care and the world. Problem based learning, with its student centered modality and professional inquiry allows for reflective proactive, in-depth inquiry and

⁵³DiBartola, 62.

⁵⁴see also Michael Krausz, "Changing One's Mind, Changing One's Emotions: An Inter-Cultural Perspective," in Philosophy from an Intercultural Perspective ed. Dieter Lohmar, (Amsterdam: Rodopi, 1997).

critical thinking, interpersonal interaction between students, self-motivation and a resultant effect of long term learning as students take ownership to the problem solving event and actually meet the process with an element of enjoyment.⁵⁵

Pence makes the following basic proposal to support the development of the ability to practice compassionately: ". . . first, flexibility in the time-demands of students to allow them to pursue particular cases in which they become involved; second, systematic acceptance by medical teachers that such activities and the moral qualities they develop are worth encouraging."⁵⁶

Again, similar to my suggestions in this and the previous chapter, it is imperative that the students be explicitly encouraged to involve themselves emotionally with their patients. If those who hold the responsibility for training and evaluating medical students do not take it to be their role to teach students to practice compassionately, then a sense for the artistry involved in practicing medicine will not be conveyed. There must be supportive physicians and administrators at the top of the medical hierarchy who truly value the artistic skill involved in developing compassionate relationships in health care. Without such support, medical students who do take seriously the suffering of their patients will be put in the unenviable (and morally challenging)

⁵⁵DiBartola, 79.

⁵⁶Pence, 190-191.

position of either learning to focus on the disease and not the patient, or suffering with her patients and thereby acting in a way not recognized by those who set clinical grading standards.

Both problem-based learning and the palliative care model provide alternatives to the curative model, alternatives which allow a greater focus on the person who is the patient involved in the health care relationship. Such alternatives also help emphasize the import of caring compassionately for patients.

In light of the suggested paradigm shift being considered here, Lu puts it as such:

. . . students need a place where compassion is taught, nurtured, and cultivated. An environment where every care giver is caught up with his or her own success or failure, self-absorbed in self-advancement, will not do it. An environment where students are brutalized or patients depersonalized will not do it. Students need a place where compassion is valued as a central goal of medicine, a place where compassion is practiced because that is who we are and what we do.⁵⁷

4) Integrate the basic sciences and the clinical study

Deans must make a commitment to broker support for a de-curricularized form of ethics instruction, to decrease the distance between basic science and clinical medicine, and to blur traditional distinctions between what is characterizes as the "art" and the "science" of medicine. From dean to department head, from clinical chief to individual faculty, from one segment of the health care team to others, there must exist a belief within the culture of medicine that in health care, issues of morality and ethics are ubiquitous to the

⁵⁷Lu, 458.

organization and practice of medicine.⁵⁸

The focus in clinical training should include the desires, feelings, perceptions, and general interpretations which are involved. Students are being trained how to do something, and this something includes patients. A scientific understanding of medicine is an incomplete understanding of medicine as a practice. Medicine, as practiced, is an art, and this art is only practiced competently with the practitioner having the ability to also consider compassionately the suffering of her patients. Without this artistic ability, the practitioner is merely a scientist imposing diagnoses and treatments upon the real lives of patients which the scientist likely does not understand.

The arts can help in coming to terms with the emotions and conflicts which are released in anyone caring for the sick. Most importantly, Downie (1992) notes that the arts generate moral questions. Yet the arts are absent from medical education. Even if a student has an interest, the lack of time created by the lecture, lab and study schedule would prohibit any study of the arts. Although medical students may have an in-depth knowledge of the physical sciences, they have little understanding of human nature and emotion as a result of this single agenda curriculum (Downie, 1992). The single pursuit of scientific mastery has resulted in a single-minded personality which allows for one right answer for a problem rather than a multidimensional, contemplative answer with comprehensive understanding (Conrad, 1988).⁵⁹

Clinical training should include a consideration of the

⁵⁸Hafferty & Franks, 869.

⁵⁹DiBartola, 31.

right and wrong diagnoses and treatment proposals in light of the lives which are being considered. The point here is similar to the one made above in the student participation-section: clinical training must include a consideration and evaluation of the artistic as well as the scientific ability of the clinical student.

5) General medical education should provide the opportunity to study subjects of special interest

Specialists have the distinct advantage, in light of practicing compassionately, of perceiving and understanding better the suffering of patients in that specialty. General practitioners do not have the technical expertise that the specialist does in the specialist's field of study. For example, a cardiologist would likely have more information than a general practitioner for a patient with a heart problem.

However, specialists will likely not have the relationship with the patient that the general practitioner has with the same patient, as the general practitioner will likely have a longer relationship and more experience with a particular patient than the specialist. The rapport and trust that is developed over time cannot be underestimated, as the patient may not be willing to share information with a stranger (specialist) which he will share with a general practitioner who he knows.

This rapport and trust gives the practitioner access to

the way in which the patient is suffering. In light of the salient features considered above, this means that the salient features of the situation (e.g., that the patient has been using illegal drugs, has been struggling in keeping his marriage together, or that he is going through and is worried about a "mid-life" crisis) will be more easily and readily brought out into the open. A specialist who does not have trust and rapport with a particular patient may sense that he "does not have the whole picture."

As specialists may deal with more patients who are strangers and have been referred to them, it will be important for them to be able to care compassionately for their patients. Having special interests will have the student motivated to learn, and may be motivated by the student's personal experiences with the study chosen as a specialty (personal experience lacking in other fields they may potentially enter).

Related to both the benefits of specialization as well as the benefits of experiencing an illness or disease for oneself ("student participation"), consider that personal investment in the effectiveness of treatments has been shown to be the major motivator behind many a medical breakthrough. In a recent special edition of Time Magazine, entitled, "Heroes of Medicine" (Fall, 1997), several health care workers were considered under a section called, "Physician, Heal Thyself." This section begins:

Detachment, viewed as a virtue among scientists, often feels unnatural to medical practitioners, who see human involvement as central to the healing art. For those who have themselves been afflicted with disease or observed it in a loved one, the experience can become a driving force in their search for a cure.⁶⁰

The health care workers focused on in this section included a physician who induced asthma episodes with himself, an HIV+ physician who searches for a cure by dosing himself with highly toxic AIDS drugs, a psychology professor who "began taking lithium and directing her research toward manic-depressive illness and suicide," a physician who acts "as his own guinea pig to discover the true cause of peptic ulcers," and a Hanoi herbal medicine doctor who is seeking "a durable cure for opium addiction by becoming an addict himself."

I present these examples to represent the benefits of specializing in medicine. In light of the value of caring compassionately for patients, the question of whether or not to specialize seems secondary, as being compassionate, whether specializing or practicing general medicine, is the major focus here.⁶¹ It is important to recognize that all health care workers must be able to practice compassionately. In light of the training which is being considered here, the important point is not how to increase the number of individuals who pursue one area of study rather than another,

⁶⁰Leon Jaroff, "Physician, Heal Thyself," Time (special issue) (Fall 1997): 84-86.

⁶¹Of course, it is important to consider the motivations for entering any particular field of study.

but instead is how to increase the number of compassionate health care workers in all areas.

Conclusion

We thus come to have relevant points of view for discrimination as a result of having certain emotional dispositions. We notice through feeling what might otherwise go unheeded by a cool and detached intellect. To see dispassionately without engaging the emotions is often to be at peril of missing what is relevant.⁶²

Compassionate action will have one better able to deal with situations in which, for example, the patient may very well be better "not getting fixed," as the (emotional as well as financial) costs of fixing those things may be too much for some patients. These attributes of that with which the patient is suffering must be perceived (in common vernacular, "sensed") by the health care worker if she is to be perceived as compassionate by the patient.

In these ways, we may be able to see better the health care worker's dispositions to act. That is, certain patterns of interaction with patients (and others in the health care setting) will reveal a general perceived character of the practitioner. It seems logical to anticipate results including surprise and a humble feeling, cynicism at this method of considering ones experiences as capturing their character, a feeling of being overpowered at the requirement

⁶²Sherman, FC, 45.

of practicing compassionately, and a general denial that compassion is important for health care in today's managed care setting where health care is primarily a business, not a place to treat AND heal. A program of teaching and fostering compassionate practice would likely be most strongly criticized by one who denies that emotional investment necessary for practicing health care competently. However, in light of the arguments presented in Part I supporting emotional investment in close relationships, and the many positive benefits of specifically practicing medicine in a compassionate way, it seems that the burden of proof is on such a critic.

Conclusion

Introducing the Humanities into Clinical Training

The image of a physician armed with a phalanx of ethical skills but shorn of virtue is a frightening depiction of what might be claimed as ethical medicine and the ethical physician. The system is driven by virtue, not facts and skills, and it is high time that medical education made concerted efforts to claim a higher moral ground by recognizing its obligation to train virtuous as well as technically competent and knowledgeable practitioners.¹

Today, clinical learning in medical education largely takes place at university hospitals. In the initial move from the university setting to the hospital, only the so-called hard sciences made the trip, while the humanities and social sciences were left behind. There has been one general negative long-term effect of this move on the way in which the practice of medicine is taught: many of those who are capable of teaching students about the art of practicing medicine are still back at the university. As a result of this, along with the lack of explicit curricular focus on developing the medical student's ability to practice compassionately, medically training lacks an adequate focus on the suffering of people who are being treated.

As compensation for leaving the humanities behind at the university as well as (and probably more importantly) because of the increase in the number of ethical issues being raised about medical practice in today's training hospital, medical

¹Hafferty & Franks, 870.

schools and residency programs offer medical ethics courses and seminars. Although this a step in the right direction, it is grossly inadequate in light of the place which values and interpersonal skill play in effectively and competently treating patients. Developing an appreciation for medical artistry, a sensibility for the salencies of situations which reveal ethically appropriate actions, and the ability to care compassionately for patients all requires the medical student to involving himself emotionally in caring for the suffering of patients.

The position of the ethics consultant in training hospitals is currently quite limited. This is because medical training largely teaches medical ethics in a theoretical way, with little explicit focus on shaping the moral character of the medical student. The clinical ethicist could be more instrumental in helping construct and implement the medical curriculum with attention being given to the socialization process of medical students. Emotional episodes during clinical training, and the values which are revealed and taught to the medical student and resident in dealing with such episodes, are a major method of socialization (the "hidden curriculum") in medical education. Such episodes can be used to help the student better understand the art of medicine and the major part which her values play in the regular interpretation (diagnosis) and decision-making of medical practice. Of course, ethicists are trained in

different ways in different programs. However, one role for a (properly trained) ethicist would be to participate in training medical personnel. As was presented, this will include not merely understand the interplay of values in the medical encounter, but also in training the personnel to enact particular values which are preferable for medical practitioners to hold.

What has been presented in this dissertation will, I hope, play a part in beginning to train medical students in their ability to care compassionately for the suffering of their patients. Such a goal can be achieved through nothing less than an explicit requirement on medical students to focus on developing the ability of medical students to care compassionately for patients. This focus must be conveyed to the medical student throughout his training. Seminars designed to foster a compassionate disposition will only be effective if accompanied by the commitment of those who design the medical curriculum and those who are responsible for actually conducting medical training. Otherwise, these skills will continue to have "second-class" status, and medical students will continue to be socialized to treat vulnerable patients in an impersonal and emotionally detached way.

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APPENDIX

APPENDIX

(For information about and/or copies of other interviews conducted, please contact me at the following address:
Box 525, Perryopolis, PA 15473)

Sample Interview from Chapter 3**Interview #11 (25 year-old male)**

i- Ok. Would you tell me about a time in which a health care worker had acted compassionately towards you?

p- Do you want one specific instance, or do want a whole cluster of instances, I guess?

i- It's up to you.

p- Either/Or? Alright. I'll tell you what, how about if I give you a little bit of each, when they haven't been compassionate and when they have been compassionate. How will that work?

i- Fine.

p- Alright. Um, I'm going to start with an uncompassionate instance. I broke my neck about four years ago. And, uh, anyway, the, uh, I went to a doctor that I know, and I went to the hospital and got all taken care of out west. And I had to come back here, so I changed doctors, and the doctor here was not very compassionate. He was just, he was just a jerk all together. And, uh, and he was, uh, he looked down on you and said like, "Aw, it can't be that bad." And, you know. . . What are you looking for here? Do you want me to just explain the whole thing to you, or?

i- And you said that this guy was not compassionate?

p- No. Not at all.

i- And why would you say that he wasn't compassionate?

p- Just because, he didn't- like uh, he was like a, he was worse than what you would think a robot would be. You know, he would just come over and feel your neck, to see if it was alright, and I'm telling him, "This is the most severe pain I've ever had in my life." You know, "Be careful." And he comes over, grabs my neck, and starts squeezing it around, like, I mean, you know, it was really hard not to flip out. And it hurt. I let out a little yell. And it was like no big deal. He kept doing it. I was like, you know- and he was like he didn't give two flips. And it was like, "No big deal. You'll be alright. Just go on with it- deal with it." And, uh,

it was, it was- the guy was a total bum. I mean it was just like, uh, he was just obviously, he just didn't care about the patient. So, uh, you know, it was like, he was using his position as a doctor, he thought of himself as a doctor as way above and beyond, you know, the person who he was actually working for and trying to help, and he just treated me like I was some lowly, don't know anything- like this is it, deal with it. So, um. . . .

Let me go ahead and give you an instance of compassion, I guess. (i- Ok) I've had a bunch of knee-surgeries, so I'll just lump them all together. I've had 10 of them, all together. And they've all been in CITY. The first one was when I was 14-15, something like that. And I went to a doctor here in STATE, and he was another uncompassionate doctor. Anyway, he was treating me as a stupid kid. "Oh, you know, well, this is wrong and this is wrong," and you know, he's all high and mighty and not compassionate, blah blah blah. And then I ended up going to CITY and the people in CITY- this doctor, he's one of the best in the world. He, uh, designed these procedures, one of only two people in the world to do these specialized procedures. And everybody knows who he is, and he's just a- you know, he does all of the football stars and athletes, and this and that. And this guy, he's the best of the best when it comes to knees. And if you would think of somebody who's going to have an attitude, somebody's going to be cocky, somebody that's that good- this guy, he's the nicest, most caring, doctor, health care worker, whatever you want to call him, that I've ever had or ever heard of. And this guy- and his whole staff, for that matter. All his nurses, and everybody, they care what's going on with you. They come in to listen to everything you say. And it's not like it just goes in one ear and out the other. They- you can tell they think about it- they respond to it, they try to help you, they're going to do whatever it takes to do what things right. So it just seems so backwards. Very, very compassionate. If there's any kind of problems, anything, it's like a, just the littlest things, you come in, and most doctors, you know, they just chit chat, and you know, they don't care what you are saying, but you know, you come in, staff will come in, and they will like, carry on a conversation with you, you know, they care what you are saying, you know, anything, golfing lately, or blah blah blah, and they carry on a conversation with you like they're your friend. So, uh, I guess it's a real class act, they care about their patients.

i- So the difference between the people in CITY and specifically the knee doctor, and the guy who saw you neck, is that the people in the CITY listened to what you had to say?

p- Oh yeah, they listened to what you had to say, and uh, more importantly they will respond to it, instead of, you know,

even if they- even if they like seem to listen to you, these people- because a lot of doctors will listen to you- these people, you know, they really take it to heart. You know, the nurse, the nurses there, you know, the registered nurse, or whatever- whatever they're called- a step right below the doctor, you know, they can do all the stitching, and whatever they're called (i- practitioner?) Yeah, something like that. Still, they're important, pretty high on the doctor scale. They're like, uh, here's home phone numbers, if you have any problems, feel free to call us there. He was like, "Anything important, we'll try to help you out as best we can." And they really did. It was amazing.

i- So they really cared?

p- Yeah, they really cared. You know, it was like they really deep down care about it. I mean, you know, from a- they don't treat it just like a job- they don't act like a robot or a machine doing their job, you know, they care about you as a person. And you know that they have feelings, and you know- it's like if I'm hurtin', in a way they're kinda hurtin'. And you can tell. And it makes any of that a lot easier. You know. When you have to spend a lot of time in the hospital And doing all of this stuff, is painful as can be. And when you know there's people there helping you, like they do, and um there for you, and you can just tell that they genuinely care. Then it's- you know, it made my job as a patient, my recovery from physical therapy and everything- much easier and quicker, and uh, from, I guess, mental aspect, it kept me in much better spirits. All that kind of good stuff. . .

i- So you said that they genuinely cared. Could you give me any examples of things that they did?

p- That they did? Like I say, I mean, the, I guess the RNs, or the PAs, the physician's assistants. You know, they- use the home phone numbers, "If you have any problems, you can call me any time there." Which is what I think way above and beyond- you know, which is- that's a specific instance. Let me think. They, uh, they let me leave the hospital a day early. That counts (laugh). Well, something that's, that wasn't really as much me as a patient- I was in- this was one of my last ones- only a few years ago- you know, I've been through all of this, and pretty much know all of the people there. I've been there a lot longer than a lot of the nurses (laugh) I know all these people. But there's a fella there who had to have the same thing done, and the procedure I had on both of my knees was bone and cartilage replacement inside the joint. It's a fairly rare thing. And, uh, there was a guy in there that's, you know, they had just told him this was wrong, and you're going to have all of this done. And I explained to him the process. And that's a pretty hefty process. You spend 6

months on crutches each time. And it's- they tell you up front- it's painful. It's not like a ligament, or a ham- or anything like that- an ACL, or whatever you want to call it. And he seemed pretty worried, and they're like, they came back and they asked me, "Hey, could you come back and talk to this guy." And you know, just things like that. And you know, most doctors wouldn't really care. And they're like, "You've been through a lot," you know, "Go back and tell him about it." And, uh, so I went in there and talked to him about it. I know that if I was in his position, it would probably make me feel a lot better. So, all depending on what the person said, I guess. But, for the most part, the doctor, you know, I guess that's not something that he did, but you know, it's like- something I don't think that most doctors or health care workers or something would do. They just say "That's what we got to do," and bang bang bang. You know, "Pay your bill and come back on operation day." You know, they, they . . .

Another specific instance. . . let me think. . .

i- Well, as far as what you just said. They had you go in and talk to this person who was going to do the same thing which you already had done. And to you that was something more than what they needed to do?

p- Exactly. I mean, much more. It seems that a lot of doctors, and I can tell you from experience, that a lot of them will say, "This is what is wrong. Suck it up, be tough." You know, and that's it. And you go into have an operation or whatever, and you don't know what to expect, it's all new and it's coming at you, and a lot of doctors will explain stuff- you know, it's, it's a frightening experience. You know, especially when you have to sign those forms saying that I will not sue if I die, you know, just things like that, you know, but um, everything that- the whole operation- any kind of operation, or anything they have to do to your body, you know, I don't think that anybody that's outside of the health care industry is ever really comfortable with having stuff done to them. And it's like they understand that, and it's like they try to, you know, be- take that into account.

And another thing. When I went in for one of my surgeries, and uh, it happened to be my birthday. Anyway, the two RNs, or PAs, or whatever they are, I don't remember, they came up and they were wheeling me in, they started singing happy birthday to me. And I came out and they had a cake or pizza or something like that. And it was like, "You know, you didn't have to do that." A lot of people wouldn't. You know, their job is done. They could have gone home. But they stuck around anyhow. So it was kinda. . .

i- So these doctors and nurses actually threw a little party for you?

p- Yeah, exactly. Gave me a little extra anesthetic (laugh) No. . . you know, just things like that. It makes you feel like- it certainly takes the edge off of the situation. It's different, out of the ordinary.

i- So, again, doing more than what they need to do?

p- Exactly. Doing way more than they need to. I mean, going above and beyond their job. I mean, their job is to fix me up and to get me better and to get me back on my feet. And they took it to a more, uh, a much more personal level. And they were- and instead of just being my doctor, they are actually my doctor and my friend. You know, I could call them any time and he's one of the busiest guys I know- and I know I could call him any time and I know that he would take time out to sit down and talk with me about that. You know, whatever. About fly-fishing or whatever. So it's uh, above and beyond. It's definitely neat. And you know, you go in, and I hadn't been in for three to four years. Something like that. You know, enough time had gone to where you remember people but it's not like you see them everyday. And, uh, I went in and it was like everybody still remembered me, they were like, "Yeah. How's your brothers," and, "How's this?," and "How's that?" I mean they remembered things about you, but it's not in your charts. It's not there, it's like, uh, you know, talking to you as your friend. "How's this and how's that?" So I mean just- even that, just remembering you. A lot of doctors you go in and they say, "What is your name?"

i- So a more personal experience?

p- Oh yeah. Much more, much more personal. And uh, like I said, it's such a- people messing with your body is such a, uh, such an unpleasant thing. Unless it's a chick. (laugh) Uh, but. . . they make it much easier. . . I can, uh, guess go a little bit beyond that, if you want (i- Mmm Hmm), and tell you about my physical therapist and the therapy center here in town. These people have become since, uh, let's see, my mom hurt her knee a long time ago, and then I got to know the people a little bit, and then when I hurt my knee, I tried to go to this one place, 'cause I can't go all the way to CITY everyday for therapy. And uh, anyway, I come back to town and try to go -- for a physical therapy center. And they were like, very uncompassionate, very, you know, "This is my job and I'm just going to do it." You know, and a lot of times the therapy is worse than anything, 'cause they are kicking your ass. But, um, just very uncompassionate. I was in the waiting room forever, and I couldn't put my leg up, and it was all crowded, I had surgery a couple of weeks before, and just, you know- that was the first time that I had surgery, and it was just a mess. And you know, I went to the therapy center, and so we went over there, and since I started going to the

therapy center, I've gotten to know the lady who owns the place, you know, her and her husband, real well. And over the 10 years that I've been doing it, they've kinda become a second set of parents towards me. You know, before that, it's like, you know, these people who come in, MJ especially, she really looks into the therapists who she hires. You know, they have hundreds of therapists working for her now, she's got 6 or 7 places open. And all the people --- she's just a real good-hearted person. She just takes a real- it's another thing like uh, when I'm hurtin, she would be hurtin, or whatever therapist, and it's like they want to see you build and grow and get you leg bent another 5 degrees. And they are just really sincerely working towards it with you. Whereas I have been to a couple of other ones. . . Like the therapy place in town, it's very hard to take. They were doing their job like robots. You know, "Ok. Bend your leg. Bend your leg. Bend your leg. Do this ten times." And that was it. But here, the therapists are really- you know, you go in there an hour, two hours at a time- and for those two hours, they are doing the exercises with you. I mean not physically, but they really sincerely want you to get better. They're not just, "Ok. Hurry up and get all of your leg-lifts done so I can get out of here." So, you know, they care, they want you to get better, they'll do anything to help you. Just like they actually care, instead of, just doing their job like a robot, I want to say.

It's like I've seen so many people, so many doctors, people around them pretty much just -- like I've seen how crummy some of them can be. It's like, it's so nice when you have people that care, doctors behind me going- they sincerely, really care, they want you to get better. It's like, you know, me being better, me being happy about my progress, and getting along like I -- kind of, it's like, it kinda builds them as a person. It's like it was more than just a job, but it's- they enjoyed it. It's what they want to do with their time. You know, a lot of them, I might go far as to say, they do it as volunteers, you know. A lot of them, you can just tell, they just care about people. . .

i- So I hear a nice- a strong division between people who care and people who don't care (p- Mmm Hmm) in health care. Uh, and the people who do care seem invested in your progress, personally invested.

p- Oh yeah, definitely. . . You know, the people who do care, I think they make such a lasting, they have made such a lasting impression on me, I don't think that I will ever forget them until the day I die. And likewise, me as a patient, it's like, you can just tell, not just because it is me, I mean, anybody would tell you that they helped me, I don't think that they'd probably ever forget them, because it's like they've been, been such a. . . you know, they've just invested themselves in the person. It seems like it means

so much to them. They just got the heart for it, I guess. And it just makes all the difference in the world. I know from experience that trying to recover from any kind of injury, especially kinda serious, that it's just as much physical- it's more physical, obviously- but it seems like it's just as much physical as it is mental. You know, you're laying in bed thinkin', "I got to get better, and I have to do this and this and this to get better," and it's so easy to just let your spirits just go downhill, 'cause it's like when you start college as a freshman, it's like graduation is just so far off, it's easy to lose sight of it. It's the same thing with any kind of injury. . . or surgery, it's so easy to- you know, you're in pain, and you can't walk, and in my case you can't do things that you had done all your life. Like when I hurt my neck, simple as turning my head, couldn't turn my head, so down with, you know, just going through the roof in pain. It's like, it's so easy to just go, "Screw it all. This sucks." And just, you know, just not do your exercises, or not go to therapy. . . physically it's- mentally you have to just keep going, you gotta keep pumped up about it, and it plays a big role in your recovery. And you got a health care worker helping you through that part, whereas an uncompassionate one just cares about your physically getting better. You're all depressed all the time about it, and a lot of them don't give a flip. You know, these people that are -- been so compassionate, and they really care about that. I mean, these people, I don't think they'd mind at all, they'd probably like it, if I was getting down about this or that, call them at home. A lot of them would, you know, prop you back up, and give you a pep talk.

I know, the people at the therapy center- you know, one of my surgeries, it happened, uh, I'd gotten to know him pretty well by this time, so I don't guess that this applies for everybody. And I had this knee surgery. I guess I was about 18 or so. Afterwards, he just spent about 2 weeks- you're not supposed to get out of bed, you know, all that bone and cartilage screwed into place, and everything, and you're not supposed to move- so really, you can't take care of yourself. And my uncle and the whole family are leaving town. And, uh, MJ came down to CITY and let me stay in their house for a few days, you know, their own house. It's like, you know, they just take such a personal interest- just anything to get better. And, uh, ever since, I mean, I said that my relationship with my therapist has been just like second parents. It's like any time there is anything is wrong with me, like if I pull a muscle, it's like, "Come on over. I'll take a look." You know, if I twist my knee, they're the first people I call. I guess it makes it kinda biased, since they're such good friends of mine now, but it's like, anything to- if somebody's hurtin', they want to help. A little off track, maybe (laugh) . . .

i- Well, uh, as far as compassion goes, that was an incredibly compassionate thing to do, for them to let you stay in the house.

p- Oh yeah. I mean they took care, and cooked the food, and helped this, and helped that. Helped me go to the bathroom. You know, they're just so- just good people. You know, I'm, whatever, indebted to them, and the doctor for that matter. The uncompassionate doctor from STATE, I talked about very briefly about my knee before I went to CITY. He said, "This is what's wrong. We could take this chunk of bone that's broken out of your knee, let it heal, and you'll probably be in a walker or a wheelchair by the time you are 30." And he didn't have any problem saying that, no promise, not "I'm sorry and it's going to be rough." --- So he didn't give a flip. Just like a robot. And, he's a real cocky individual, I don't know if that's got something to do with it. Maybe he actually felt bad and that's how he deals with himself. I wouldn't guess that's the case with this particular guy. But, you know, when somebody tells you that when you are 10 years old, that's got to be overwhelming. It's like somebody stabbing you. . .

i- So you have a robot on the one hand just giving you the basic facts, and then you have these people who actually take you into their house . . .

p- And would do anything for me. It's just incredible how different it is. Especially such a clear cut line, I mean I'm sure there's a lot of- I don't think anything in this world is just black and white. But from my experiences what sticks out- there's definitely a line. There definitely is a line. There definitely is one. That just sticks out in my mind from all the experiences I have of doctors. And it's just amazing how, you know, how some of them care so much, and how some of them care so little. It's like, uh, I think, I think maybe the case with some doctors -- you know, like, "You'll not going to be able to walk right ever again." You know, maybe some of them feel bad about it. They don't want to get all emotional about it. I mean, a lot of times I hear that they're trained not to put a lot of emotion into it. It's like you can see through that with a lot of them. Like this fella in town, he's just a cocky bastard, he didn't care, you know.

i- So some of them are involved and are actually bothered by things that are wrong with you, while the other ones just. . .

p- I don't know that I'd use the word "bothered." Maybe they're bothered, maybe they're not. But like, the people in CITY, they keep such high spirits about everything, they don't give the impression- maybe they are or not bothered- but they

give the impression, like, "This is what's wrong. We can do this and this and this." "We're going to get you better." "We're going to take care of you" It's like they don't even let you really start thinkin, like, "Hey, I might not walk." It's like, you know, they're just so high on spirits, and they like, "We're going to take care of you," instead of, "We're going to go in and operate, and we're going to take this part out, and we're going to replace it with this, and do that." But it's like, "We're going to take care of you and this is how we're going to do it." It's like two different perspectives. A really, really, like. . . I think it's appropriate to compare, to have the one's who just want to do this and this and this, to kinda like robots. Just do it, you know. They're just doing their job. And it makes the- makes everything more difficult. I guess the mental aspect of it all . . .

i- So the people who really care for you, help you psychologically to deal with what you're dealing with?

p- Oh yeah, definitely. It's not like they just sit there and counsel you, but it's just, you know that they're there for you, that they're really on your team and will do anything for you. It's just. . . yeah, definitely. It would be interesting to see some kind of study about how people recover from similar injuries from Dr. A whose known to be a schmuck, and Dr. B, who's a real compassionate person. Assuming that the actual cutting scales are pretty much the same. I just think the mental aspect of it, just being there for you, nice and kind, you know, "Anything we can do for you," staying in high spirits, keeping you pumped up, just makes all the difference in the world. You know, everything.

i- What do you think the result of the study would be?

p- I really honestly think that the psychological and mental part- you know, the people who have higher spirits and people who have been with a compassionate doctor, I really, honestly think that their recovery is generally going to be quicker and better, and maybe faster, and end up stronger in the end, instead of somebody who's just kinda being toughed through it. I really think that it's, that the psychological aspect of it, plays a huge role, just in how they take care of you.

i- So these compassionate people do more than what's required of them?

p- Yeah, definitely. I mean, yeah, I think so. I guess one person could say that it's the doctor's job to not only cut you open physically, but also, you know, take you-care about you or something. And somebody- that my be their understanding of what a doctor is supposed to do. Another person's idea

might be that they're just supposed to cut you up and clear you off and go. So to me, they're doing more than what is required of them, but everybody looks at it differently, so.
. . .

i- But, whether it's required or not, it has a more positive effect on your outcome, on how you end up?

p- Without a doubt. I definitely think so. . .

i- Ok. . .

p- Not from experience, but I would speculate that terminally ill people maybe would live a lot longer with compassionate people. That's really got no relevance to what we're talking about (laugh), but it's just that I would guess that, compassionate health care workers- that's the way to go. You know. . .

i- So they really care about whether you get better or not and you psychological well being, as opposed to the robots?

p- Exactly. I think most of them do understand that the recovery- the psychological effect plays a real big role, I think they know that also. . . so

i- Would you say compassionate people are just different sorts of people than the robots?

p- Oh yeah. I would say that it's not a difference in how they do their job, but it's a difference in who they are as a person. It's a difference in their disposition- you know, if they got a good heart, or however you want to say it, the difference is if they are a good person deep down. Not how they'd been trained, or what medical school they went to. Although it makes a difference, but when it comes to the compassion part, it's not something that can be taught, it's something that you can work on, but I don't think that it is really something can be taught. . .

i- So you have this group of people who want to be health care workers, and some of them are robots and some of them are compassionate? (p- right) And the compassionate ones will do whatever they can? They'll go above and beyond what is required of them in this job? (p- right) But the robots will do just what they need to do? (P- they'll just get in, do what they need to do, and make it for tee time) And so in the first example you gave, of your neck, this guy didn't even listen to what you were telling him, which was this is hurting me (p- didn't listen, didn't care). Now what would the compassionate person had done in that same situation?

p- The compassionate person, I mean. . . I can tell you, when I broke it I was snow skiing. Anyway, I get to the hospital, and the lady there, she -- anyway, I spent a lot of time to get to know her. It's not like she's coming in and grabbing and feeling. She listened to what I had to say. And taking every precaution to, you know, make sure that she didn't hurt me. You know, not like long-term, I might be paralyzed or anything. But just, make sure I'd comfortable, and it was like she heard what I said, and you know, with this- instead of saying, "Here's this neck brace. Put it on. It will be the best thing for you." Instead, she said something to the effect of, "Well we could do this or we could do this. This will help you like this and what are your thoughts on it." And uh, whereas the noncompassionate guy like the next fellow that just messed up my neck, saying more or less, "There's nothing wrong" . . . didn't care what I said. Didn't even care about my reaction. Grabbing my neck. And you know, I've gone through a lot of knee surgeries, and I've gone through a lot of crap, but nothing has ever hurt more than when he grabbed my neck. It's ridiculous because it was like he didn't even care. He didn't even care. You know, he did it and I more or less went through the roof in pain. And he just kept doing it. It was ridiculous. He didn't care about it at all, and pretty much told me that there was nothing wrong with it. I was ready to hit him. But, I mean there's- it's my opinion that there's no place in the medical community for this guy. Somebody with an attitude like that. I mean it was ridiculous.

i- So, uh, compassion may be going above and beyond is required, but there's a certain amount that is required?

p- There's a certain amount that is required. Even these people who act like robots, a lot of them will still treat you like a human. But this guy, it was like he was working on a freakin engine on a car. You know, he was just cranking away. Yeah, you're right, there's a certain amount of compassion that you just have to have, to be a person, I guess. I don't know, I mean. . .

i- . . . So, uh, we've talked about a lot. What do you think are the basic characteristics of the compassionate health care worker?

p- Basic characteristics. I'd say, um, they're, they're, who they are, how they feel about people. You know, some people are egoists. Selfish and whatever's for me. Those are the people who just don't care. And then you have the people who are good people who care about how people are, and just care about people in general. I think that's the biggest part, is what kind of actual person they are. You know, it's- that's really the biggest part. Because if you got this health care worker and they really care about their fellow human beings,

then they're not going to come in and see you wearing ---, they're going to try to help you out. But somebody who doesn't really care about people, that's where you get the robots. . . maybe what they put in, you know, that's overtime- like the people who are call- any time, 24 hours a day. Not necessarily -- people, when their shift's over, they're going to take off, you know, for example. But people are like, they're not just there to do a job, but they like what they're doing. They really care about people. You know, they'll put more time into it, they'll put more energy into it. . . those are probably the two biggest things. . .

VITA

Matt Stolick was born in Greensburg, Pennsylvania on September 18, 1969. He graduated from Mary Fuller Frazier High School in 1987 and from Westminster College (Pa) in 1991 with a B.A. in philosophy. He attended Louisiana State University Law School in Baton Rouge, Louisiana in the fall of 1991 and spring of 1992. In the fall of 1992 he entered the post-baccalaureate program at the University of Pittsburgh. In the fall of 1993 he entered the University of Tennessee-Knoxville. In the spring of 1995 he received his M.A. in philosophy. He received his doctoral degree in August of 1998.