APA Newsletters

Volume 06, Number 1 Fall 2006

NEWSLETTER ON PHILOSOPHY AND MEDICINE

apa
The American
Philosophical Association
University of Delaware
Newark, DE 19716

ISSN: 1067-9464

APA NEWSLETTER ON

Philosophy and Medicine

Rosamond Rhodes & Mark Sheldon, Co-Editors Fall 2006 Volume 06, Number 1

FROM THE EDITORS

This is a fascinating edition of the *Newsletter on Philosophy and Medicine*. It includes papers from two Committee-sponsored sessions and a wonderful poem.

Mary V. Rorty of Stanford University organized this year's Committee-sponsored session at the APA Pacific Division meeting. The topic of this year's meeting was, "Medicalization: Rhetoric and Value." The term "medicalization" itself usually carries a negative connotation. This session was designed to look at the use of the term and the benefits and disadvantages associated with bringing a condition into the purview of medicine. The panelists, John Hardwig, Felicia Nimue Ackerman, and James L. Nelson, discussed the ways in which the incorporation of medical treatment into each stage of life is, in fact, a good or bad thing.

The papers by John Hardwig, Felicia Nimue Ackerman, and James L. Nelson are all included within this issue and provide diverse opinions on the subject. In his paper, "Medicalization and Death," John Hardwig carefully analyzes the implications of the term "medicalization" in today's society and then delves into the medicalization of the dying process. Hardwig explains how putting off death can cause harms to society and the patient. In her paper, "In Praise of Fairy Godmothers: A Limited Defense of Medicalization," Felicia Nimue Ackerman argues that medicalization is not the evil it is made out to be. She maintains that if medicine could create a magic pill to solve a medical problem there would be little reason not to take it. In "Boxing with Shadows: Medicalization and Other Fetishes," James L. Nelson looks at medicalization with a sympathetic but skeptical eye. He shows us how to appreciate some implications of spreading the domain of medicine while being wary of other expansions.

Lee M. Brown of Howard University organized the APA's Central Division Committee-sponsored session. The topic of this year's meeting was "The Role of Compassion in Medical Education and Medical Practice." For this session Lee Brown had recruited a large cadre of speakers: Laura Ekstrom, Gordon Greene, Ben Rich, Sandra Shapshay, Howard Spiro, and Angelo Volandes. The panel offered their views on empathy in regards to medicine. They raised questions about whether and how empathy contributes to medicine or hinders the practice. These insightful discussions led directly to consideration of the implications of empathy for medical education.

We have four contributions in this section, three from session presenters along with the comments of the organizer, Lee Brown. In her paper, "Compassion, A Double-edged Scalpel," Sandra L. Shapshay explores the proper level of compassion between doctor and patient. She explains a fitting level of compassion as one which allows a bond to form without impeding the responsibilities of the doctor. In "The Role of Compassion in Medicine," Lee M. Brown argues for the importance of compassion in science-based medicine, showing how better healing can be achieved through compassion. Ben Rich sheds light on aspects of the problem that arise in medical education. In his paper, "Breeding Cynicism: The Re-Education of Medical Students," Rich explains the phenomenon of the hidden curriculum which tends to purge compassion from trainees in the process of becoming doctors. Howard Spiro's "Comments on Empathy" distinguishes empathy from compassion. He explains why physicians must be empathic in order to relate to their patients and how empathy implies understanding rather than paternalism.

We are also happy to include "Henrietta Pratt, 80, Has a Surprise for You," a new poem by Felicia Nimue Ackerman.

In order to continue offering our readers exciting issues jam-packed with timely and informative pieces chock full of provocative philosophical discussions, please continue to send us your work. We also remind you to think of this *Newsletter* as a place for your announcements, letters, papers, case analyses, poetry, and stories. Please feel free to volunteer a book review. Your contributions and queries should be sent to Rosamond or Mark at the addresses below. Please include your phone and fax numbers and email address.

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FROM THE CHAIR

On Compassion, Collaboration, and Some Things Coming Up

David DeGrazia

With summer beginning and the three Divisional meetings for 2005-06 in the past, it seems a good time to record some notes on the Philosophy and Medicine Committee's activities.

My previous column discussed the panel we ran at the Eastern Division meeting in Boston, so let me move to those that took place this spring. At the Central Division meeting in Chicago, Lee Brown of our committee chaired a panel on the role of compassion in medical education and clinical practice. The speakers were Laura Ekstrom (William and Mary), Gordon Greene (University of Hawaii–Manoa), committee member Ben Rich (University of California–Davis), Sandra Shapshay (Indiana University), Howard Shapiro (Yale), and Angelo Volandes (Harvard). As Lee related afterwards, the panel addressed, among other themes, the concept of compassion and its relation to pity, sympathy, and empathy; their roles in humane treatment; the distinction between technical competence and humane competence; the effects of a work environment in which doctors are encouraged to spend little time with each patient; the optimal quality of contact between doctors and patients; the ways in which medical education desensitizes future practitioners; and the effects of sensitivity on patient recovery. Following the talks, interactions between the panel and audience were animated and illuminating. Panelists agreed that the topic merited a day-long event, so Lee is exploring the possibility of organizing such a program at Howard University. I was delighted to hear this report of our panel at the Central meeting.

I am equally pleased by the developing collaboration between our (American Philosophical Association) committee and the American Society for Bioethics and Humanities (ASBH). As discussed in my previous column, a panel organized by Rosamond Rhodes—coeditor of our newsletter and *ex officio* committee member—on the twenty-fifth anniversary of the Belmont Report ran at both the annual ASBH meeting in Washington, D.C., last October and the Eastern APA meeting in New York last December. Now we have arranged with ASBH for the panel organized by committee member Mary Rorty for the recent Pacific meeting in Portland, OR—"What's Wrong with Medicalizing?"—to reconvene next fall at ASBH's annual meeting in Denver. In the recent Pacific incarnation, in addition to Mary, who served as chair, the panelists were Felicia Nimue Ackerman (Brown), John Hardwig (University of Tennessee), and James Nelson (Michigan State). By all reports, it was highly successful. When it reconvenes in Denver, the panel will be of special interest to ASBH members who are not members of the APA or who were unable to attend the session in Portland. Prospects are bright for continuing such APA-ASBH panel sharing in the foreseeable future.

Looking to the upcoming academic year, our committee has begun plans for panels at the three meetings. Bob Baker is organizing a panel, to take place at the Eastern meeting in Washington, D.C., on ethical issues pertaining to epidemics, natural disasters, and bioterrorism. So far he has lined up Zeke Emanuel (NIH), Bonnie Steinbock (SUNY), and Dan Brock (Harvard) as speakers. (Having not heard any of these scholars address this particular set of issues, I am especially looking forward to this.) Meanwhile, Gary Seay has agreed to constitute a panel tentatively entitled, "Parental Discretion in Decision-Making for Children: The Case of Genetic Testing for Adult-Onset Disorders," for the Pacific meeting in San Francisco. And Mark Sheldon is working on a panel on ethical and philosophical issues connected with the pharmaceutical industry for the Central meeting in Chicago.

In addition to planning panels, the committee is undertaking to update our webpage. We will replace the 1997 survey of bioethics programs (primarily a list) with links to several up-to-date listings. The improved webpage will also include the *Newsletters* we have published since 2000 and more comprehensive information on our panels. In consultation with the APA, we may make other improvements.

In closing, one more piece of good news. I had expected in this column to wish the best to Lee Brown, whose three-year term was coming to an end. But, energized by the panel he organized and noting his earlier inability to participate fully due to medical issues, Lee requested another year on the committee—a request I enthusiastically endorsed. Thanks to Bill Mann, acting executive director of the APA, for giving Lee and the rest of the committee another year of collaboration.

Best wishes for the summer.

ARTICLES

Medicalization and Death

John Hardwig

University of Tennessee

Americans have enormous faith in medicine. A 1994 study found that 34 percent of Americans believe that modern medicine "can cure almost any illness for people who have access to the most advanced technology and treatment."[1] One has to wonder what these Americans think they will die of. Lack of access, presumably. By contrast, only 11 percent of Germans believe that modern medicine can cure almost any illness. The unbounded confidence of many Americans in modern medicine is clearly related to medicalization. I myself have worked on what I call *the medicalization of death*. I will return to that topic. But, first, it will repay our attention to consider what medicalization is. As with most concepts at the center of controversy, it is a slippery notion.

Medicalization

Medicalization is not a value-neutral concept. When someone talks about the medicalization of some phenomenon or aspect of life, she implies that there is something problematic or troubling about the way we are dealing with it: features of the phenomenon are lost or distorted through medicalization. The particular aspect of life is not well or completely understood from within a medical perspective. Perhaps, also, it is not effectively treated by our medical approach, or there are disturbing consequences or unfortunate side effects of having the matter managed by medicine. (These side effects are not *medical* side effects, for the remedy for side effects is more and better medicine.) None of this necessarily means that the medicalization of something cannot be, on balance, a good thing. But it is not a good thing without remainder. And the remainder is large enough to be cause for concern.

We do not, then, talk about the medicalization of cancer or Alzheimer's disease because we believe that cancer and Alzheimer's are unambiguously diseases and that neither is poorly treated or distorted by a medical approach. This is true even if the medical treatments we have are completely inefficacious and have horrible physical side-effects, as was recently true—and may still be true for all I know—of our treatments of most lung cancers. Inefficacious treatment of a cancer may precipitate concerns about informed consent, about violations of patient autonomy, about the still-prevalent problems of physician paternalism. But not about medicalization because most of us steadfastly believe that a medical approach to cancer is on the right track. It's the right way to go. Nonetheless, one might imagine someone who was concerned about the medicalization of cancer. Presumably she would believe that we have misdiagnosed the problem of cancer—perhaps that our medical approach to cancer causes us to downplay the effects of carcinogens in our environment, the role of diet in preventing cancer, or the power of the mind to cure cancer. This view would be that there are—or could be—better, non-medical approaches to cancer.

Some people may be concerned about the medicalization of ***any***thing at all, even the most straightforwardly physical diseases. A Christian Scientist, for example, might have concerns about the medicalization of *any* and *all* "diseases," perhaps about the deployment of our concept of a disease in the first place. At the other end of the spectrum, we could also imagine someone who is ***un***concerned about the medicalization of anything. I can imagine her saying, "If your love for your wife or for philosophy should falter, and there were a good pill for this, why not take it?" I have a colleague who claims that if her love for her husband were to fade, she would want that pill. Perhaps. But wouldn't she be concerned that this pill might mask the underlying causes of her fading love, rendering her unable to address them?

Some, then, are concerned about the medicalization of anything at all, and some may be unconcerned about the medicalization of everything. But most people fall somewhere in between. The vast majority of us can imagine things we would not want to see medicalized and other things for which we would readily embrace a pharmacological solution. If this is correct, neither across-the-board critiques of medicalization nor wholesale arguments against these critics speak for us. A more fine-grained analysis is required to capture our views. And the different beliefs and values that comprise a pluralistic culture like ours will standardly imply differences about which aspects of life are seen as problems, which problems are viewed as appropriate for a medical approach, and which are seen as foci of concerns about medicalization. The charge of medicalization is, then, like a Rorschach test.

Can more be said about this middle ground most of us occupy? It is worth noting that it does make sense to be concerned about the medicalization of a straightforwardly physical and health-related phenomenon—the medicalization of obesity or some forms of diabetes, for example. And this concern about a medical approach might remain even if one were interested only in the health-related aspects of obesity or diabetes. It also makes sense to worry about the medicalization of some purely physical symptoms—pain, for example. If my back hurts after I play tennis or my knees ache after I run, that may be important information. These aches and pains might be warning signs. If I had a pill that would prevent them, I might work myself into serious orthopedic trouble. However, I do not believe that everyone should share my concerns. If someone makes her living playing tennis or running marathons and regularly medicates her aches and pains knowing full well that she might later pay an orthopedic price, I have no objection.

Problems with Medicalization

Though we can be concerned about the medicalization of straightforwardly physical problems and symptoms, the more common concern is about a medical approach to problems that are thought of as mental, psychological, spiritual, or social. One may be concerned that Johnny's failure to sit still and pay attention in school is medicalized. Or that the process of aging is medicalized. Or that depression is medicalized. The *New York Times* recently carried a report about the soaring use of sleeping pills in the United States, and it quoted psychologists who are worried about the medicalization of difficulties with sleeping.[2] A recent graduate student at Tennessee wrote her dissertation attacking the medicalization of addiction. Another recently loaned me a book entitled *Medical Care of the Soul*, the title of which was jarring due to its suggestion that there is a *medical* approach to *spiritual* concerns.

Still, there are "mental" or "psychological" problems that many of us would be delighted to learn we can now treat pharmacologically. Concerns about medicalization do not parse neatly into the two sides of the mind/body dualism. A tacit endorsement of dualism is not a prerequisite for concerns about medicalization. Thoroughgoing materialists or identity theorists might still hesitate to take a pill for their faltering marriages.

As should be obvious by now, I suspect that the roots of the medicalization of a problem almost always go deeper than the power of the pharmaceutical industry or of the healthcare industry as a whole. Admittedly, drug companies, hospitals, and physicians have a lot of power. Their ability to influence us to accept their views and viewpoints is enormous. And the power of the healthcare industry is usually increased by medicalization. So, healthcare corporations have good reason to support medicalization almost wherever they find it and to induce us to support it, as well. All that is admitted.

But I think healthcare institutions have this great power partly due to something in us. We support healthcare as we do because we believe in it. We reach more readily—even avidly—for medical solutions to our problems than many other peoples do. Manipulated victims of the machinations of big pharma we may be. But I do not think the difference between German and American convictions about the power of modern medicine is simply the result of Americans having watched more commercials for pharmaceutical products. Rather, a medical approach to a problem will be embraced by some and rejected by others depending on what they see as a problem, how they frame that problem, what they count as a solution, their background convictions, their values, their projects, etc.

Moreover, no one will stick with a medical approach to her problems if it does not work at all. There is, then, another side of this value-laden concept. Medicalization of aspects of life exists because a medical approach is at least partly *successful* in dealing with them. At the very least, we must *believe* that it is working or that it offers our best hope. (Concerns about medicalization are not, in any case, reducible to concerns about the placebo effect.) If doctors were completely unable to help us with a problem, there would be no concern about the medicalization of it. Moreover, normally acceptance of a medical approach to a problem must be fairly widespread before it will make people uneasy about its medicalization. So, if a medical approach to a problem is widely enough accepted to trigger concerns about medicalization, it must deliver at least some of what many people want. Critics of medicalization (such as me) must acknowledge this fact. And a medical approach is certainly often capable of masking or numbing the pain of the part it cannot resolve. We must acknowledge that, as well.

Medicalization must, then, be a response to something in us. I have mentioned our faith in medicine and the partial successes of a medical approach. Is there anything else? Without straying too far into armchair sociology, there are at least two additional candidates. The first is our love of convenience and easy solutions. We greatly prefer an easier solution to a more arduous one. A good diet pill would be vastly preferable to getting more exercise. And why, after all, isn't easier better? A second is that we want and expect to feel good all of the time. It's not just that we fear that something might be seriously wrong if we don't feel good. Our expectation is that feeling good is the way we should almost always feel. Everybody likes to feel good, of course; everybody prefers feeling good to feeling bad or even feeling blah. And if physiological side effects or long-term risks are not the issue, what's wrong with wanting to feel good? What are the bad personal or cultural consequences of satisfying the desire to feel good?

Those who opt for the medical approach may not—probably normally do not—share the concern implied by *medicalization*. So, there is often also a streak of paternalism in these concerns. I might be concerned about the medicalization of, say, aging, and all the botox, tummy tucks, and facelifts employed in it. But the guy who is having his tummy tucked and his face lifted obviously thinks he is getting a good thing. He is eager to spend a considerable sum on these treatments, and he may be very pleased with the results. So, if my concern is for him, too, I must hold that he is not fully and accurately aware of what's good for him. There is considerable social support for medicalization in our culture. And, thus, one who worries about medicalization may occupy something akin to the position of a cultural critic who stands outside of the mainstream, worrying about what "those people" are doing and where the society is going.

To recapitulate: talk about "medicalization" implies concern about it. And if this concern and the medicalization itself are both widespread, it implies a kind of cultural—if not personal—*ambivalence*. The medical approach to this thing is partly successful, partly unsuccessful. It is partly illuminating, partly distorting. It is partly helpful, but it is also part of the problem. The success, illumination, and helpfulness explain the support for medicalization. The failure, distortion, and unhelpfulness explain the unease about using the medical approach. Those who embrace a medical approach to a problem and those who criticize it will usually have different beliefs, values, and projects. They evaluate the partial successes and partial failures differently.

One final point. *Who is harmed* by medicalization? Concern standardly implies belief that someone is harmed. Who? There are at least five different groups that might be harmed:

1) *The clients/patients* whose problem is being treated medically. This is the paternalistic concern. Facelifts or depression patches may be bad even for those who get them, despite their eagerness to have them and their delight in the results. The harms to them from medicalization will not, as I hope I have made clear, be limited to physiological harms and health risks.

2) *Others* may be harmed, even if the individual who receives treatment is not. Susan Bordo remarked that she looks older these days because of all the people with facelifts that surround her.[3] Perhaps, then, she has been harmed by others' facelifts. Our concern about the use of performance-enhancing drugs in sports is at least partly this—a concern for the competitive advantage they bestow on users. In a very different way, people are harmed by lack of access to medical care that results from the medicalization of so many things and our unwillingness or inability to pay for it all. The working poor get thrown off the Medicaid rolls partly because of medicalization.

3) *Society* or *our culture* could be harmed as medicalization could promote lack of personal responsibility or provide chemical alternatives to the willpower or self-control we need. Physicians now speak comfortably of "life-style diseases." But the core concept of a disease is something that *befalls* an innocent or non-contributory person. For example, the medicalization of addiction is often promoted as a better approach to the problems of addiction because it provides an alternative to the moral condemnation of the addict. If it is an illness, we don't have to see it as a moral failing or even a weakness. But that approach may not be good for our society or for our culture, even if it is beneficial for individual addicts. The disease model of addiction may make it easier for people to become addicts.

4) *The medical profession* could be harmed as medicine is stretched beyond its proper domain and unreasonable expectations are created for it. Many physicians are uncomfortable with the physical/psycho/social concept of illness however much they may see the relevance of all these factors. This concept of illness simply asks too much of a physician. If doctors are now required also to provide medical care for the soul, how can anyone be a competent physician?

Finally, 5) *other professions and other professionals* could be harmed as their disciplines and practices are emptied of content and resources are allocated away from them. What do counselors offer when there is a patch for depression and a pill for anxiety? What is the role of clergy if there really can be medical care of the soul? Coming now to the medicalization of death, clergy who were once central in the care of the dying have been pushed into the corners, behind the doctors and nurses, carefully not interfering with even the respiratory technicians and the LPNs.

Our New Death

The medicalization of death must be considered in light of the new kind of death we have invented in the past sixty years or so. Before World War II, most people died of infectious diseases. And most such deaths were relatively quick—a matter of days between the onset of a terminal illness and death, or at least delirious non-comprehension. Those deaths also normally came much earlier, often in what we call the prime of life. People who became debilitated or bedridden also did not last long. They developed a pneumonia and, since pneumonias couldn't be effectively treated, they died. For this reason, the threat of being bedridden for years and years did not loom large. Pneumonia—"the old man's friend"—would reliably deliver an elderly person from that peril.

With the development of effective antibiotics and the respirator, we find ourselves facing a very different kind of death. Dr. Joanne Lynn once observed that the average American now knows *three years* in advance what she will die of. Lynn also reports that the average American male is debilitated for five years before he dies; the average American female for eight years before she dies. We live in the shadow of death for a long time—three, five, eight years. And, given anticipated progress in medical science, all of these numbers will be larger by the time we reach the ends of our lives. Earlier diagnoses will be possible, giving us more advanced warning of our terminal illnesses. Better treatments will also be available, allowing us to fight our terminal illnesses for a longer period. Unlike most people in previous generations, we now live facing death for a very long time.

This new kind of death has brought with it two new fears—precisely the opposite of the fears of all generations prior to ours. Traditionally, the fear of death involved three features—death was unpredictable, usually at least fairly quick, and it almost always came too soon. First, death could come suddenly. It could all be over, if not in the blink of an eye, then in a few days. Second, death could not be predicted—one never knew when a terminal illness might strike. Third, death very often came before one had a chance to live a full life, to raise her family, or to try to make the contribution she hoped to make. Although these traditional fears are with us still, most of us now also have the opposite worries—that death will come very slowly and too late—long after life has lost its savor, long after we have ceased to have a "life," perhaps long after we even are ourselves.

In the timeframe of an evolving culture, sixty years is a very recent phenomenon. Culturally, we are prepared for the older kinds of death and have not yet had time to adjust to this new kind of death. As a result, most of my parents' generation was caught off guard. They had no experience of long, drawn out deaths…until they came to their own. My mother, who had watched her mother die "a beautiful death" lasting only a few minutes, sat in despair by the side of her nursing home bed for years. She said over and over, "Why does this have to take so long? I'm ready to go. I've been ready for *years*. Why does this have to take so long?" Her sister took more active steps. Perfectly lucid at age ninety-two, but nearly blind, bedridden, and without any terminal condition whatsoever, she decided to stop eating. Her nursing home supported her in that decision.

Your cohort and mine are different. Almost all of my friends have a personal horror story about relatives who lingered on in a frail or demented state, or with chronic illnesses that lasted a frightfully long time. Although I won't be here to see it, it will be interesting to see what my generation does with the knowledge we have of long, drawn out deaths and of deaths that come too late. I wonder whether my generation, armed as we are with first-hand experience of our new kinds of very bad deaths, will make markedly different choices at the end of life or whether our time-honored cultural expectations, created to deal with traditional deaths, will overcome the lessons we think we've learned from our experience of our parents' and grandparents' deaths.

The Medicalization of Death

The medicalization of death was fueled by the fears and attitudes shaped by those earlier, pre-World War II deaths. When almost all lives were cut off or cut short by death, more life was an almost completely unalloyed good. In that context, the medicalization of death made perfect sense. If a doctor might help me survive the crisis of my present illness, he should be in charge when death threatened. If a hospital could improve my doctor's chances, everyone would want to be taken there. But it is also this new kind of death—too long and too late—that precipitates most of my concerns about the medicalization of death.[4]

The reason for the medicalization of death is not far to seek—we don't want to die. Moreover, the success—or half-success, at least—of the medical approach to the problem of dying is also obvious: doctors and hospitals and medicines can indeed postpone death. Medicine enables us to live longer and to put off dealing with death. That is a very good thing…at least until we opt for one medical intervention too many or find that death comes to us too slowly or too late.

It is not difficult, then, to understand our support for the medicalization of death. In fact, it might not even be a bad thing. The bad death so many of us now get may simply be the price we must pay for medical progress and the benefits we receive from our advanced medicine. Very few of us would want to be without these benefits. In any case, it is not at all clear how we could disentangle medicalized death from the rest of medicine in order to de-medicalize death while retaining the other benefits of advanced medicine.

Is Death Still a Crisis?

Yet I have concerns and we do fear medicalized deaths. As we have seen, if we see something as appropriately characterized as a health crisis, appropriately treated by medical means, and treated medically without unfortunate consequences, then we do not have concerns about medicalization. So, we might begin to articulate concerns about the medicalization of death by considering whether death at the advanced age at which most of us will die should be viewed as a health crisis or a medical problem at all.[5]

For some, death cannot be a crisis. Modern medicine often enables us to postpone death until we do not have to deal with it at all. If my body gives out before my mind, I may well face a long and difficult dying process, filled with concerns about my impending demise. That is living in the shadow of death or facing death. But my mind can give out before my body. I may descend deep into dementia while still in robust bodily health. (Some doctors believe that 40-50 percent of those eighty-five and older have Alzheimer's.) If that is my fate, I can outlive all my concerns about death and dying. For in order to have these concerns I must be able to understand death and to recognize myself as an entity that endures through time. Dementia could well leave me without either capability. The impending death of a demented person can be a crisis only for her doctors and her loved ones. Aside from the discomfort of the dying process, death is simply not a problem at all for the demented.

For the competent old person, death surely can be a crisis. But should it be? And should we conceive such a death as a *medical* crisis and thus as appropriately treated by medical means? There is something profoundly correct in Daniel Callahan's observation that the death of a thirty-seven-year-old is tragic in the way the death of an eighty-year old is not.[6] A thirty-seven-year-old's life has been cut off, cut short. But there are no reasonable expectations or hopes that are denied or cut off by a death at age eighty either for the octogenarian who is dying or for those who love her. It's hard, it's painful, but it's normal and only to be expected.

Although I'm in good health, at my age—sixty-six—I can feel my body and my mind beginning to shut down. Some day, my body will shut down completely and I will die. That's the fate of all living things. I've known that this would happen to me for sixty years now. So, I should not be surprised and certainly my doctors cannot be surprised. If I have reached my present age and am not yet prepared to die, then my outlook on life is fundamentally skewed—at odds with the biological realities that create and sustain my life. I do not believe there is any disrespect or disvaluing of the aged in this. It is a simple acknowledgement of the implications of being alive and aware that we are alive. "Of course you're dying, John! What did you expect?"

If death at my advanced age is a crisis at all, it is a crisis in my basic beliefs and values, which are fundamentally out of touch with reality. Why should a team of doctors rush in to try to "treat" my fanciful desire for a still longer life or my inability to cope with the fact that I, like all living things, will die? If I need treatment for this condition, wouldn't it be counseling rather than all-out medical attempts to extend my life? After all, even if a heroic attempt to prolong my life succeeds, I will be left in the same predicament—still unsatisfied, still unable to accept my death.

The medicalization of death is, then, supported by notable successes—life is prolonged and death can be postponed even to the point at which we can avoid facing death at all. Yet, Alzheimer's has little to recommend it as a solution to the problem of death. The best life is not the longest one. The best death is rarely the one that can be put off longest. And, for most of us, death can come too late. The medicalization of death yields only half-successes. There are, I believe, harms both to others and to the one dying in the medicalization of death.

Harms to Others

I want to focus my concerns about the medicalization of death on harms to the dying. That's where the conversation needs to begin. But I do want to at least mention four concerns involving harms to *others* from the medicalization of death. First, it exacerbates the spiraling cost of healthcare and fuels the lack of access to healthcare. My concern about the medicalization of death is in part a concern about intergenerational justice: "You've had a long ride on the merry-go-round now, Johnny. It's time to get off and let someone else have a turn." True enough, our society could afford to provide everyone with all the life-prolonging medical care that they want. But that fact does not get me off the hook. The problem of intergenerational justice arises *for me* in a context of a society that refuses to do so. Can I justifiably occupy a Medicaid-funded nursing home bed when working people in the prime of life cannot get medical care due to inadequate Medicaid funding? Probably not.

Moreover, although this country could still pay for all the healthcare anyone wants and needs, that is unlikely to be true much longer. Healthcare costs are growing much faster than G.D.P. in almost all developed countries. Countries that have long prided themselves on universal access to healthcare—Canada, for example—are developing private healthcare systems. Unless we figure out a way to grow our economies much faster than we currently can, universal access to the most advanced medical technology is unsustainable for any country. Medical science can, I believe, discover new treatments much faster than we can discover ways to pay for them. And that will continue to be true, I suspect, indefinitely into the future. If the medicalization of death results in lack of healthcare for some who are much younger and not dying, this represents a very serious critique of our approach to death.

Second, burdens on the family are imposed by the attempt to prolong the lives of the elderly and dying.[7] Chief among these burdens are financial costs and the burdens of caregiving. It may sound vulgar and callous to consider money in the context of providing care for an elderly family member, especially when life itself is on the line. But on the personal and familial level, the human costs of having to pay for healthcare can be enormous.[8] (More than half of the bankruptcies in the U.S. now involve unpaid medical bills.[9]) For the vast majority, there is more than money at stake; one must be fairly well off for cost to be "just money."

If there is not enough money or too much love to consign an elderly family member to a healthcare institution, care must be provided by family members. Although providing such care can be meaningful—especially if it does not go on too long—evidence is beginning to accumulate about the costs of personal caregiving. If I become one of the frail elderly and my wife cares for me in our home, the odds are that she will be deprived of her remaining days. Valued activities and friendships will drift away, as she has no time for them. She will probably become hopeless, then depressed. Eventually her health will be compromised. In fact, she will be much more likely to die in a given period than equally-healthy women who are not caregivers for their partners.[10] Ironically, as she contributes to my health she undermines her own; I lengthen my life by shortening hers.

Third, we are on new, unfamiliar, and complex moral terrain with this new kind of death, a terrain with slippery slopes all around. Morally, a death that comes too soon is much simpler. "We did all we could," we say, and there is moral consolation in that. Deaths that come too soon do not challenge our basic values or call upon us to face difficult decisions. But deaths that come too late are morally difficult. They will ultimately call on societies to step up and make decisions about when life is and is not worth preserving. Should anyone who is old, feeble, and possibly demented be allocated a Medicaid-funded nursing home bed? Should she be allocated a bed while we are trimming the rolls in order to keep Medicaid within budgetary limits? I don't think so. But the decision not to pay for continued upkeep will be morally and also politically perilous. We rightly fear such decisions. But the medicalization of death means that we will not be able to avoid them much longer. I will return to the moral difficulties of a death that comes too late.

Fourth and finally, there may be harms to the medical profession and to our society in deaths that come too late. Faced with the threat of an unexpected and early death, we try to prolong life. We do so almost automatically and without soul-searching. With such deaths as our paradigm, we could adopt a very simple moral maxim—save lives! Whenever possible, prolong life! As long as possible! That was simple, clear, easy to follow, and ethically compelling. But now we face the difficult moral issue of when to stop trying to save a life. We can prolong the life of this person if we choose and we must decide how far to go with the effort. One needs only to look at the depth and breadth of the concern aroused by the Shiavo case (which many of us think was a no-brainer) to see how challenging these issues will be and for how many people. The moral burden of this choice is weighty. And since we must be concerned about the distribution of healthcare, we cannot leave these choices to patients and their families. They must be made by distant, powerful, relatively affluent outsiders. Our society and our physicians will have to come to terms with a whole series of profound moral issues raised by deaths that are too slow and too late. Can physicians help patients avoid a death that comes too late? Can they refuse to treat dying patients who want to live without undermining their personal integrity as physicians? Can they refuse to authorize such treatment without compromising the fundamental refusal to judge the worth of persons and their lives that is so fundamental to medicine? "If life were a thing that money could buy / The rich would live, Lord, and the poor would die."[11]

Harms to the Dying

I believe that harms done to *others* by the protracted end of life provided by medicalized death are sufficient to make a compelling case. But there are also harms to those who die in a contemporary medical mode. Our medical capabilities have increased our life spans and thereby given us more life. But it has also delivered us over to chronic illness and to a long period of debility at the end of life. It thereby creates the fear of a death that comes too late and, unless we are very savvy and courageous, greatly increases the odds that most of us will get precisely such a death.

I will leave to the side the interesting but speculative questions about whether aging can be conquered and, if so, whether we would continue to want more life after having lived without mental or physical deterioration much longer than we now do. I have students who say they expect to live to be 400 years old. It may be that death comes too late only because of chronic illness and deterioration. I don't know about that. In any case, I will focus my remarks about harms to the dying on our new fear: a death that comes too slowly and too late. I will address three groups of harms to the dying: the harms of technological brinksmanship, the difficult decisions and deeds we are faced with, and the temptation to focus on the medical details of dying at the expense of the human task of bringing life to a close.

1) The first group of harms can be grouped under the "technological brinksmanship" most Americans practice at the end of life.[12] If death might come too late, there is a very serious practical problem of how many life-prolonging medical interventions to accept. If I accept too few, I will die too soon—before I have completely drained the satisfaction available to me and much earlier than I needed to die. But if I accept too many treatments, I will die too late. I will then find myself in a state I never wanted to be in—a state that is painful, debilitated, meaningless, or dysphoric.

Part of the difficulty is simply in knowing when you are dying. In earlier times, one was thought a fool if he could not recognize the approach of death. Now, for many terminal illnesses, even your doctor cannot tell. Once, in the midst of an ethics consult, I asked the medical team whether this patient was dying. One of the doctors responded, "People are not like Butterball turkeys. There's no indicator in their chests that pops out when they are done." It's one thing if I have only a few more weeks or months to live regardless of what treatments I accept. If that's all I have left, I might not call 911. But it's quite another if I might be able to live for several more years with an acceptable quality of life. If that will be the outcome, I may well want aggressive life-prolonging treatment. Often, my doctors will not know and so I cannot know either.

One harm of technological brinksmanship is that if we accept one medical intervention too many, we may be stuck with a long period of very low quality life. We may have inadvertently delivered ourselves into the hands of a death that comes too late and too slowly. But if the brinksmanship were generated only by medical uncertainty, we could expect the problems of the medicalization of death to disappear as our prognostic abilities improve. Some more advanced APACHE test would give us the information we need about how much time we have left. Then we would be like Butterball turkeys and we could better calculate whether another medical intervention would be worth it to us. Increased prognostic certainty would undoubtedly help. But I think there's more to it than that.

2) There are certainly very difficult decisions and ethical peril in all of this. When medicine could do little to prolong life, death came to us and our lives were over at a time not of our choosing. It wasn't up to us when we would die. Now it is. For medicine can now do much—often too much—to postpone death. We must learn to go to meet death. So we need, at a minimum, to learn how and when to call a halt to medical interventions. And without a social practice or a compelling moral tradition, we must do this individually, each for herself. If each must take the necessary steps for herself, we will need to take them while we're still competent and comprehending. And when the time comes, we may find that we are not conveniently dependent on some medical technology that can be discontinued. Medicalization has thus thrust hard decisions and difficult, dirty deeds into our hands. We may have to step up and do drastic things even in the face of less than certainty and without much moral guidance if we are to avoid deaths that take too long or come too slowly. Otherwise, we will be stuck. Many people do feel stuck. The drastic steps required to get unstuck are morally problematic, often religiously forbidden, and personally difficult.

Avoiding a death that comes too late certainly does not always involve suicide. But sometimes, I think, suicide is perfectly fitting and morally acceptable. Sometimes even morally praiseworthy.[13] Moreover, suicide is very different when your life is essentially over than it is when it is just beginning or somewhere mid-stream while there is still time and strength to turn a life around. So, I believe that suicide by a debilitated elderly person, or an old person or younger person suffering from chronic serious illnesses, is a very different thing from suicide in a younger healthy person. But I know of no persuasive philosophical articulation of the moral differences. In any case, suicide can give someone a much better death than the available alternatives. That much must surely be obvious in an age where even hospice—precisely because of its focus on a good death—is using terminal sedation on perhaps as many as one-third of its patients.

3) Medicalization focuses us on treatment decisions and tempts us to ignore the human tasks of dying. In earlier times, death came to us. There was not much that could be done to avoid or postpone death's visit and that visit, characteristically, came upon us as an interruption. We were cut off in midstream, midcourse, mid-task. Ineffectual as the attempt may have been, the appropriate attitude in these conditions was to try to avoid or flee death. But now we need to learn how to come to death. If we do not come to death, our medical technology will keep death at bay until we one day realize that death has come too late. Our lives are over, but death has not yet come. Then, if suicide is not an option, all there is to do is wait for death to show up.

In order to accomplish the human tasks of dying, we need, first, the wisdom to recognize when our lives are over. Not in the sense that life itself can no longer be prolonged, but in some deeper, more human sense more like an honest acknowledgement that my *bios*, my biography, is now completed. Then, for better or worse, there will not be much I can add to my own life any more, and my part in the ongoing drama of life and even in the unfolding lives of my loved ones will be over. We now need the skill of acknowledging, "this is enough," or "I've done all I can do."

There may be a few things I can still change, a few things I can accomplish. And, if these are important, a chance to make these changes could give me a reason for attempting to prolong my life. But bringing my life to a close as opposed to merely coming to the end of it usually also involves recognizing that many things are now unalterable, or that I no longer have the strength, the energy, the time, or the wit to alter them even if they could once have been changed. There may be many things that I wish I had done, experiences I wish I had had. But as my energy fades and my time horizon closes in, surely I must recognize that I will not be able to do them all. Choices have also been made for a very long time now that inevitably leave roads forever not traveled, harms unalterably done, and ill-will irretrievably sown.

As I come to the end of my life, I should not be surprised, then, that there are many good things that I will not experience and good things that I will leave undone. I must not succumb to the temptation to tarry because I wish things had been different or there are things I wish I had done. If I do, I will find that death comes too late. I must not postpone—I must proceed to change or finish up what I can. But I must also make my peace with things I wish had been different but are now unalterable.

Because of the way we now die, there will not, for most of us, be a bright line with more *life* on this side and mere existence on that. Part of our predicament is that *we* will have to draw this line, and we can no longer rely on the inexorable progress of a terminal illness or the limitations of our medical technology to draw it for us. For many, there is no obvious place where the line is to be drawn. But it is also not arbitrary. One place is clearly not as good as another. If it were, death could not come too late. But we know it can. It so often does.

Bringing a Life to a Close

We need, then, to become better strategists of the end game. On the simplest level, this means developing more wisdom about when to accept and when to reject medical interventions. But choices about medical treatments, though sometimes important, are only the most superficial level. Medical interventions are means to an end. What is the end? If we believe that death can come too late, then life-prolongation is not an unquestioned good. How much more life? More life for what? The medicalization of death tempts us to think the primary issues are about prolonging life, or about medical treatment decisions. But those decisions are decisions about tactics, and tactics are senseless apart from broader strategies that require, in turn, a goal or mission.

For some, the goal seems to be any life that is still of acceptable quality. "I can still take this. It's not too bad yet." But this attitude invites death to come too late. Life of acceptable quality shades into life of unacceptable quality—pointless, debilitated, uncomfortable, painful, undignified—a life often completely absorbed by meeting the life-maintenance needs of the body. In the experience of my family, even a life that is pain-free and, thus, potentially still pleasant has proven to be unacceptable. Both my mother and her sister ended up with a long stretch of perfectly lucid and pain-free, though meaningless and purposeless, days. They found that unbearable. They could not abide struggling each day to distract or amuse themselves—to somehow fill the unending string of days. This long stretch of purposeless days may well have cost my mother her religion. My aunt didn't even have a terminal illness and that compounded her problem. For both of these women, life is simply not about trying to keep yourself amused, much less comfortable. Both of these women felt stuck, though my aunt found a way out by not eating, and she was fortunate enough to be in a nursing home that supported her decision. I'm not there yet and I may surprise myself. But for me, now, happiness or satisfaction is much closer to a sense of meaning or purpose than it is to pleasure. If even pleasure is not enough for me, a string of pleasant days will certainly not be, to say nothing of merely pain-free days.

Once we recognize that our lives are over, we need the skill of wrapping up, of making an ending to our lives instead of temporizing or stalling or delaying. For the best death is not the one that can be put off longest. Once I recognize that I am now in the end game, there are loose ends to be tied up, amends to be made, loved ones to be prepared and encouraged to go on without us. Also, (intra)personal tasks of evaluating and hopefully coming to accept the life I have lived, or at least acknowledging that it is now beyond my strength to significantly reverse the course of my life. And, hopefully, making my peace with that.

That is the internal dimension of bringing one's life to a close. Ira Byock, a hospice physician and one of the new gurus of a good death, has written about the interpersonal dimension of bringing life to a close. In Byock's experience, people die well if they can say five things to their loved ones: *I forgive you. Please forgive me. Thank you. I love you. Good-bye.*[14] This way of thinking of a good death helpfully relocates the issues away from medical technology and the uses of it. A good death is not primarily about successfully navigating medical treatment decisions and thereby getting as close as possible to the technological brink without falling into the abyss of a death that comes too slowly and too late. It is about accomplishing the human tasks of bringing a life to a close. Barring sudden incompetence from a massive stroke or the like, these are things we can all do. If this is what it takes to die well, we all have the wherewithal for a good death within reach. We just need the wisdom to know when, then the virtues and skills required to step up and do it.[15] Even the good-byes can be said. Toward the end of her life, my mother always said ordinary good-byes with an undertone of possible finality—"I don't know whether I'll be here the next time you come."

Finally, there may also be something to the idea of not hanging around the stage after you've said your final speech. The actor is supposed to exit after his final lines when he no longer has a role to play in the drama unfolding around him. He is not supposed to stand—or lie in a hospital bed—in the corner, trying to stay out of the way of the lives developing around him, but distorting the entire drama despite all his efforts. And honesty compels me to admit that I could one day be largely irrelevant to the lives of even my loved ones. My highest virtue, then, to stay out of the way? Having reached the end of my life, wrapped it up and concluded, better, perhaps, to leave.

Conclusion

Let me end now by briefly reviewing the connection of all this with medicalization and then suggesting an encouraging word. When death normally came too soon and more life almost always had a clear point to it, medical life-prolonging treatments were a pretty unambiguous good. The doctor would be the pivotal figure at the bedside of anyone with a serious illness and that was fitting, for the stakes were high. But if death can come too late, long after life has lost its purpose and even its savor, then the medicalization of death may be a hindrance. Medicalization, I believe, tempts us to temporize, to stall, to postpone by holding out the promise of more. Then we must either do drastic things or we may get stuck with a death that comes too late and too slowly. Medicalization also tempts us to focus on medical decisions, as if they were the main path—or barrier—to a fitting end of life. Under the auspices of medicine, a good death tends to be reduced to a pain-free death. The physicians who preside over death are equipped neither by temperament nor by training to help me discern when my biography is complete and then to help me with the skills to wrap things up and leave. By its very nature, medicalized death gives me a plethora of means and a paucity of ends.

It is not clear, however, that there are other, non-medical people better equipped to help me develop the virtues and skills I will need. Going to meet death is a new art and part of the difficulty of dying well in our society is that we have not yet acquired this art. But it is not clear that most of our chaplains, rabbis, priests, and imams can help us much. A hospital chaplain told me that he thinks that none of the major religious traditions help very much with the kinds of deaths we face. Joanne Lynn tells of a patient who eloquently observed, "No one in the Bible died like this."[16] Our religions were formulated to cope with deaths that are very different from ours. We may, then, be pretty much on our own when it comes to developing the discernment, virtues, and skills needed to die well and at the right time.

And now, the encouraging word: it is quite possible that our difficulties with this new kind of death are all *transitional*. Medical technology has given us tremendous power, but we do not yet know how to use our new capabilities wisely. We do not yet even know how to think about the ways our lives end nowadays, much less how to develop the skills we will need to bring our lives to a fitting close. But it may be that, in time, people will work all this out. They may look back on the difficulties we faced at the turn of the millennium and marvel at our inability to roll back the medicalization of death. They may wonder at the knots we tied ourselves in, at the ethical conundrums we gave ourselves, at our inability to draw a line marking an appropriate end of life. I am not, then, convinced that any of the concerns I have about the medicalization of death are timeless philosophical truths. With time, we may learn to handle gracefully and appropriately our new kind of death. But I will not see that day.

Endnotes

1. *New York Times*, December 24, 2005, A14.
2. *New York Times*, October 19, 2005, A14.
3. S. Bordo. "The Empire of Images in Our World of Bodies." *The Chronicle of Higher Education* (Chronicle Review section) (2003).
4. The medicalization of *death* is ambiguous. "Death" could refer to the dying process or to the moment of death, and hence to the *definition* and *determination* of death. Both have been medicalized. It now takes a subspecialist to ascertain whether someone is dead. Culturally, we have not yet caught up with our new definition of death and that leads to fear and anger—"they killed my daddy." But I am more interested in the medicalization of the process of dying. For economy of style, I will use both "the medicalization of death" and "the medicalization of dying" to refer to the medicalization of the dying process.
5. I cannot discuss here the question of whether a terminal illness in the prime of life is a health crisis, appropriately medicalized. It surely makes more sense to try to preserve life if one is thirty-six and facing a life-threatening illness. But even a thirty-six-year-old who is dying is not usually well served by maximal efforts to save her life.
6. D. Callahan. *The Troubled Dream of Life* (Simon & Schuster, 1993), 180+f.
7. I have written extensively about these problems. See: J. Hardwig, "Is There a Duty to Die?" *Hastings Center Report*, 27, no. 2 (1997), 34-42; J. Hardwig, "Dying at the Right Time—Reflections on Assisted and Unassisted Suicide," in *Ethics in Practice*, edited by Hugh LaFollette (Blackwell, 1996); J. Hardwig, "SUPPORT and The Invisible Family," *Hastings Center Report*, 25, no. 6 (1995): S23-S25.
8. K. E. Covinsky, L. Goldman, et al. "The Impact of Serious Illness on Patients' Families," *JAMA*, 272 (1994): 1839-44.
9. D. U. Himmelstein, E. Warren, D. Thorne, and S. Woolhandler. "Illness and Injury as Contributors to Bankruptcy," *Health Affairs* (2005 Jan-June Suppl.): W5-63.
10. One study found that caregivers for partners who reported stress were at 63 percent greater risk for mortality than the control group. R. Schulz and S. R. Beach, "Caregiving as a Risk Factor for Mortality: The Caregiver Health Effects Study," *JAMA*, 282 (1999): 2215-19. In fact, spouses who were already strained experience no increase of distress and a reduction of health-risk behaviors upon the death of their spouse. See R. Schulz, S. R. Beach, et al., "Involvement in Caregiving and Adjustment to Death of a Spouse: Findings from the Caregiver Health Effects Study," *JAMA*, 285 (2001): 3123-29.
11. Traditional spiritual.
12. Daniel Callahan coined the term "technological brinksmanship" and wrote insightfully about it in *The Troubled Dream of Life*, 1993.
13. See J. Hardwig, "Dying at the Right Time—Reflections on Assisted and Unassisted Suicide" in *Ethics in Practice*, edited by Hugh LaFollette (Blackwell, 1996).
14. I. Byock. *Dying Well* (Riverhead Books, 1997).
15. On the contributions of patient virtues to a good death, see W. P. Kabasenche, *Virtues and Dying*, unpublished Ph.D. dissertation, University of Tennessee, 2006.
16. J. Lynn. "Living Long in Fragile Health: The New Demographics Shape End of Life Care." *Improving End of Life Care: Why Has It Been So Difficult? Hastings Center Report Special Report*, 35, no. 6 (2005): S14.

In Praise of Fairy Godmothers: A Limited Defense of Medicalization

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"Who would be sick, and he might be whole?"[1]

Around Thanksgiving 2004, I posted the following puzzle on an Internet lateral puzzle forum.

> Fairy Godmother: A Thanksgiving Puzzle
>
> All our lives, millions of people, including me, have had a two-pronged wish that seemed grantable only by a fairy godmother. Half of that wish has come true!! Although I am (& fervently believe in being) a "glass is half-empty" rather than a "glass is half-full" type, I must admit that this is something to be thankful for. What is it????[2]

For those unfamiliar with lateral puzzles, such puzzles are descriptions of situations that are paradoxical or peculiar but have logical explanations, which are uncovered through a series of yes-or-no questions. A woman quickly guessed the wish: to be able to eat everything you want without gaining weight. In case you are wondering how you could have missed this astonishing development, keep in mind that I said only half of the wish has come true. Why, after all, do people want to avoid gaining weight? Primarily for two reasons: people want to be healthy, and they want to look good. We have yet to discover the magic pill that will keep overeaters from getting fat or make fat people beautiful. But—incredibly—we now have magic pills that can take much of the medical risk out of seven-layer cake, ice cream sundaes, Big Macs, potato chips, and pizza. You can eat all you want of these delights and still have a better blood lipid profile than if you lived unmedicated on fish, tofu, and broccoli. Just take a statin to raise your good cholesterol and lower your bad cholesterol. You may think I am starting to sound like a statin commercial, but statins are the only product I know of whose advertisements understate their effectiveness. An advertisement for Lipitor gives the following advice.

Along with your medicine, remember to follow these healthy living tips to help lower your cholesterol[3]:

- Follow a cholesterol-lowering diet
- Make exercise a part of your life
- Lose weight, if you are overweight
- Quit smoking

In fact, however, as I happily told the forum, if you take Lipitor and ignore the advice, the pill may give you a great lipid profile all by itself. I have found a cholesterol-lowering diet totally unnecessary for this purpose.

Upon reading the responses to this cheery information, I almost wondered whether I had inadvertently typed in "cocaine" rather than "Lipitor." Some of the disapproval was that intense. Several people made reasonable, practical points, such as that statins do not keep your weight down; so if I indulged myself enough to get fat, Lipitor would not protect me from such obesity-related health risks as diabetes. But some of the disapproval seemed ideological. Some people simply seemed hostile to the idea that you can have a great lipid profile without having to struggle for it. Couldn't I see how decadent it was to want to have my cake and my low cholesterol, too? Why was I taking the easy way out? For the same reason I turn up my thermostat in winter rather than chopping my own firewood—I thought that answer was obvious. But when I checked the bioethics literature, I was surprised to find bioethicists who defended an outlook similar to what I had encountered on the lateral puzzle forum. This paper will discuss their reasons.

Clearly, this issue falls under the heading of "medicalization." The President's Council on Bioethics defines "medicalization" as follows.

> "Medicalization," a term coined by sociologists, means in the first instance a way of thinking and conceiving human phenomena in medical terms, which then guides ways of acting and organizing social institutions. More fully, it is the tendency to *conceive* an activity, phenomenon, condition, behavior, etc., as a disease or disorder or as an affliction that should be regarded as a disease or disorder [in that] (1) people *suffer* it (the essence of patient-hood), or it befalls them; they are *victims* of it (hence, not responsible for it; (2) the causes are *physical* or *somatic*, not "mental" or "spiritual" or "psychic"; (3) it requires (needs) and demands (has a claim to) *treatment*, aimed at *cure* or at least at relief and abatement of symptoms; (4) at the hands of persons trained in the healing arts and licensed as *healers*; and (5) this conception of the condition will be supported by the society, which will also support efforts at treatment out of its interests in the *health* (as opposed to the morals or the education) of its people.[4]

This definition invites several objections. For example, considering something a disease neither entails absolving the patient of responsibility for it nor entails believing he has a claim to treatment. AIDS is a disease even according to those who think people who contract it through drug use or sex are responsible for contracting it, and heart disease is a disease even according to those who think obese people and smokers have no claim to treatment. Of course, in making this point, I am not endorsing these unsavory views. Furthermore, even if costs make it unfeasible for everyone to have a claim to every medical treatment, Andrew Stark points out that "the cost of treating a condition should have nothing to do with the question of whether it is legitimately a medical one."[5] But these are side issues for this paper, where my aim is to defend a limited form of medicalization—a form that "medicalizes" high cholesterol in the sense of deeming it altogether fitting and proper for people to seek treatment in the form of a "magic bullet" instead of changing their personal habits. This limited claim clearly does not entail that medicalization is appropriate for all conditions where the medicalized person seeks it, let alone where he resists it, as when someone who is satisfied with his unconventional personality and lifestyle has a diagnosis of mental illness thrust upon him.

Why would any bioethicist object to statins? As with my fellow puzzle forum members, some of the reasons can be practical. People can point to the side effects of the drugs or to the fact that, unlike lifestyle changes, statins do not address such risks as diabetes. These points are reasonable, but I will get them out of the way quickly, as philosophically they are much less interesting than the ideological objections. Obviously, people should not count on a drug to address problems outside its sphere. Most unfortunately, this means that statin-users still need to restrict their total calorie intake. Periodic cake, cookie, and candy sprees interspersed with dieting work fine for me. Those who object that this illustrates how drugs are used to compensate for unhealthy eating habits invite the reply that statins prevent such eating habits from being unhealthy, just as central heating prevents spending the winter in Minneapolis from being unhealthy. Admittedly, statins have had very bad side effects—primarily muscle and liver problems—for some people, who should stop taking these drugs. Fortunately, these muscle and liver problems are generally detectable before they can become irreversible. A more insidious problem is the possibility of long-term side effects that can surface years or even decades after new drugs are introduced. This danger needs to be assessed against the possible long-term dangers of going without the drugs. Moreover, drugs can have unexpected long-term benefits as well as unexpected long-term harms.

Far more interesting are the ideological objections to magic bullets. That is part of why bioethicists who discuss medicalization often imagine that such treatment has no side effects, in order to think "about what medicine should do in a world without technological limits."[6] For the rest of this paper, I will follow this supposition, as well as Stark's suggestion to "[i]magine that money is no object."[7] Stark's objections to the easy way out are ideological. Thus he denigrates "a change—a new individual trait or achievement [as] not genuine [when] it comes too easily."[8] Stark puts forth what he calls a Kantian view that "cure should never diminish a person's genuine, struggle-born achievement, whatever it may be,"[9] where by "struggle" Stark means "the most effective action that an individual can take…as long as that action necessitates exertion or difficulty."[10] Not being a Kant scholar—to put it mildly—I will not try to decide whether Stark is giving an accurate account of how Kant would handle the cases at issue here. Instead, I will call the view Stark's view. Stark's book explores the ramifications of the view. I am interested in assessing the view on its own merits. What is wrong with abandoning struggle once it becomes unnecessary for the goal in question?

Stark's view sees struggle as constitutive of a person's genuine self. He says, "Every doctor swears to do no harm to the person. But the Kantian doctor additionally swears to do no harm to the subject"[11] and that diminishing someone's struggle counts as diminishing him as a subject. Stark even says his ideal Kantian doctor will not administer a cure if it will diminish a patient's struggle. Stark's view holds that someone who, struggling to diet and exercise, wants a magic bullet for obesity (or, presumably, cholesterol), must promise his doctor that he will redirect his struggles to some other arena, for example, by working for Amnesty International.[12] Stark's ideal Kantian doctor thus resembles a Catholic doctor who, considering himself pledged to do no harm not only to the person but also to the immortal soul, refuses to prescribe contraceptives. In both cases, the objection to such medical practice is almost too easy. The doctor is imposing his own contestable ideology on a competent adult patient. Stark's view mandates a level of intrusion far beyond what current medical practice countenances. By contrast, consider the mainstream view of Ezekiel K. and Linda L. Emanuel. The Emanuels favor what they call the deliberative model of the physician-patient relationship, in which "[t]he aim of the physician-patient interaction is to help the patient determine and choose the best health-related values that can be realized in the clinical situation. …The physician's objectives include suggesting why certain health-related values are more worthy and should be aspired to."[13] This sort of doctor will be attractive to some rational patients. But other rational patients, who have well-defined values and who value independence of judgment, will regard such a doctor as intrusive. Personally, I am about as interested in my doctor's opinion of my values as I am in my dry cleaner's opinion. But the Emanuels add that "the [deliberative] physician aims at no more than moral persuasion; ultimately, coercion is avoided, and the patient must…select the ordering of values to be espoused."[14] The Emanuels' approach is far less intrusive than Stark's view. The role of the Emanuels' deliberative physician does not include withholding a medically unproblematic magic bullet if his attempts at persuasion fail, let alone requiring its user to redirect his struggle to some other cause, such as Amnesty International.

Even apart from the Kantian doctor's authoritarianism and intrusiveness, the question remains of what is so terrible about ending avoidable struggle. It may be tempting to reply by treating struggle as (to use George Bernard Shaw's phrase) "a moral gymnasium,"[15] in the sense that struggle that is unnecessary in a particular case may serve to may build one's character so that he will be better equipped to struggle in cases where struggle is genuinely necessary to achieve a desirable end. The President's Council on Bioethics says that

> healthy people whose disruptive behavior is "remedied" by pacifying drugs rather than by their own efforts are not learning self-control; if anything, they may be learning to think it unnecessary. People who take pills to block out from memory the painful or hateful aspects of a new experience will not learn how to deal with suffering or sorrow.[16]

This begs the question against the view that learning to take a pill is itself a way of learning how to deal with suffering or sorrow. Furthermore, to the extent that pacifying drugs are both effective and desired by the user, self-control may be unnecessary. In practice, however, people who take such drugs are likely to have plenty of other opportunities to learn self-control. And the council acknowledges that some "people, suffering from certain neuro-psychiatric disorders, become capable of learning self-control only with the aid of medication addressed to their disorders."[17] Stark himself acknowledges that the struggle against obesity may deflect one's attention from other causes. Moreover, even to the extent that the "moral gymnasium" defense is factually accurate, for Stark's view it is beside the point. His view rejects "a utilitarian justification for struggle."[18] Why isn't unnecessary struggle just pointless make-work or analogous to the make-work that might be given to children, or worse yet, prisoners, to keep them out of trouble? Stark's answer seems to be that the

> genuine self—otherwise known as the "subject"—constructs my life. It does so by working over the years to improve some of [my] characteristics and attributes…to discard others, and to preserve still others. When and as this genuine self does so…it transfers its own genuineness to the new attribute. That new trait…becomes…part of my genuine self, not something beyond it, because it was attained by my self's own acts: its discipline, perseverance, and effort.[19]

So why does Stark's view countenance struggle-free cures for someone who has been struggling against his obesity and promises to redirect his struggles elsewhere? Why doesn't it hold that such cures would prevent the person's new slimness from being part of his genuine self? The answer is that it is struggle in general that Stark's view connects with the genuine self. Accordingly, if someone who has been struggling to bring his weight down asks his doctor for a magic bullet for obesity but promises to redirect his struggles toward a political cause, "[h]e is asking the doctor to allow him not to shrink the acreage that his genuine self covers, only shift it."[20]

Stark's view is disrespectful of the variety of human temperaments that can give rise to genuine selves and worthwhile lives. James Lindemann Nelson distinguishes between Margaret Walker's notion of a career self, who "sees his life (aspirationally, in any event) as a unified field in which particular enterprises, values, and relationships are (in principle) coordinated in the form of a 'rational life plan'…or a 'quest'…or a 'project'"[21] and a "seriatim self," deriving from Hilde Lindemann Nelson's concept of "living life seriatim," where life is seen "less as an overall unified project and more as a set of fits and starts."[22] He adds that the seriatim self "may live a life…more shaped by contingencies than by the expression of personal agency"[23] and may "place a greater importance on the goods of relationship."[24] Sue Donaldson suggests that meaning in life can come not only from striving but also from savoring "the intrinsic fascinations of the external world."[25] Appreciation of beauty, love, and friendship all seem a worthwhile part of the genuine self. Not only can they occur without struggle, but, as I will argue presently, a struggle to love may undermine love's authenticity. Even scientific and technological achievement can arise less from struggle than from ingenuity. When I was in grade school, my class put on a play called "The Laziest Man in the World." The title was Benjamin Franklin's self-description. He was too lazy to work, he said, so he invented labor-saving devices.[26] Perhaps Stark would reply that Franklin was being ironic and that inventing Franklin's labor-saving devices required much exertion on his part. Perhaps it did. What if it didn't? What if it was almost 100 percent inspiration and almost no perspiration, or if the struggles Franklin's inventions enabled him to avoid exceeded his struggles to invent them? It would still seem unreasonable to consider Franklin's labor-saving devices as other than genuine products of his genuine and unique mind. And people who choose to use such devices, like people who choose to take statins, are exercising the uniquely and genuinely human rational ability to choose to improve one's life by profiting from the advances of civilization.

Now consider another objection to magic bullets. The President's Council says

> the "naturalness" of means matters. …In most of our ordinary efforts at self-improvement, whether by practice, training, or study, we sense the relation between our doings and the resulting improvement. …There is an experiential and intelligible connection between means and ends; we can see how confronting fearful things might eventually enable us to cope with our fears…
>
> In contrast, biotechnical interventions act directly on the human body and mind to bring about their effects on a passive subject, who plays little or no role at all. He can at best *feel* their effects *without understanding their meanings in human terms*. Thus, a drug that brightened our mood would alter us without our understanding how and why it did so, whereas a mood brightened as a fitting response to an arrival of a loved one…is perfectly, because humanly, intelligible.[27]

This passage is as open to objections as the ones I quoted earlier from the same source. For one thing, taking a drug does not preclude understanding how it works, nor does it entail passivity. The drug-taking subject may be quite active in developing this understanding as well as in trying to acquire information about what drug will work best for him. If he lives in a world where most doctors are of Stark's persuasion, he may even have to struggle to find a maverick who will give him a magic bullet. Still, when it comes to changes in one's mental life, there is a grain of truth in the quoted passage. This has to do with the reference to a "fitting response." Feelings, beliefs, and attitudes can have reasons; so there may be a sense in which it is inauthentic to have a pill change one's feelings, beliefs, or attitudes when one sees no reason that justifies the change. Carol Freedman argues, "When an emotional problem is sourced in our interpretation or reasons, then we should have a basic commitment to addressing it with insight and understanding. …For central to our maintaining the idea of a self is the commitment to regard some of our actions and attitudes as justified by our reasons."[28] We can also have a legitimate interest in evaluating other people's mental lives in non-mechanistic terms. As Bonnie Steinbock asked in correspondence, "Would you be happy to discover that your devoted lover fell in love with you after taking a love potion?"

But more objections arise. First is the possibility that not all facets of everyone's unmedicated mental life are authentic. If a depressed person has no identifiable reason for being unhappy, why would it be inauthentic for him to lack a reason in which to ground lifting that unhappiness? As I have indicated, even the President's Council endorses certain uses of psychoactive drugs.[29] Note also that even when the claim about reasons applies, it does not necessarily point in the same direction as Stark's view. Although Dan Brock remarks that "altering a fundamental character trait or psychological feature by a 'quick fix' of 'popping a pill' seems to some people too easy and less admirable than changing that trait or feature through hard-earned insight psychotherapy,"[30] insight therapy that enables someone to understand his new feelings in terms of his reasons for them need not in principle be hard-won at all. A flash of insight—what psychologists call the "ah ha" phenomenon—is just as "humanly intelligible" as insight that is difficult to achieve in that it is just as much a matter of understanding the meaning of one's feelings in human terms in the sense of understanding them in terms of one's reasons for them. Note also that struggle can sometimes make feelings seem *less* authentic. Steinbock's rhetorical question about love prompts me to ask another one: Would you be happy to discover that your devoted lover fell in love with you after a long struggle to do so? The recent spate of books and courses offering instruction in how to "make marriage work" invites the suggestion that we take the word "work" as a noun rather than a verb, so that "[i]t's probably just what those self-help books do, turn your marriage into a chore."[31] Finally, and most importantly for this paper, the distinction between reasons and causes applies only to mental life. It makes sense to want to understand one's feelings, beliefs, and attitudes in terms of one's reasons for them. There is no parallel with respect to a physical process of lowering one's cholesterol.

But here is how the President's Council follows up the passage I quoted about the importance of understanding "in human terms":

> And not only would this be true about our states of mind. ...Human experience under biological intervention becomes increasingly mediated by unintelligible forces and vehicles, separated from the human significance of the activities so altered. The relations between the knowing subject and his activities, and between his activities and their fulfillments and pleasures, are disrupted.[32]

These remarks cry out for critical scrutiny. Although the Council acknowledges that biological intervention is intelligible in scientific terms, it uses examples such as steroids in sport to argue that "from the athlete's perspective, he improves as if 'by magic', without the self-conscious or self-directed activity that lies at the heart of better training…he risks a partial alienation from his own doings, as his identity increasingly takes shape at the 'molecular' rather than the experiential level."[33] In reply to the obvious objection that "[e]ven in the most self-directed activities, we remain ignorant, on the level of experience, of what is transpiring chemically in our bodies,"[34] the council says the difference "is *not absolute but a matter of degree*."[35] But, as Stark points out, "an athlete is *no more* conscious of the ways in which training, exercise, or diet alter her body—the molecular processes at work do not enter her consciousness—than she is of the way in which steroids accomplish the same end."[36]

The council contends that

> things essential to sport—such as aspiration, effort, activity, achievement, and excellence—are essential also to many aspects of the good human life. Examining the significance of performance-enhancing biotechnical powers for human sport may help us understand the significance of such powers for excellent human activity more generally.[37]

But an analogy with sport impedes understanding the issues at stake with statins. While reasonable people can disagree about the relative importance and value of effort and natural talents in athletics, sport is clearly an area where it is true that "the 'naturalness' of means matters,"[38] as does effort. As Brock points out, "sometimes a valued human activity is defined in part by the means it employs, not just by the end at which it aims."[39] A ball's falling into a basket is not an intrinsically desirable end in isolation; means and context are what make it desirable and give it significance. An activity that required no effort for anyone could hardly be a sport at all. A prize could be given to the person who best met some standard regardless of method, but this would no more involve athletic competition than would awarding a prize for being the tallest person in a room. The crucial distinction is between activities that are valued as achievements, so that the means is a central part of the activity, and those where what matters is the result, provided that the means are not themselves immoral. For most people, scrubbing the bathroom floor is a means to a clean floor rather than an opportunity to develop and display their floor-scrubbing skills. That obviously does not make it acceptable to scrub one's floor with someone else's face, but it makes it irrelevant to worry about using unnatural means or taking the easy way out. Rejecting such a worry is likewise reasonable when it comes to lowering one's weight or cholesterol.

So we have two distinct ideological objections to magic bullets. First is Stark's objection that they might diminish the subject by diminishing his struggle. Second is the objection that they are in some sense "unnatural," in the sense of being unintelligible in human terms. These objections are logically independent. The President's Council says, "the point is less the exertions of good character against hardship but the manifestation of an alert and self-experiencing agent making his deeds flow intentionally from his willing, knowing, and embodied soul."[40] And, as I have indicated, Stark's view can allow magic bullets as long as they do not diminish the subject's total struggle. He might have yet another ideological objection, though. This arises from the fact that he would consider a drug "artificial enhancement," hence taboo, if it brought its users to a level no one had reached by non-medical means such as diet.[41] He introduces this stipulation in response to Joseph Rosen's remark that "were he given permission by a medical ethics board, he would try to engineer a person to have wings."[42]

I am unsure whether statins get anyone's cholesterol level below what Stark calls "a populated social ideal"[43] that has been achieved by means he deems non-medical. But why would it be so terrible (rather than so wonderful) if they did? For that matter, why would it be so terrible if Joseph Rosen engineered wings for people in a world where neither money nor biological side effects were a problem? The conservative approach of the President's Council stresses "the danger of degradation in the designed, considering how any proposed improvements might impinge upon the nature of the one being improved"[44] and maintains that "to have an identity is to have limits."[45] But Ray Kurzweil aptly suggests that the essence of being human lies not in our limits but "in our ability to supercede our limitations."[46] What, after all, could be more distinctively human than our human intelligence and rationality, which is precisely what enables us to supercede our limitations? This is not to deny that our human ingenuity could lead to our destruction, for (hackneyed) example, through a nuclear holocaust. But the objections the President's Council levels against limit-breaking biotechnology have little to offer people who do not already subscribe to the council's quasi-religious worldview. And Leon Kass's slogan, "shallow are the souls that have forgotten how to shudder,"[47] prompts a reply that I have given elsewhere, "narrow are the souls that cannot comprehend that different souls shudder at different things. I shudder at the thought of being denied lifesaving technology because it violates Kass's particular conception of dignity."[48]

I end by returning to the sport analogy. Some people may choose to treat weight and cholesterol reduction as resembling sports, in that the magnitude of the achievement as an achievement becomes at least as important as the magnitude of the result. I'll stick with Lipitor. I'm just waiting for my fairy godmother to grant the second half of my wish and come up with a pill that will let me eat everything I want without gaining weight. If she could grant the first half, why not the second? And for the sake of smokers, who rival fat people for the non-athletic title of America's number one pariahs, I hope their fairy godmother comes up with a magic bullet to neutralize the effects of nicotine. And do you know what else? If Joseph Rosen ever gets permission to engineer a person to have wings, then, to paraphrase a line from a famous song of the civil rights movement, I'll be flying right there.

> Once upon a midnight dreary, while I pondered weak and weary,
>
> Over many rich delights that I was greatly longing for:
>
> Chocolate ice cream, then a truffle, chocolate cake with chocolate ruffle,
>
> All the cravings I must muffle, muffle, though it pained me sore.
>
> "Eat some broccoli," I muttered, "even though it pains you sore—
>
> Only this, and nothing more."
>
> Ah, distinctly I remember it was in the bleak December,
>
> But the following November opened up a bolted door.
>
> So that now when I am eating ice cream, I'm no longer cheating,
>
> And my joy's no longer fleeting, fleeting as in days before.
>
> Lush dessert is not beyond me, as it was in days before.
>
> What's the secret? Lipitor!

Endnotes

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Boxing with Shadows: Medicalization and Other Fetishes

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For present purposes, I'm going to understand the charge that some problem, or some feature of life, has been medicalized as implying that ideas shaped by medicine's technical powers and therapeutic practices, or its characteristic explanatory structures, or its common patterns of valuation, over-influence how people see and respond to that problem or feature. Medicalization, on this account, is a distinctive sort of distortion of social understanding: perhaps due to a kind of opportunism on the part of those who wield or want to wield social clout, or maybe resulting more directly from a kind of infatuation with medicine and its track record against disease and trauma, we cramp lots of disparate issues into a shape spuriously unified to look like the sort of thing with which medicine can deal.

"Medicalization" *can*, of course, be used without critical intent. Yet it is, I think, more commonly employed in the rather grumpy way I've suggested and, so used, carries the implication that we'd understand our problems better, and, at least often, respond to them more efficiently and effectively if we saw them free of the cognitive and affective static imposed by medicine and its trappings. I say "often" since at least some complaints filed under this head don't really seem to hinge on whether medicalizing a problem retards its resolution. Imagine, for example, that there's a pill in our future that will help those prostrated by grief over the death of a loved one—not by making their grief vanish but by moderating grief's excesses, moving the bereaved through mourning's "stages" with dispatch, while at the same time allowing mourning the chance it needs to do its necessary psychic and social work. Some still might regard the use of such a pill as an objectionable instance of medicalization, despite—or perhaps because of—its effectiveness. I think this is a telling feature of the medicalization complaint, for reasons to which I'll return.

There is also a more political understanding of medicalization, which takes it as a process by which power is transferred from citizens to the state, or the medical profession, or both, without proper acknowledgment of individual liberties. I won't discuss the political dimension here, except perhaps by implication.

There's no doubt that medicalization has gone on, nor that it continues, and to our cost. Yet having granted that, I'm going to try to dig out some of the *contrasts* that seem often to fuel the charge of medicalization. In general terms, here's the sort of thing I have in mind: it's often said, with considerable plausibility, that we medicalize death, and aging, and childbirth, and classroom disruption, physical failings and declines, unhappiness, our experience of our sexed and gendered bodies, and on and on and on. If only we could exorcise medicine's baneful over-influence we'd be—just what, exactly? More likely to see these phenomena and their attendant problems for precisely what they are? Alert to a much richer expanse of possible solutions? Less likely to manipulate people and more likely to treat them as if they were citizens of a Kingdom of Ends?

Well, possibly. But my worry is that the medicalization complaint sometimes—perhaps often—is prompted by other more or less unified habits of thought and assessment, and that these habits carry with them their own tendencies to cause distortion. I'll try to explain why I think this is a point worth taking to heart, and to start to rough out how its implications might point to better ways to identify, assess, accommodate, or counter at least some of the kinds of charges that get expressed under medicalization's umbrella. Here's the suspicion: while, say, Big Pharma might well be doing some very nasty things to society, and while it may well be the case that lots of us die in ways that could be much improved, it may not turn out to be very helpful at all to see these problems as instances of a single phenomenon, "medicalization." Maybe our problems with Pharma have as much or more to do with capitalism than medicine, our problems with death more to do with religion than with healthcare. And so forth.

Sorting Out Medicalization.

First, let me underscore a couple points that I may have made too quickly in the opening sketch.

One concerns whether medicalization as a concept merely *describes* a recognizable complex of thoughts and attitudes, or whether it additionally *explains*, at least in some part, why people's thoughts are prone to take that sort of shape, and why it assumes whatever influence it may have. Seeing medicalization as a descriptive concept—one that, as it were, denotes symptoms and not causes—prompts this sort of question: Are medical terms, metaphors, procedures, values, and so forth tempting for various reasons to those with antecedent interests in certain kinds of social control? Examples of such employment of medical terms are numerous, most infamously perhaps in the recruitment of medical language by the Nazis and their tame physicians as part of the Final Solution. Surely, anti-Semitic mania didn't emerge *because* of medicine's social influence and technical prowess. Rather, anti-Semitism predated scientific medicine and worked its way into expression through medical terms and via medical actions—in part, perhaps, because it was thought that a connection with concern about "hygiene" might provide anti-Jewish policies with a sort of patina of rational justifiability. The Nazis could have dropped all their medicalized language and kept doctors out of the camps, and their program would have been likely to emerge nonetheless, surely just as heinous as ever.[1]

Other uses of medicalization, though, suggest that there may be something within medicine itself that prompts a kind of imperialistic disposition on the part of some people (social theorists, policy makers, healthcare providers, business executives, and so forth)—this is the use with which I'm going to be particularly concerned. In such instances, medicine is taken to generate its own motivation for influencing social structures and practices. The notion here is that the success of medicine (perceived or real) in responding to a certain prominent class of the problems that human beings confront is itself a powerful goad to try to see other problems as amenable to the same kind of solution—in somewhat the way, perhaps, that rationalist ambitions were sparked by the power of mathematics, or various reductionist programs in philosophy by the power of the empirical sciences. In cases like this, as contrasted with the Nazi case, if we're misdiagnosing problems by setting them under medicine's spell—giving unruly kids Ritalin when we should be giving them spankings, or something of the sort—we presumably would be making progress if we became disenchanted.

I also want to underscore something already at least implicit in what I've already said about efficiency and appropriateness—namely, that the charge of medicalization is not solely an epistemic indictment. Medicalization is often portrayed as a tool to achieve, preserve, or extend social power—as well as to ameliorate social problems—not merely by importing a certain set of techniques, but also in part by imposing an over-simple or at least inaptly tailored regime of values on humans and human interactions. Rather than see people as, say, free and independent agents, whose problems should be solved in ways that take account of their rational agency and their distinct visions of the good, as we might think characteristic of liberal conceptions of politics—or, to take another example, as sinners whose problems require repentance and expiation, as we might think characteristic of some religious conceptions of life—medicalization tends to depict people not so much as agents but, rather, as patients, not so much as individuals as parts of a population with an expanding burden of illness, or as potential vectors of disease, or in some other way that attenuates individuality and responsibility. Looking out from that vantage, we're inclined to seek for, engineer, and implement responses to people's problems in ways that get their normative support from the powerful values we associate with health or, perhaps, with its metaphoric extensions. The visions of the good that support medicalized initiatives may seem more authoritative then they actually are, that is, because of the conception that health is a primary good, something that all rational agents needs to rank high on their lists of things to be pursued. Hence, the concern that other important human values—e.g., civil rights, pious resignation—are at risk from medicalization.[2]

Medicalization's Underside

There's hardly any denying that seeing things steadily and whole, being disposed to think outside boxes, and appreciating people in all their rich complexity, as responsible agents, as ends rather than means, are all on the side of the angels, while tendencies of thought that systematically undermine these virtues are bad. But examination suggests that it's not only champions of the epistemically undistorted and the ethically well-defended who complain about medicalization; the complainers can themselves oftentimes embody habits of thought that reflect a substantive and controversial agenda. Behind charges of medicalization there can lurk ways of perceiving, structuring, and responding to problems that also constitute, or fuel, or otherwise lend themselves to distortion.

For example, what I'll call (not altogether happily) "naturalization" appears to give rise to at least some charges of medicalization—a hankering, that is, for ways of understanding, resolving, dissolving, or living with problems that prizes a sort of quietism, a resignation born from a proper understanding of the limits we do and ought to have. People used to die, or age, or give birth, or settle classroom disputes, or seek for happiness, as *Deus sive Natura* intended—or such is the image that sparks the thought that we've done something wrong in approaching these features of life with weapons from the medical armory.

In his contributions to a discussion of medicalization held by the President's Council for Bioethics, Leon Kass provided a nice statement of something in the neighborhood of what I have in mind here. In an open letter to a Council colleague he wrote,

> The push for medicalization…is [thus] only partly driven by new technologies, though the availability of effective drugs and other instruments lends much support to a medical conception of the problem, and contributes to creating demand for medical services as treatment. It is also driven by deep cultural and intellectual currents: for example, to see more and more things in life not as natural givens to be coped with, but as objects rightly subject to our mastery and control; to have compassion for victims more than to blame perpetrators, even when the victims are victimized by their own perpetrations; to see the human person in non-spiritual and non-moral terms, but as a highly complex and successful product of blind evolutionary forces (which still perturb him through no fault of his own). It is also driven by commerce and the love of technique, the inflation of human desires to remove all obstacles to our happiness.[3]

This view splits the difference a bit between my "description/explanation" distinction, although the brunt of Kass's concern seems to be that it isn't primarily the power of specifically medical modalities that cause medicalization. Rather, recruitment of such technologies is promoted by other features of a pragmatic culture. It is tempting to see those "deep cultural and intellectual currents" as just the ones which contemporary medicine both swims in and stimulates. I, however, want to focus attention on a different point.

Kass's words bespeak something other than a contrast between medicalization as a kind of motivated distortion of reality, on the one hand, and a kind of flexible, alert readiness to see problems for what they are and to follow the best paths to solutions wherever they may lead, on the other. What stands as medicalization's alternative, as Kass sees it, is a much more definite nexus of ideas and assessments. It counsels resignation in the face of difficulties that are obdurate because there is some normative authority that mandates their obduracy; it insists that there are some objects not "rightly subject to our mastery and control." If objects of that sort are causing us problems, they are not, to use a distinction of T. S. Eliot's, the kind of problem that ought to be solved—*even if they can be*—but, rather, the kind of problem that ought to be lived with, drawing on humility, patience, and grace rather than technology—or so I understand Kass's imagined contrast.

In fairness, I must note that Kass's approach to medicalization is intended, so he avers, to leave completely open the question of whether medicalization is a good thing or not. ("I intend a descriptive account, not a moralizing one."[4]) But I find it hard not to see some grumpiness in his characterization of the notion, and a corresponding enthusiasm for the counter-ideology. If I'm right about that, and right as well about the rather substantial moral commitments that nourish what I understand to be a critique, then medicalization, at least as Kass deploys the idea, needs to be seen not as a distortion to be unmasked and discarded but as a distinctive and substantial position, opposed not by Reason but by specific kinds of reasons that themselves might be contestable and confused.

If, for example, medicalization is open to criticism for portraying people too readily as patients and, thus, is too blithe about excusing them from responsibility, Kass's (apparently supernaturally tinged version of) naturalization seems prey to a penchant for moralizing—and not very attractive moralizing, either. At some level, it seems to be a kind of ethics of taboo. Taboo, however, isn't even a likely starter for reasoned assessment, so a fair critic should look for another reading. Perhaps Kass is concerned about hubris. Yet that idea can't do much on its own, either—we need a good account of what makes a certain ambition overweening.

A more interesting line of moral thought that might be operating here connects to the "fragility of goodness" slogan—which I take to express the idea that much of what is most deeply characteristic and most valuable about human life is conditioned by its evanescence, its insufficiency, its enormous vulnerability.[5] Here we have a serious position, one I'm not inclined to deny. However, I don't see any realistic prospect for medicine's rendering human lives systematically invulnerable any time soon—indeed, quite the contrary—so neither am I inclined to join those who want to warn us about the worrisome growth of our power over nature. In my view, we can stand to develop a good bit more power before we need to be concerned about whether we've got too much.

Indeed, other people who complain about medicalization seem to be concerned about matters that are quite different from—perhaps even inconsistent with—Kass's worries. For instance, there are those who think that the problem with medicalization is that it tends to laden people with *more* moral obligations, holding them to a higher standard of accountability for their health, with the anxieties and burdens attendant on having one's moral agency (over)extended.

More generally, we can here see again the fault line between worries about medicalization that are more or less pragmatic in their character (where the concern is that throwing drugs at a problem might just make it worse, or that intensified monitoring of normal deliveries causes more harm than good, and so forth), and those that are ideological in character (where whether an instance of medicalization works or not is beside the point—unless, indeed, working well is precisely the problem). Pragmatic concern with medicalization should focus on whether we're in effect encouraging bad medicine, turning too many things into nails just because we've got a hammer.

The proper response to pragmatic worries may be equally pragmatic—for example, more and better medicine—and that doesn't seem quite to capture what's at the bottom of the worry about medicalization, as I hoped to suggest with my earlier reference to the pill that regularizes and moderates mourning. A critic of medicalization in psychiatry might point out that, although melancholia and mourning can both be called depression, there's a lot that's different about them.[6] Just so, and the related concern about harming patients by misdiagnosis and poorly targeted therapy is a serious and straightforward one. But if the resistance to the medicalization of mourning survives the development of the pill I've described—as I suspect it might—then we've got something other than either a concern for health or for clear thinking—we've got a substantive and controversial counterposition.

Such counterpositions may be more than merely an alternative to medicalization: they may be *contributors* to what medicalization is taken to be. It's against a particular set of commitments concerning the nature of human beings, human problems, and the limits of human agency that a different collection of activities and attitudes assumes a particular character—becomes "medicalization," as opposed to medicine—and, as I'm understanding the matter, poses a particular set of worries. For example, the medicalization about which Kass speaks is, at least in part, that set of practices that keeps us from fidelity to preferred views of human origins (Creationism, perhaps? Intelligent Design?), as such infidelity is effected by people who wear white coats. But lots of us who tend to wear black jackets instead are also—perhaps in a rather more focused way—doing what we can to promote faithlessness to those views. Insofar as it is of paramount importance to a person to keep non-Darwinian conceptions in working order, the social penchant for looking to medicine for responses to problems might seem to take on a kind of cultural significance and threat it might not otherwise present. What's more, beguilement by medicine can take on lots of forms—if opponents of the cultural currents identified by Kass were to spend too much of their time railing at medicine for how it turns those currents into entrenched practices, they might miss other features of the social world that were actually doing more "mischief" than medicine.

I want to discuss another possible contrast to medicalization, one I'll label "socialization." What I have in mind is the objection that "medical models" of disability are across the board harmful because disabilities are not fundamentally due to bodies that don't work as they ought but, rather, to societies that don't work as they ought. This is perhaps less discussed under an explicit medicalization heading, possibly because there's less of a sense that a class of human problems dealt with in nonmedical ways has been progressively colonized by medicine. If there's movement in prevailing understandings of disability, it seems to be going more in the social direction. But the complaint that a medical model of disability is inappropriate seems substantially a medicalization charge, so I'll consider it here.

As a number of commentators have noted, the "most basic cooperative framework" in a given society will determine who is and who is not "disabled"[7]; being disabled, then, is not a monadic property, but a relational one. If we combine this highly plausible idea with another notion—that many features of human lives that are poorly suited to the prevailing cooperative frameworks emerge not from anything that can easily be regarded as a pathology or a trauma but, rather, are a matter of being at the tail end of a normal distribution of properties—we come up with a view that may look with suspicion on a conception of disabilities as diseases or traumas and, therefore, as problems.

I say *may* advisedly here, of course, because there seems nothing in this nexus of ideas that implies that medical approaches need not be useful for people facing these problems: conditions may be part of normal species variation, and, yet, distinctly problematic. Their problematic status may reflect something like an ill fit between physical powers and social requirements, but it may be much more efficient (and not otherwise objectionable) to alter a person's body than it is to change her society so as to relieve the problem.

One source of suspicion here is provided by people who think that medicine needs to be kept in bounds by a combination of (a certain understanding of) its tradition and by features of the natural world. It's permissible—even laudable—when medicine responds to pathologies or traumas—and particularly okay when those conditions can be identified without our having to deploy values, or at least values that anyone would contest. But, the thought continues, we should be very wary, or flat-out outraged, if medicine tries to meddle with conditions other than diseases and traumas. (Admittedly, a good deal of present day medicine goes on in precisely these ways, but we should, on this view, try to roll that back, and certainly not encourage it—otherwise, we're "medicalizing.")

Yet the motivation for this kind of restriction isn't clear at all. One thought might be that medical responses to such problems eviscerate agency, distract from political dimensions of problems, leave people discontented, even ashamed of themselves, send invidious messages to those who have the conditions that medicine targets, interfere with the formation and transmission of individual identities and broader subcultures centered around certain conditions. But if this is what's at issue, the connection to whether we've got the right analysis of "disease" doesn't really seem much to the point.[8] Here, one wants to say that the problem doesn't lie so much with strategies and tactics as with the evaluative understandings we allow to track them, and that we ought to be able to make some judicious distinctions here. If it happens that pain, discomfort, restricted abilities, shortened life-spans, etc., can be avoided or ameliorated with heathcare techniques, we ought to be able to figure out ways to take advantage of those benefits while reducing or eliminating the problems concerning agency, shame, identity, and so forth. Indeed, we sometimes may find that the problems are more in the perception of the critic than in the actual social effects emerging from medicine, even as now constituted. Yet even when this is not so, the concern that needs to be sorted out is not in any determinative way a matter of reining in medicine, but of freeing it from a set of ideas about its "proper" place, about what it is to be a patient, and so forth.

Bioethics and the philosophy of medicine have, I think, a role to play here. Recently, another member of the President's Council involved in their discussion of medicalization, Paul McHugh, has acknowledged that mental health providers often are called to respond to people whose problems are not traceable to some lesion in their brains. Despite his concern that medicine in general and psychiatry in particular has "imperialist tendencies to bring more and more of ordinary human living under its jurisdiction and control,"[9] McHugh does not think that physicians should turn all the ordinary humans away. Rather, in a working paper prepared for the Council, he calls for an improved psychiatric nosology that would identify four reference classes of complaint: (1) the class of conditions encompassing the diseases of the brain (e.g., dementia, bipolar disease); (2) the class of conditions encompassing destructive behaviors where choices play a role (e.g., drug addiction); (3) the class of conditions encompassing "problematic dispositions" (such as mental subnormality, and histrionic tendencies); and (4) the class of conditions derived from troubled life experiences, social maladjustments, and such things as grief and jealousy. In cases that fall in classes (2)-(4), McHughs writes, physicians *qua* physicians should attempt to respond to patient need, but in a way that is clear about the limits of their expertise, and that will alert patients to the fact that there are other sources of help for their problem. In his view, this allows medicine to provide what it can to those whom it might help, without claiming in some imperious way that it has a defining stake in all problems.

I think this view particularly laudable in that it renounces the idea that medicine goes wrong if it tries to help people whose problem is neither disease nor trauma. What's less laudable is that it sees the obligation to warn about limitations and inform about alternatives as pertinent only to categories (2)-(4), and not to medical conditions themselves. Although some critics who profess concern about medicalization or medical models have portrayed bioethicists as part of the problem, it seems to me, on the contrary, that it is something very similar to these warnings about limitations and openness to alternatives that prominent currents in bioethics have been trying to effect on medicine generally, by encouraging physicians to honor the individuality, the schedules of value, the self-conceptions, and practical identities that emerge out of their patients' personal and cultural surrounds—in short, to see their patients as agents.

The moral here is that the kind of response to medicine that comes from those making the medicalization charge from the perspective of socialization can be seen, when appropriately deflated, as akin to what bioethics has tried to do, without (typically) the same kind of frontal assault. Concerns that something has been medicalized can be eased by the kind of work that bioethics ought to do—e.g., making healthcare safe (or safer, at least) for people who are not only patients, and who have problems other than those to which medicine can effectively respond.

A Closing Caution

Considering these contrasts suggests to me that there is a peculiar kind of caution we ought to observe before we label a pattern of social response to some problem as an instance of medicalization. The concern is that at least some of our charges of medicalization may be self-indicting. The notion that we are confronting, at the object level, a pattern of action or policy that has enough, and the right kind of, unity to be usefully characterized as "medicalized" is itself an indication of a problem. Our critical thinking would seem to be disordered by an overly simple grasp of the social role medicine plays, as well as by the "shadows" medicine casts. By "shadows" I mean medicine's "rivals": the natural and the social, and also perhaps the commercial, the traditional, the "non-hubristic," the religious, and so forth, also over-generally imagined as rather tightly unified ways of understanding and responding to the world. *What* we're thinking about—social life, and the ways people try to cope with it—is nicely variegated. It's *how* we think about social life when we're keen to see in it instances of medicalization that may well be the very problem against which we inveigh.

This kind of thought doesn't exclude the possibility that medicalization, in the "classic" sense, does indeed go on. There are too many examples of people's lives being smashed in the name of racial hygiene and its like, too many instances of vulnerable people being manipulated into accepting forms of healthcare they don't want as they give birth, live, and die to doubt that. However, a little more skepticism about medicalization as an explanatory concept may lead us to wonder whether the recruitment of medical nosologies, practices, and value patterns to understand and resolve social problems may not itself be a variegated phenomenon with multiple causes, expressions, and degrees of depth and tenacity.[10]

Endnotes

1. It's also common to see medicalization explained in part as a function of physicians' desire to extend their own influence and feather their financial nests. Robert Nye's useful "The Evolution of the Concept of Medicalization in the Late Twentieth Century," *Journal of History of the Behavioral Sciences*, 39 (2003): 115-29, which focuses on the political dimensions of medicalization, argues that the picture is more complicated. I'm grateful to Mary Rorty for the reference.
2. A last comment by way of set-up: it's clear from my examples that I'm not inclined to restrict medicalization to problem-gobbling imperialism as practiced by doctors. In his contributions to a President's Council on Bioethics (PCB) discussion of the concept in 2003, Leon Kass seemed to think that such a restriction was appropriate. He requires medicalization to involve conceiving of an "activity, phenomenon, condition, behavior, etc." as a disease or disorder, or as an affliction that should be so understood, and that therefore is to be transferred to "physicians or others trained in the healing arts" to be cured (www.bioethics.gov/background/kass_mchugh.html, accessed June 21, 2006). It seems to me, on the other hand, that medicalization's metaphoric surge can run both ways, transforming problems not previously seen as medical into ills in search of therapies, but also pressing social agents not previously seen as healers into the posture of faux doctors.
3. From Leon Kass's contribution to an exchange with Paul McHugh, discussed at a meeting of the President's Council on Bioethics, June 12, 2003, available at www.bioethics.gov/background/kass_mchugh.html, accessed June 21, 2006.
4. *Ibid*.
5. I'm thinking here of Martha Nussbaum's work, of course, but also of Erik Parens's article, "The Goodness of Fragility," *Kennedy Institute of Ethics Journal*, 5, no. 2 (1995).
6. Indeed, as one did. See Paul McHugh's contribution to the epistolary exchange with Leon Kass, cited in note 3.
7. As discussed in Allen Buchanan, Dan W. Brock, Norman Daniels, and Daniel Wickler, *From Chance to Choice: Genetics and Justice* (Cambridge, 2000), 20.
8. Another concern might be economic: if we don't rein in medicine according to some reasonable concept of its proper sphere, there will be no controlling it, and healthcare spending will ruin us. Again, though, that's what might be

called an external criticism of medicalization. The problem with medicalization, on this view, is simply that we can't afford to do it as much as otherwise seems attractive.

[9] See the link cited in note 3.

[10] I'm grateful to Mary Varney Rorty for spearheading the panel for which an earlier version of these remarks were drafted, to my co-panelists for their own good thoughts and their comments on these ideas, to Rosamond Rhodes for a perceptive edit, and to Hilde Lindemann for her valuable philosophical and editorial suggestions.

Compassion, A Double-edged Scalpel

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Compassion is a double-edged scalpel: it is an indispensable tool in forging a trusting relationship between physician and patient, and may help motivate the physician to alleviate the patient's suffering, but it also poses a problem for maintaining professional boundaries, boundaries that protect the physician from experiencing too much suffering and protect patients by maintaining physician objectivity and impartiality when needed.[1] In this paper, I wish to focus attention on these drawbacks of what I will call "unbounded" compassion on the part of the physician, and I will propose a model which will, I hope, illuminate what properly bounded compassion in medical practice should look like.[2]

I define compassion, following Martha Nussbaum, as "the painful emotion caused by the awareness of another person's undeserved misfortune."[3] Such awareness involves three judgments: that a serious misfortune has befallen someone; that the person did not bring this suffering on herself; and that this person is in some sense valuable, that is, her good is to be promoted.[4] Although cognitive faculties are at the core of compassion (more so than in many other emotions), the compassionate person need not articulate these judgments to herself in order to experience the emotion. In addition, the identification of the emotion with evaluative judgments is not meant to limit the phenomenological richness and content of the emotional experience.

John Deigh has identified a weakness with Nussbaum's definition of compassion, that it cannot account for compassion that is "transformative of the subject's ends." Consider, for example,

> [a] child of affluence…who grew up knowing only suburban prosperity…and without ever encountering urban slums or rural squalor might, when confronted for the first time with such human misery…experience a powerful wave of compassion through which the desire to help the victims of poverty replaces her prior indifference to their plight.[5]

Since the judgment that others' ends are important is always already a facet of compassion, for Nussbaum, compassion that *awakens* a sense of the importance of others' ends is not accounted for. However, this is not a serious problem for my use of the definition in the context of medical ethics as it is inherent in the physician-patient relationship that the patient's ends do already matter for the physician—it is part of the role of the physician to promote the patient's welfare.

In this paper, I will address compassion somewhat separately from empathy—although the two are often interrelated—as the latter is, strictly speaking, neither necessary nor sufficient for having compassion (empathy may be necessary, however, for the most attuned and ideal forms of compassion). I define empathy, following Alisa Carse, as "the ability and disposition to imagine (as best we can) how others feel, what they fear or hope for, and how they understand themselves and their circumstances."[6] Thus, while empathy involves a great deal of imagining, one can feel the painful emotion of compassion for a patient suffering from AIDS without attempting to experience vicariously what her first-personal experience of the illness is like. And a torturer can use empathy imaginatively to engage another's situation as if in her shoes, without experiencing compassion and its corresponding feeling of sorrow because he does not see that the victim's good is to be promoted.[7] Notwithstanding, according to the psychological literature on the topic, it is typically the case that people who engage empathetically with suffering persons will experience compassion for them.[8] Additionally, having an *appropriate* feeling of compassion will often involve empathy. For instance, Gina might feel tremendous compassion for Frank, who is blind, upon meeting him. Gina believes (falsely) that he must suffer a great deal on account of his disability. But let us suppose that Frank has learned to cope very well: his passion in life is classical music, and his blindness has heightened his aural sensibilities. He enjoys an active career as a violin teacher and, from his own perspective, a life that is just as satisfying, if not more, than the average sighted person. In this case, attuned empathy in the course of conversations with Frank would dispel the false belief that Frank is a victim of serious misfortune and, with it, the inappropriate feeling of compassion (though the feeling may linger for a while even after the belief has changed).

Meaning to "suffer with" another (cf. the German "Mitleid"), compassion is an emotion that metaphorically extends a person's boundaries. This takes an extreme form in the philosophy of Schopenhauer, who saw compassion as the very basis of morality, and affirmed that the compassionate person recognizes that he is, metaphysically, one with another. Schopenhauer writes,

> Hence the radical difference of mental habit between the good character [the compassionate one] and the bad [the egoist]. The latter feels everywhere that a thick wall of partition hedges him off from all others…the good character, on the other hand, lives in an external world homogeneous with his own being; the rest of mankind is not in his eyes a non-ego; he thinks of it rather as "myself once more."[9]

Nussbaum eschews Schopenhauer's robust metaphysical account of the fusion of self and other and draws attention to the fact that in order to have bona fide compassion for another, one must also attend to the ways in which the other is *different* from the self. For example, a physician who is *not* an avid runner needs to attend to the real differences between himself and his patient, which give the patient's marathon-career ending knee injury supreme importance for him: "these recognitions are crucial to getting the right estimation of the meaning of the suffering for the suffering person. What is wanted, it seems, is a kind of 'twofold attention' in which one both imagines what it is like to be in the sufferer's place and, at the same time, retains securely the awareness that one is not in that place."[10] On either construal of compassion—Schopenhauer's boundary-erasing or Nussbaum's two-fold attention to another's as well as one's own experience—one's boundaries of concern are extended outward toward another, and we suffer with another.

It is uncontroversial that a certain amount of compassion is essential for good medical practice; accordingly, many codes of medical ethics (such as the AMA's) stress the importance of compassion, stating that "a physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."[11] Yet, many codes also underscore that the physician "must establish and maintain *appropriate relational boundaries…*"[12] The guidelines thus implicitly speak to the double-edged nature of this boundary-extending emotion. Too much compassion on the part of the physician poses problems. This is captured, in an implicit manner, in the well-known professional directive not to treat oneself or one's own immediate family. According to the AMA's practical guidelines for physicians, "[p]rofessional objectivity may be compromised when an immediate family member of the physician is the patient. In emergency or isolated settings, physicians can treat themselves or family members until another physician becomes available."[13]

Why shouldn't a physician treat herself or her immediate family? If physicians are exhorted to be compassionate in professional codes, and one typically feels greater compassion for family and friends than for strangers, it would stand to reason that family and friends would be precisely those persons who a physician would be most competent to treat. Yet, the AMA guideline implicitly recognizes that crossing relational boundaries may involve too much emotional engagement with a patient risking physician objectivity and patient welfare. An additional unstated worry is the danger to the physician's own well being if she crosses the line between work and family; between the professional and the personal—where a bad medical outcome might mean a personal loss and failure that engulfs her entirely.[14]

Another worry concerning unbounded compassion concerns partiality. Imagine the following case: Ms. Turner, a beloved mother of three and kindergarten teacher, struck down by a drunk driver, lies brain dead in the ICU. Assume that the determination of brain death is not controversial and that her further care is obviously futile according to the hospital's well-justified medical futility policy. Her family requests, however, that her care be continued for a few days longer; they wish to grieve for Ms. Turner over the weekend at her bedside. Several other patients await a bed in the ICU. The physician is not acquainted with these patients except for the fact that their needs are rather urgent. While it is understandable that a physician's compassion for this endearing patient and her family might motivate him to keep this patient on life support for a few more days, his compassion may run counter to the demands of distributive justice. It is likely in this scenario that the physician's professional obligation is to try to convince the family to discontinue life support as soon as possible, and to take steps to do so if the family will not relent. Compassion in this case comes into conflict with the demands of justice and the physician's professional obligations and needs to be properly bounded.

It may be argued, however, that compassion does not truly conflict here with professional obligations but, rather, compassion for Ms. Turner has obscured the compassion he ought to have for the patients on the waiting list for the ICU. On this reading of the conflict, it is not too much but, rather, too little compassion that is the problem: he lacks sufficient compassion for the patients on the waiting list. But this does not plausibly capture the nature of the conflict. The physician in this case does not know who the other patients are, and without putting a name, face, and narrative to the next patient on the waiting list, it is implausible to say that the physician could or should have real compassion for him or her. Thus, the conflict in question here seems to be more plausibly captured as one between compassion and impartial professional obligations. One can see how compassion is a "double-edged scalpel" in this case, for it may conflict with professional obligations, but it is also indispensable for treating Ms. Turner and her family in a humane fashion. If a physician did not share in the family's sorrow to any extent, he might act in a very authoritarian manner to discontinue life support. With compassion, the physician is more likely to engage in a sympathetic and respectful dialogue with the patient's family in order to try to achieve the same end humanely.

In fleshing out these features and drawbacks of compassion in clinical medicine, I wish to propose that a helpful model for the kind of bounded compassion salutary for medical practice is, surprisingly, the model of the emotionally engaged spectator of tragic drama. I am not here giving an argument by analogy to the effect that the guiding normative principles of tragic spectatorship ought, on the strength of the analogy, also to govern the physician's practice, but I do think that the model of bounded compassion offered by the sophisticated tragic spectator constitutes a heuristic device to illuminate ways in which the physician can and ought to place limits on the compassion she feels in medical practice, in an effort to maintain the proper professional boundaries. But this suggested model might seem, at first glance, rather inappropriate: What has removing a tumor or treating an infection to do with watching a performance of *King Lear*? Or *Death of a Salesman*?

Although I acknowledge (and will explore shortly) the significant disanalogies between the virtues and experience of the physician and the tragic spectator, there are two relevant similarities between good spectatorship and good practice of medicine that I would like to explore: first, the good spectator at a (good) tragedy ought to be emotionally engaged, for one does not really "get" the drama if one does not feel compassion (fear and pity, classically speaking) for the tragic hero and in proportion to the horror and undeserved nature of the suffering. Yet, the good spectator does not forget the boundaries of the spectacle and rush the stage to prevent Gloucester's blinding, for she knows that it is not real, and when the play is over, she can go home and cease to worry about the tragic hero. The compassion is thus *bounded* by artistic conventions: she experiences the play in a manner that is both emotionally engaged but sufficiently detached so as not to be overwhelmed by suffering, or forget that she is playing the role of the spectator.

Similarly, the physician needs to emotionally engage a patient, and to respond sensitively to the patient's (and patient's loved-ones') suffering. In a study of the clinical role of empathy, Jodi Halpern has made a sustained case that empathetic engagement with patients (which may often lead to compassion) is a superior stance for physicians than *detached* concern for patients.[15] The two main mechanisms Halpern identifies by which empathy proves therapeutic are, first, the case in which the patient recognizes that her physician empathizes with her experience but where the physician shows *resiliency* in the face of this experience. The second mechanism is "when a suffering person feels that another person is affected by her grief, sense of catastrophe, or fear, and yet remains vital and emotionally present…"[16] Clinical empathy involves a good deal of emotional labor, however, and physicians need to do it while remaining *resilient*, without burning out, without becoming so overwhelmed by the suffering that they can no longer do their jobs competently or leave the painful emotions at work to go home and lead normal lives. Obviously, this is not always an easy thing to do. The effective physician will feel compassion for the suffering patient, just as the spectator of tragedy does, but the compassion experienced in each case is bounded by conventions: conventions of dramatic fiction and conventions of the professional role.

The kind of thinking I'm suggesting on compassion has already been experimented with by the faculty of the Department of Medicine at the VA Los Angeles Healthcare System and the School of Medicine at UCLA. With compassion-building in mind, researchers developed a program called the *Wit* Educational Initiative utilizing Margaret Edson's Pulitzer Prize winning play to educate medical students, residents, and staff providers concerning the "humanistic" elements of end-of-life care. In their report, Dr. Lorenz and his co-authors conclude that the theatrical experience was emotionally powerful for the trainees, and promoted more compassionate care, but did so in a "safe" way:

> One reason our program may have been so well received among trainees is that it allowed them to experience the strong emotions that accompany a realistic portrayal of terminal illness, but *within the safe environment of a theater seat*. …In summary, we found that many learners found the psychologically realistic, emotive experience of the dramatic arts appealing. …Such holistic approaches to medical education should be considered by educators in promoting compassionate end-of-life care.[17]

The authors of the study were trying to sensitize trainees to the lived experience of dying patients. They do not suggest that they were teaching trainees to adopt the complex attitude involving both emotional engagement and critical distance in the initiative; however, it seems a reasonable suggestion that the "safer" theatrical stance might itself constitute part of the training in good patient care. That, perhaps, in a McLuhan-like fashion, the medium is also part of the message.

Obviously, there are crucial differences between the role of tragic spectator and physician in that the spectator observes and engages emotionally with the drama but is not an active participant in it. Except in cases of experimental theater, the spectator cannot change the outcome of a play. The tragedy unfolds before the spectator's helpless eyes. The physician, by contrast, can affect the outcome of the tragic situation, either by relieving suffering entirely and helping to restore health (turning what might look like a tragedy into a "Hollywood happy ending"), or by blunting the effects of the misfortune by providing knowledge of the causes of suffering, relief from pain, an additional sense of dignity and control over the situation. Insofar as the physician is in a position to change the outcome of the situation, she is both spectator and co-author of the drama (along with nature, and the patient) simultaneously. Insofar as these are strong differences, there is a danger in completely aestheticizing the situation, and putting the physician in a more passive spectatorial role. No patient wants to hear the following from their physician: "My, my Mr. Johnson, I've never witnessed such a fascinating tumor such as yours! It grows at such a sublime rate. You are, without a doubt, my most interesting patient!" Obviously, striking the proper balance between emotional engagement, action, and an aesthetic/critical distance seems to be an art in itself.

Notwithstanding, this important disanalogy between the spectator and the active participant, a second salient analogy is to be found in the mode of attention that the sophisticated spectator and the physician pays to the tragic situation. The sophisticated spectator of *King Lear* will attend not just to his feelings toward the characters, but also to how the plot unfolds, (e.g., through the use of metaphor and symbol, in specific arrangements of verse, through foreshadowing of certain events). That is, the spectator attends to the aesthetic qualities of the piece in a dialectic of emotional engagement and spectatorial detachment.

Recently, some medical school curricula have been experimenting with courses in art appreciation. Unlike the emotional development of compassion in the *Wit* program, these are experiments focused on developing students' observational skills more broadly, to deepen their ability to look with discernment, that is, aesthetically. In a paper called "Learning to Look: Developing Clinical Observational Skills in an Art Museum" the authors describe how Cornell University medical students, with the help of an art educator, developed their observational skills by studying paintings in the Frick Collection in New York City. In addition to learning to pick out markers of health and disease in portraits, for example, the students were also trained to see indications of emotion, character, class, and the subjective life of a person through sophisticated engagement with the paintings.[18]

For the sake of my arguments here on the proper bounds of compassion, such experiments, while not specifically designed to limit compassion, rely on similar underlying hypotheses about the necessity for a certain amount of critical distance alongside emotional engagement. Similarly, the good physician will maintain enough critical distance from the patient to be able to look and listen to the patient in a discerning manner, to hear what the patient is describing, but also to ferret out what might be going unsaid; to pick up clues as to the patient's character, emotional state, moments of self-deception, or significant gaps in the narrative.

In a complicated dialectic between empathetic understanding of the patient and critical distance from the patient, the physician can determine the proper medical diagnosis and treatment and, yet, can still emotionally engage a patient to speak with him and to determine the most humane and respectful course of action for the patient. If the physician oversteps those boundaries for compassion, however, the physician starts to play the role of the close friend or family member to the patient. And insofar as she does this, then she shouldn't be treating the patient because her objectivity is thereby compromised. Thus, the good physician is similarly both emotionally engaged and yet detached enough from the "spectacle" to attend to the medical-scientific features of the situation.

Endnotes

1. I wish to thank those present at the panel "Compassion in Medicine" at the 2006 APA Central Division meeting in Chicago for very lively and helpful discussion. Thanks especially to Lee Brown, who organized the panel and offered constructive criticisms of my paper. Laura Ekstrom, Gordon Greene, Ben Rich, Howard Spiro, and Angelo Volandes offered stimulating and insightful exchanges on this topic. Many thanks to my husband, Steven Wagschal, for helpful comments on this paper.
2. My discussion of compassion is limited to the role of physicians. I believe the role of compassion in nursing is better treated separately.
3. Martha Nussbaum. *Upheavals of Thought* (Cambridge: Cambridge University Press, 2001), 301.
4. *Ibid*., 321.
5. John Deigh. "Nussbaum's Account of Compassion," *Philosophy and Phenomenological Research*, LXVIII, No. 2 (2004): 465-72 and 469. Deigh borrows this example from Stephen Darwall in *Impartial Reason* (Ithaca: Cornell University Press, 1983).
6. Alisa L. Carse. "The Moral Contours of Empathy," *Ethical Theory and Moral Practice*, 8 (2005): 169-95, 170.
7. Martha Nussbaum makes these points in *Upheavals*, 328-29.
8. See C. Daniel Batson et al., "Is Empathy-Induced Helping Due to Self-Other Merging?" *Journal of Personality and Social Psychology*, 73 (1997): 495-509.

9. Arthur Schopenhauer. *On the Basis of Morality*. trans. Arthur Brodrick Bullock (Mineola, NY: Dover, 2005), 141.
10. Nussbaum, *Upheavals*, 328.
11. American Medical Association, http://www.ama-assn.org/ama/pub/category/2512.html, accessed on April 2, 2006.
12. *American Academy of Otolaryngology-Head and Neck Surgery Bulletin*, March 2006 (full Code of Ethics found at www.entnet.org/academy/policies/ethics.cfm).
13. AMA's Code of Medical Ethics: A Practical Guide to Physicians, www.ama-assn.org/ama1/pub/ upload/mm/369/professionalismppt.ppt, accessed on April 2, 2006.
14. My discussion of "bounded compassion" is similar to Alisa Carse's conception of "properly contoured empathy"; in both notions, role-related obligations are important in delimiting the boundaries of proper empathy and compassion. Carse writes, with respect to empathy, "receptivity to the other must not be confused with self-abnegating absorption into the other or moral subordination to her. A properly empathetic caregiver must, on the one hand, be sufficiently respectful of and open to the one in need, while on the other, sustaining the requisite degree of self-possession, emotional equanimity, and critical distance to avoid self-effacement," p.176
15. Jodi Halpern. *From Detached Concern to Empathy: Humanizing Medical Practice* (Oxford: Oxford University Press, 2001).
16. *Ibid*., 142.
17. Lorenz, Steckard, and Rosenfeld. "End-of-Life Education Using the Dramatic Arts: The Wit Educational Initiative," *Academic Medicine*, 79 (2004): 481-86.
18. Bardes, Gillers, and Herman. "Learning to Look: Developing Clinical Observational Skills at an Art Museum," *Medical Education*, 35 (2001): 1157-61.

The Role of Compassion in Medicine

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Recent research from varied disciplines indicates that medical patients receive better quality medical care and are more likely to recover completely from an illness, disease, or injury when medical and ethical decisions concerning their care are informed by information realized through empathy and when their care is compassionate or at least tempered by compassion.[1] If that is correct, the implementation of compassion-based medicine as a standard of healthcare poses significant challenges. Modern medical care is driven primarily by science and the treatment of symptoms, and it has had tremendous success. In efforts to address the merits and the viability of incorporating compassion-based medicine into healthcare, practical concerns about the role of compassion in the treatment of patients have evoked theoretical concerns about the implications for relying on compassion for improving patient well being.

Practical Concerns Raised by Compassion

With respect to the more notable practical concerns, foremost is whether significant improvements in medical care can be realized by attending to patients with medical perspectives informed through empathy. The research of Cassell, Halpern, Spiro, and others alleges that healthcare is significantly improved when medical perspectives are informed through empathy. It seems obvious that, in many circumstances, the more a physician knows about a patient the more informed decisions she can make about what is best to do for the patient. Empathy provides a vehicle for accessing information about the patient's feelings that are difficult or nearly impossible to realize through ordinary interviews. In addition, the patient tends to feel safer and less vulnerable when his physician takes a sincere personal interest in what and how the patient feels. This tends to normalize blood pressure and to firm up the immune system.

Another practical concern is whether ethical decisions about patient care would be improved were they informed from empathetic perspectives. When making ethical decisions, all aspects of the patient's well being must be considered. Determining what is most important to the patient is often an obstacle. There are occasions when the patient is not in touch with his or her own feelings about such matters. There are also occasions when the patient lacks the verbal skills or the presence of mind to convey accurately what is felt. The more pertinent information had by the treating physician about what is felt and wanted and not wanted by the patient, the more informed a decision can be about what is best for the patient. Given patient autonomy, having insight into the emotional state of the patient avails a physician of the opportunity to discern what the patient sees as best and right. Empathy provides a viable avenue into the psychological makeup of the patient. Thus, the treating physician is better able to make decisions consistent with the patient's psychological and spiritual makeup. It can also be the case that such information permits the physician to justify a decision that is counter to what the patient claims he wants.

Another is whether components of medical education should be changed in efforts to foster the development of empathetic dispositions toward patients.[2] Medical education is extremely rigorous and disciplined. In some respects it can be considered cruel. Moreover, during students' formal medical education, little attention is given to how to behave caringly and with professional integrity. Because of the culture of medical school,[3] students quickly develop survival skills for protecting their careers, and by so doing they tend to develop insensitivities to professional indiscretions that challenge the potentials for patients to realize maximum recovery and a return to full health, and they subsequently develop insensitivities to patient distresses. In addition, little attention is given to how to treat patients in a genuinely humane manner while protecting oneself from becoming emotionally involved in patient concerns. Becoming too involved can cloud professional judgment and can put the physician at risk of internalizing the feelings of patients. Detached concern becomes the norm.[4] The current culture of medical education needs to be changed in efforts to enable physicians to develop the required skills to attend to patients in a caring manner without having concerns about over-extending themselves emotionally. Moreover, were medical students treated in a more humane manner they would more likely attend to patients in a more humane manner, and perhaps the former would help reduce depression among medical students.

That said, it is not wholly obvious that current medical education can foster the development of empathic dispositions toward patients. Still medical education can be more humane,[5] and medical education can be adjusted so that students receive skills that will enable them to provide humane treatment of their patients. The medical schools of the University of California–Davis and Howard University are revising their curricula and their student evaluation protocols to attend better to such matters.

Philosophical Concerns Raised by Compassion

A concern of another sort is whether physicians should be required professionally to have compassion for their patients. The answer to this question is no, and the reasons require considerable explication. Compassion can perhaps best be characterized as "an empathy driven desire to enhance the fortune or reduce the misfortune of the person for whom empathy is had."[6] In other words, "compassion" for another is "the having of a firm desire to do all within one's reach to enhance the well-being of the person for whom empathy is had." Unlike sympathy, an empathetic response is not to the condition or state that precipitated the feelings of the other. It is instead an involuntary emotional identification with the feelings of another. Loosely speaking, one empathizes when one feels the feelings of another, when one has the other's feelings. However, such loose talk is problematic, since it is not obvious that a person can literally experience another person's feelings.[7]

My recognizing that someone is in pain is not the same as my experiencing that person's pain. Also, feeling pain that one believes another is feeling is not the same as experiencing the other person's pain. That instead constitutes, at most, feeling a pain like the other's. However, within current African-American culture the idiomatic expression, "I'm feeling you" seems to capture well the alleged relationship between an empath and the person to whom the empath is emotionally connected. Implied is a felt understanding and appreciation of the other's intentions, reasons, motives, attitudes, desires, and dispositions during a specific moment. Still, the notion of two persons having the same feelings whereby one possesses the feelings of the other seems to be impossible, except in the case where each person is experiencing sentiments of the same kind. But, here, the sentiment of each is her own and not the other's. They can be alike and perhaps identical with respect to content, but the feelings of one are hers and not the other's. To claim otherwise seems to be metaphorical. By analogy, "You can walk a mile in my shoes, but you can't take a step in my feet."[8] Your feet are as your feelings, something only you can experience when a part of you.

Although many may have feelings with identical content, received wisdom has it that feelings which are another's are only another's—that only the person having some particular feelings can possess those feelings. My "feeling you" implies no dual ownership of feelings. It implies instead only my understanding and appreciation of your feelings and your emotional state of being. One can be empathetic without understanding or appreciating the relevant feelings, and one can understand and appreciate another's feelings without being empathetic—without, in the relevant sense, feeling the feelings of the other. The point here is that the identification required for empathy cannot be one whereby another literally experiences the feelings that you are having both as her feelings and as your feelings.

Another characterization has empathy as the taking away of another's feelings. As your feelings become mine you lose your feelings to me. My having your feelings then amounts to my having feelings that were once yours. But that characterization is not amenable to the work that is intended for empathy and compassion in medical environments. An original *Star Trek* episode featured this characterization of empathy, whereby an empathic individual began healing a terminally ill person by taking on the other's illness. The exchange was linear and opposite. As the empathic one took on the feelings of the other, the other became well, and, of course, the empathic one became correspondingly ill. The episode was fantasy, and there is no known empirical evidence to suggest that such a transfer can or should take place.

A secondary use of "empathy" is to refer to the projecting onto another the feelings believed to be had by the other. Such a usage in medicine opens the floodgates to paternalism. Believing oneself to have knowledge of another's feelings via projecting one's feelings onto another sidesteps the gathering of potentially critical information about one's patient. Furthermore, one can be mistaken in one's assessment.[9] To make informed decisions, physicians need to know what the patient actually thinks and feels.

It makes more sense to characterize empathy as a profound awareness of one's own emergent feelings with an associated awareness that another has feelings of the same kind and quality. In the absence of empirical studies to clarify what occurs during empathy, we can speculate that the quality of the awareness also prompts a feeling that one is experiencing the feelings of the other. Loosely speaking, the feelings had by an empath are identical to those of the person whose feelings he experiences as his own. Concerning the onset of compassion, the empath's experience of the other's feelings as the same as his prompts a desire to rectify the misfortune or to otherwise enhance the fortune for the person for whom empathy is had.

> The emergent desire to help the other mirrors one's desire to help oneself. That is to say, just as it is rational to want one's own misfortunes to be reduced, and just as it is rational to do what is appropriate to reduce one's own misfortunes, it is rational to want to reduce the misfortunes of those for whom compassion is felt—those with whom one identifies. Although there is some discrepancy over what counts precisely as identity in this context, a common thread is the requirement that the perceived misfortune is experienced as one's own. (Empathy, unlike sympathy, requires identification.) It is out of this felt experience that a desire to reduce the perceived misfortune emerges. Hence, assisting the other is analogous to assisting oneself, and since it is rational to want to enhance one's own well-being, when the opportunity arises, it is rational to want to enhance the well-being of the person with whom one identifies.

However, mitigating conditions may arise that thwart the emergence of compassion.[10]

Because compassion emerges from empathy and because empathy is an involuntary response to the feelings of another, no one can be justifiably required to be compassionate. One can decide not to act on a desire to help another, and, in that sense, being compassionate can be resisted. However, few have the ability to will themselves to be compassionate. Except in extraordinary circumstances, one cannot make oneself have feelings for another. Just as we cannot will ourselves to love someone whom we do not love, we cannot will ourselves to have caring feelings for someone about whom we do not care. Perhaps after extensive time and efforts sentiments can change, but sentiments do not change immediately by merely willing them to change. Physicians can be compelled to give care, but they cannot be compelled to have caring feelings. Moreover, requiring physicians to behave in a manner that is not true to their feelings promotes insincerity, and that is not healthy for the physician. Also, patients can usually discern when a physician's concerns are genuine or mere affectation, and the latter is not appreciated. Empathy and compassion are grounded upon feelings for others, and the having of those feelings is not something that is in the control of the person having them.[11] It is common wisdom that we have little choice about what we like and feel, but we have tremendous choice about how we act. That said, a physician cannot be required to be compassionate or generally held responsible for not being compassionate. It would be unethical to hold a person responsible for what is not in the person's ability to control.

Compassion in Medical Education

In keeping with the spirit of the research of Cassell, Halpern, Spiro, and others that laud the contributions of empathetic and compassionate medical care, a more viable alternative would be enriching medical education to enable students to develop a more humane sensitivity to others and a more humane practice of medicine. This can be viewed as having a compassion-like sensitivity to patients—a commitment to do all within one's reach to foster and nurture the well being of patients. With that, having compassion is not necessary. Furthermore, one can be a competent physician without being a compassionate person. I was attended by a surgeon who had terrible people skills but was wise enough to have a physician's assistant with wonderful people skills who did all but the required surgical procedures. The surgeon's having a "front-man" showed his awareness of a need to be humanely sensitive to patients for realizing the best medical outcome. Our seeing the humanity in others involves reference to the humanity in ourselves, and as in the case of having a desire to assist those with whom we identify via empathy, we similarly have a desire to assist those whose humanity we recognize as our own.

Properly directed, the discipline inherent in medical training can nurture students' abilities to be more humanely sensitive to others.[12] Observation and assessment during medical education provide opportunities for medical schools to identify and remediate students who have limited empathic dispositions or challenged humane sensitivities toward patients. Developing such sensitivities can be made a requirement for graduation. So, medical students would not be unfairly discriminated against by being denied permission to practice medicine when failing to pass the humane sensitivity standard.

Conclusion

There are circumstances when the most effective healing can be achieved only by "taking all the tears away."[13] Merely providing means for absorbing the tears is not the same as taking the tears away. There can be underlying concerns that can inhibit regaining health. Desired, in the relevant context, is a recognition that will remove the need for crying—that will rectify the cause of the tears. Attending to another on that level requires a profound humane or empathic sensitivity—an ability to enter the emotional space of another and to facilitate healing the emotions that foster or enable physical pain, illness, and suffering. Many patients are in need of that level of sensitivity, while few physicians are prepared to embrace it. Experiences teaching healthcare ethics to medical students inform me that many physicians and medical students believe that attending to patients with the mentioned level of sensitivity is outside of the purview of medicine. They propose that it is the duty of nurses, psychologists, and social workers to attend to patients on that level. Nonetheless, when a physician has an opportunity to intervene on that level, it seems that a professional and humane duty arises to do all that can be done to attend appropriately to the patient's needs.[14] Moreover, doing so is in keeping with the modern Hippocratic Oath that most medical students embrace at graduation.[15] With respect to the Hippocratic/ethical foundations that ground medicine, I suggest that medical education better prepare students to intervene on such a level. Effectively treating patients often requires more than prescribing medicines, repairing fractures, or performing surgical procedures.

Seeing the humanity in others and treating others in humane ways requires neither compassion nor empathy. The emotional component that grounds empathy and compassion is not required for treating patients humanely, and having it cannot be mandated, since having it is not readily within one's control. Both compassion and empathy contribute enormously to the well being of others, and a humane sensitivity to others can approach the quality of intimacy realized through empathic sensitivity. Moreover, the quality of intimacy often required for attending well to patient needs can be achieved through humane sensitivity. Unlike the compassionate treatment of others, the humane treatment of others can be mandated, and treating others humanely yields healthy outcomes in arenas where empathy and compassion are missing.

Acknowledgments

I thank Dr. David R. Kurtzman for assisting me in editing this essay, and I thank Angelo Volandes, Ben Rich, Gordon Greene, Howard Spiro, Jodi Halpern, Laura Ekstrom, and Sandra Shapshay for sharing their perspective on the role of compassion in medicine and for providing me the impetus to write this essay.

Endnotes

1. Jodi Halpern. *From Detached Concern to Empathy* (New York: Oxford University Press, 2001).
2. An empathetic disposition is an emotional openness to experiencing or to otherwise psychically coming to know in depth what is felt by others.
3. See Ben Rich's "Breeding Cynicism: The Re-Education of Medical Students" in this issue of the *APA Newsletter on Philosophy and Medicine*.
4. Halpern, 2001.
5. Rich, in this issue.
6. See Aristotle's *Politics* (1252a24-1253b22), and *Rhetoric* (1385b12-1386b8). See also L. A. Blum, "Compassion," in *Virtues: Contemporary Essays in Moral Character*, edited by Robert B. Kruschwitz and Robert C. Roberts (Belmont, CA: Wadsworth, 1987), 229-36. See N. E. Snow, "Compassion," *American Philosophical Quarterly*, 28 (1991): 195-205. See Lee Brown, "Compassion and Societal Well-Being," *Pacific Philosophical Quarterly*, 77 (1996): 216-24.
7. For example, let us suppose that two coins are flawlessly fashioned from the same mold. Let's also suppose that all of their physical characteristics are the same and that each coin is possessed by a different person. Either person recognizing the other's coin as identical to hers or either otherwise feeling it to be the same evokes no implication for having possession of the other's coin. Although the coins are identical, experiencing one's own coin would not count in and of itself as experiencing the other's coin. It seems apparent that I would have to experience the other's coin for it to be appropriate to say that I have experienced the other's coin. My not having contact with the other coin, but knowing that the two coins are identical, is not the same as experiencing both coins.
8. George Clinton's *Parliament/Funkadelics*. "Can't take a step in my feet" is a lyric in a song in a recording whose name I cannot recall. The recording was made between 1970 and 1980.
9. One can be mistaken about the existence of an object that one believes oneself to be experiencing. For example, neural stimulation within the brain can bring to consciousness experiences had years past, but are experienced as current. My having the experience of eating pistachio ice cream does not imply the existence of pistachio ice cream or that I am eating. The phantom limb syndrome is another example of having an experience for which there is no corresponding object.
10. Lee, 1996.
11. *Ibid*.
12. According to Dr. Gordon Greene, a Rinzai Zen Master and the Director of the Program for Medical Education in East Asia at the University of Hawaii at Manoa, "Zen Buddhist monasteries make use of rigorous discipline to foster within monks the development of compassionate dispositions, and that discipline, though different in content, is similar in kind to that found in medical school environments." 2006 APA

Central Division meeting session: "The Role of Compassion in Medical Education and the Practice of Medicine."

13. Al Green, "Let's Get Married," *Greatest Hits*. Hollywood: Hi Records, 1972.
14. See Immanuel Kant's *Metaphysics of Morals*, (239-241) and (448-453), trans. Mary Gregor (New York: Cambridge University Press, 1991), 65 & 241-47. See Immanuel Kant's *Groundwork of the Metaphysics of Morals*, trans. H. J. Paton (New York: Harper and Row, 1964), 67.
15. "I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of over treatment and therapeutic nihilism. I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug. I will not be ashamed to say 'I know not', nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery." Excerpt from the 1964 adaptation of the original Hippocratic Oath by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University. See http://www.pbs.org/wgbh/nova/doctors/oath_modern.html for a discussion of Lasagna's "Modern Version of the Hippocratic Oath."

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Breeding Cynicism: The Re-education of Medical Students

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Introduction

The surgeon-author Richard Selzer writes the following in an introductory piece to a text entitled *Ward Ethics—Dilemmas for Medical Students and Doctors in Training*:

> Medical students are so altruistic and humane when they start and then somewhere along the line they lose it, it's beaten out of them. My own training as a surgeon is an example. Training in surgery has traditionally been carried out "en militaire." It was awful when I was in training because the brutality was handed down from the chiefs of surgery all the way to the chief resident, the intern, the medical students, and the nurses. We learned to pass on the brutality because it had been done to us and if you quailed or if you showed any kind of fear or sense of having been embarrassed, then you lost points and you were subject to further ridicule. It was a bad way to become a doctor because it was inhumane. You were brutalized emotionally, and sometimes physically, and it still goes on.[1]

Selzer's view that students enter medical school brimming with altruism and flush with humane impulses, and only in the process of becoming a physician have this driven out of them, is not without its critics. A phenomenon characterized as the "premedical syndrome" has been recognized for decades.[2] Its symptoms, if we are to stay within the genre of the pathological, include behaviors that are described as "overachieving, excessively competitive, cynical, dehumanized, over-specialized, and narrow."[3] These behaviors are ostensibly reinforced by the obsessive focus of medical school admissions committees on certain numerical indicia of aptitude for medical school, i.e., grade point average (GPA), particularly GPA in the pre-medical sciences, and performance on the Medical College Admission Test (MCAT). While there has been some effort of late to incorporate more humanistic perspectives into the medical school admissions process, through required essays about why the prospective student wishes to become a physician, probing values-oriented questions in the campus interview process, and evidence of prior engagement in socially motivated extracurricular activities, the fact of the matter is that students without an outstanding GPA and high MCAT scores will not be admitted. Indeed, one can argue that it would not be fair or reasonable to admit such students because they would not have a realistic prospect of passing the rigorous basic science courses of the first two years that can be challenging even for those who entered with high GPAs and MCAT scores.[4]

However, for purposes of this paper, let us concede Selzer's point and look for solid confirmatory evidence of the inhumanity of medical education. Recently, the medical school where I serve as bioethics faculty surveyed its fourth-year medical students about the treatment they had experienced in their third-year clerkships. While the precise results remain confidential, suffice it to say that they do nothing to discredit Selzer's assertions in the above-quoted passage. Moreover, there is a wealth of additional data in the recent medical literature supporting the proposition that, as described by Selzer, medical students and residents perceive that their clinical training takes place in a hostile, and sometimes even abusive, atmosphere.[5] At some point the persistence of this state of affairs morally implicates the faculty and administrators who are ultimately in control of, or at least responsible for, those venues of medical education. More specifically, that would include clerkship directors, residency directors, and clinical department chairs.

Hopefully, a closer examination of the culture of medical education will provide a basis for understanding the precise nature of the problem and formulating proposed solutions to it. Just such an inquiry was advocated in a provocative presentation by Leon Kass commemorating the twentieth anniversary of the Hastings Center, when he urged those in the field of medical ethics to devote more attention to "institutions and customs that help shape the profession of medicine, especially that influence the attitudes, sensibilities, and habits of medical practitioners as moral agents…what is praised and blamed, honored and held shameful, in medical training and medical practice."[6] But overarching this inquiry and analysis is a still more fundamental question: How could any rational person, not to mention an entire profession, ever expect to fashion humane, compassionate, caring physicians in an educational environment characterized by harshness, rigidity, and cynicism?

The Culture of Medicine

Medical school constitutes the quintessential example of the process by which carefully selected laypersons are transformed into professionals. Because of the systematic progression of the student from the pre-clinical to the clinical years of undergraduate medical education, followed by the internship and residency training of postgraduate medical education, the amalgamation of education and enculturation is much more extensive than in other professional education settings such as law school. The traditional law school curriculum had the very modest goal of teaching students—in one year of required courses and two years of electives—to "think like a lawyer."[7] The task of teaching law students how to actually practice law was deferred and implicitly delegated to the early employers of the recent law graduates. Law schools did not even prepare their students to pass the bar examination that is a prerequisite to practicing law in any jurisdiction. Law graduates had to expend additional time, effort, and money taking commercial bar review courses. Recently, some law schools have begun to shoulder a portion of this responsibility by incorporating legal practice skills courses. However, the elite law schools, and those that aspire to be considered in their ranks, continue to be subjected to the strong criticism that there is a persistent, and perhaps even expanding, gulf between legal education and legal practice.[8] Traditional doctoral programs in philosophy have a similar pedagogical priority.

Medical education, by contrast, is a transformative process by which knowledge, skills, attitudes, indeed, an entire professional persona, are imparted. With even more refinement, as medical students in the fourth year decide what medical specialty they will enter, and begin to interview for residency slots in that specialty, the general professional persona of the physician begins to undergo a refinement process that exemplifies the wide disparity among physicians depending upon their area of specialization. The values and ways of being in the world of patient care of surgeons are radically different in important ways from those of family practitioners or psychiatrists. In a very real sense, medical students must decide not only what kind of medicine they want to practice but what kind of person they want to become and what medical ideology or creed they choose to adopt.

Yale surgeon and writer Sherwin Nuland, in his 1994 book *How We Die*, provides a vivid illustration of precisely this point in his discussion of his care of an elderly woman named Hazel Welch. In his dogged determination to convince the ninety-two-year-old Miss Welch to undergo major surgery to repair a life-threatening rupture of her duodenum, Nuland attempts to explain why he simply could not take "no" for an answer, despite the fact that it constituted the patient's clearly informed refusal of the procedure:

> The code of the profession of surgery demands that no patient as salvageable as Miss Welch be allowed to die if a straightforward operation can save her. …Viewed by a surgeon, mine was strictly a clinical decision, and ethics should not have been a consideration.[9]

In a few simple sentences Nuland sweeps into oblivion decades of legal and bioethical consensus about the rights of patients to determine their own medical fate. But this "Code of Surgery" is, according to Nuland, embedded in a still more fundamental fact about the intrinsic values of the medical profession, which he expresses in the following effusive prose:

> The challenge that motivates most persuasively; the challenge that makes each of us physicians continue ever trying to improve our skills; the challenge that results in the dogged pursuit of a diagnosis and a cure; the challenge that has resulted in the astounding progress of late-twentieth-century clinical medicine—that foremost of challenges is not primarily the welfare of the individual human being, but, rather, The Riddle of his disease.[10]

Thus, from Nuland's perspective, the core values of contemporary medicine not only deny the proposition that physicians should respect patient values but even challenge the idea that caring for patients, rather than solving the pathophysiological riddles that their diseases present, should be what motivates people to enter medicine in the first place. No one has captured the logical and moral fallacy of the view Nuland espouses more lucidly than Eric Cassell, who insists that "doctors do not treat diseases, they treat patients." Moreover, he observes that "the same disease in different individuals may have a different presentation, course, treatment, and outcome."[11] It is because the proper focus of the physician must be the patient, not merely her disease, that the attributes of altruism and humaneness are as essential to the ideal physician as mere technical competence. Yet, as Cassell also observes, "these values are not central to the training programs of modern medical centers."[12] In order to understand the process by which certain implicit values of medicine—in this case those espoused by Nuland, not Cassell—are imparted to medical students, we need to discern two quite disparate elements of the medical school curriculum.

The Medical School Curriculum

In a seminal article on medical education, a critical distinction was noted between the "formal" curriculum—the courses that actually appear in the official catalogue, and the "hidden" curriculum, which is predominantly concerned not with the imparting of knowledge and skills but, rather, with "replicating the culture of medicine."[13] Traditionally, the first two years of medical school are taught by basic science faculty in the form of classroom lectures on such subjects as anatomy, pathology, physiology, biochemistry, pharmacology, and microbiology. While there has been some reform of the "preclinical" years to provide students with limited opportunities to encounter the actual settings in which patient care takes place, these remain a very small portion of the first two years of medical school. Consequently, these years are dominated by the formal curriculum. In stark contrast, year three of medical school consists of a number of required clerkships of roughly eight weeks. Those clerkships are usually medicine, surgery, pediatrics, primary care, obstetrics and gynecology, and psychiatry. In the clerkships, students work with residents, attending physicians, nurses, and other healthcare professionals in the actual care of patients. The fourth year of medical school is highly flexible and intended to allow the students, within certain broad parameters, to design their own panoply of courses consistent with the nature of the residency program they expect to enter following graduation. For students who expect to enter residencies that are not among the specialties that comprise the clinical clerkships, such as anesthesiology, dermatology, and ophthalmology, the fourth year provides the time and opportunity to pursue these as clinical electives.

Clearly, the third and fourth years are when the "hidden" curriculum is an important element of the educational process. Indeed, when required ethics instruction has found its way into the first two years of medical school, the faculty who teach it often lament that what the students learned about ethics in the formal curriculum of those years is largely undone by the oppositional forces of the hidden curriculum in the clinical years.[14] If the primary pedagogical emphasis of the first two years of medical school is the curriculum of the basic sciences, the parallel emphasis in the last two years is clinical medicine, i.e., learning to perform like a physician. What receives little, if any, attention is how to act with professional integrity and caring. This major deficit is evidence of a compromised professional pedagogy, i.e., one that gives disproportionate attention to only two dimensions of practice—the intellectual (knowledge) and the technical (skill), virtually ignoring the third—the moral (attitudes).[15] In fact, the data suggest that in their clinical years students are not merely deprived of meaningful opportunities to consider the ethical dimensions of what they are learning on the wards, they are routinely exposed or subjected to ethically problematic behaviors which they perceive and attach significance to, but those in positions of authority over them often do not. For example, in one study residents' uncaring, hostile, or disrespectful attitudes toward patients were essentially ignored by attending physicians or addressed in a jocular, off-hand manner that implied toleration.[16] There is no reason to presume that the attendings would have responded differently if the negative attitudes of the residents had been directed at medical students rather than patients. This phenomenon has generated an entire new genre of medical literature, "ward ethics."

Ward Ethics

Ward ethics concerns the real-life ethical dilemmas that medical students encounter on the clinical wards as physicians-in-training who are actively involved (with varying degrees of supervision) in the care of patients. The types of issues students routinely encounter, and how they elect to deal with them, takes us to the very heart of the concerns about the ethics of medical education.

One analysis of the most commonly recurring issues in ward ethics identified the following: performing procedures (without adequate knowledge, skill, or supervision), being a "team player," challenging medical routine, knowing the patient as a person, and witnessing unethical behavior.[17] Clearly, the second and third issues are interrelated. If one's objective is to be consistently viewed as a "team player," then one cannot challenge medical routine that comports with the *modus operandi* of the powers that be in the academic medical center. Similarly, witnessing unethical behavior, particularly if it is not infrequent, becomes an acute problem if the student has the temerity to report it. A number of recent surveys of medical students reveal that the most common response of medical students to the unethical situations they encounter is silence.[18] The rationale most commonly offered for the silence has much less to do with student doubts about whether the conduct is truly unethical but, rather, with fears about reprisal for challenging medical routine or being labeled by residents or attending physicians as someone who is not a team player. Some students, however, do report that as they continue to witness what they previously considered to be unethical or unprofessional conduct, with no adverse consequences to the actor, they gradually come to question their earlier perceptions of ethical transgression. After all, if speaking in a derogatory fashion about some patients or colleagues without justification or provocation, or refusing to respect patient wishes and values were truly a violation of ethical and professional standards of conduct, surely someone other than a medical student would recognize that fact and take appropriate remedial measures.

Students find ludicrous in the extreme the suggestion that they have any ethical responsibility to speak up, as has been suggested in at least one article on the subject.[19] They express amazement and disbelief at any assertion that medical students should be expected to engage in acts of moral courage in addition to acts of intellectual brilliance, technical skill, or sheer physical endurance. One astute observer of medical education has identified the singular paradox that while patients and society expect physicians to be autonomous, alert, creative, and decisive, they spend most of their professional education demonstrating docility by passing on the common rule for surviving the clinical years: "Don't ask questions."[20] The paradox is actually even more remarkable, since medicine is supposed to be one of the learned professions. How one becomes learned (as opposed to simply knowledgeable) without voicing questions in the presence of one's teachers and fellow students defies understanding.

It may not be simply cynicism that the contemporary system of medical education is breeding but depression and disillusionment as well. A recent article reported that while students entering medical school are no more prone to depression than other persons their age, medical students are more prone to depression than their non-medical peers, and the prevalence increases disproportionately during medical school.[21] At one very prominent medical school 25 percent of the first and second-year students were considered to be depressed.[22] One fourth-year medical student who sought mental health treatment noted that her depression seemed to start in the third year, lamenting: "I don't like what I'm seeing in the hospital; that's not how I want to practice medicine."[23]

At this point we should return to the fundamental question posed early in this paper: How could any rational person, not to mention an entire profession, ever expect to fashion humane, compassionate, caring physicians in an environment characterized by harshness, rigidity, and cynicism? The most plausible answer, of course, is that one could not. But perhaps that is no longer the goal of medical education, if, indeed, it ever was.

Today's academic medical center is buffeted by unprecedented market forces. Patient care must comport with the demands of the business of healthcare delivery, including diminished reimbursement for patient care, competition by the other hospitals and clinics in the area that are not expected to train the next generation of physicians or to care for this generation of the medically indigent and uninsured patients. Medical faculty, too, must meet many more expectations than their competing colleagues in the community. Not only must they provide and supervise patient care, but they must also pursue highly competitive federal research grants and take responsibility for the formal curriculum of the medical school. Perhaps these multiple pressures simply make a humane, caring, nurturing, and supporting learning environment, particularly on the clinical wards where third and fourth-year medical students spend most of their time, a completely unreasonable expectation. This may be why third-year students in particular report that it is not unusual to be treated by some faculty, attending physicians, and senior residents as though they are simply in the way, making the primary task of delivering patient care more difficult than it would otherwise need to be.

Despite such countervailing practical considerations, the accreditation bodies for undergraduate and graduate medical education have placed increasing emphasis upon the responsibility of academic medical centers to cultivate professionalism. Professionalism in this context is described as including the following humanistic values: honesty and integrity; caring and compassion; altruism and empathy; respect for patients, peers, and other healthcare professionals; and adherence to high ethical and moral standards. The delineation of such standards of professionalism include no exceptions for the financial or practical exigencies facing academic medical centers, their faculty, or their administrators.

Professionalism, one would hope, encompasses the role of medical educator. The report of the Association of American Medical Colleges Medical Schools Objectives Project published in 1998 listed as the first among the stated goals and objectives of medical school education the cultivation of altruism. Among the elements of altruism the report identified were:

- Knowledge of the theories and principles governing ethical decision making.
- Compassionate treatment of patients, and respect for their privacy and dignity.

- Honesty and integrity in all interactions with patients' families and colleagues.
- Commitment to advocate at all times the interests of one's patients over one's own interests.[24]

Similar admonitions have been provided by the accrediting organization for graduate medical education. In 2002, the Accreditation Council for Graduate Medical Education (ACGME) promulgated six general competencies for graduate medical education. One of these was professionalism, which was stated to include the following:

> Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to demonstrate:
>
> 1. respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest…
>
> 2. a commitment to ethical principles…
>
> 3. sensitivity and responsiveness to patients' culture, age, gender, and disabilities.[25]

Clearly, both undergraduate and graduate medical education programs have been recently charged with a responsibility to ensure that ethics, values, and professionalism are infused throughout their curricula. However, if the reports of widespread mistreatment of medical students are reasonably accurate, then many institutions are out of compliance with AAMC and ACGME standards. At the very least, these faculty members are not consistently practicing the professional ethos they are charged with teaching.

Perhaps in recognition of this fact, increasing numbers of institutions have at last begun to promulgate policies and procedures designed to address the very problems that we have considered. The recent proliferation of these policies indicates: 1) the problem is persistent and pervasive; 2) such conduct on the part of medical educators is not deemed to be a necessary or even acceptable aspect of training; and 3) medical schools *appear* to be serious about addressing the problem.

Remedial Measures: Medical Student/Resident Mistreatment Policies

One such policy, at UCLA, begins by setting out a standard of conduct based upon the premise that optimal learning can take place only in an environment in which teachers and students treat each other with respect and that is free of "harassment, intimidation, exploitation, and abuse, and one in which feedback regarding performance can be shared openly without concern for ridicule or reprisal." Among the examples of mistreatment listed in the policy are:

- Criticism or other actions that can reasonably be interpreted as demeaning or humiliating.
- Assigning duties as punishment rather than education.
- Asking students to carry out personal chores.
- Intentional physical contact such as pushing, shoving, slapping, hitting, tripping, throwing objects at, or aggressive violation of personal space.[26]

The policy calls for the establishment of a Student Mistreatment Committee (SMC) comprised of three faculty, one third and one fourth-year medical student, a nurse, a chief resident, a graduate student, and a member of the Gender and Power Abuse Committee. The committee will process complaints when informal efforts to resolve the situation have been exhausted. Following investigation by a subcommittee, the SMC makes findings that are forwarded to the Executive Associate Dean for a final decision. The policy also calls for disciplinary action for malicious accusations or retaliation against those reporting mistreatment. Since promulgation of the policy, complaints by students have been handled informally through the campus ombudsperson and clinical program directors. There has not, as yet, been a need to resort to the formal procedures set forth in the policy. Each year students are surveyed about mistreatment by the Dean's office.

Within the last year, the University of California–Davis School of Medicine has adopted a Professionalism Policy that establishes an Optimal Learning Environment Committee (OLEC) to respond to complaints of mistreatment made by medical students or residents. The committee is to consist of a faculty chair, three additional faculty members (one basic science, one medical specialty, one surgical specialty), two fourth-year medical students, two chief residents (one from a medical and one from a surgical specialty), one graduate student, and one clinically active RN.

What many of these policies do not address are the "Ward Ethics" issues that do not technically constitute student mistreatment but, nevertheless, tend to breed cynicism in medical students. These are the negative behaviors by those in mentoring or role-modeling relationships to students, such as speaking disparagingly about patients or making them the objects of derision.

Conclusion

Returning to the overarching question with which we began this analysis: "How could any rational person, not to mention an entire profession, ever expect to fashion humane, compassionate, and caring physicians in an educational environment characterized by harshness, rigidity, and cynicism?" The answer is that no one could. In order to explain the pervasiveness of abusive behaviors by some of those in positions of responsibility, we need to consider as the primary culprit the unreflective repetition of routines and practices that even at their inception had neither moral nor pragmatic justification. There is an exquisite irony in the fact that in this era of high tech, evidenced-based medicine, these anachronistic and ethically flawed approaches of utilizing intimidation and humiliation as a means of training and enculturating medical students persist although devoid of any justification other than the ritualistic mantra that "we have always done it this way."

Going forward, medical school policies prohibiting abusive behaviors toward students must become a vital part of the ethos of the institution and of the profession, and not mere window dressing intended to placate credentialing bodies. If medical students are admonished to demonstrate moral courage by reporting abusive behaviors by faculty or residents that they experience or witness, then the institutions and their leaders must in turn demonstrate the moral courage involved in rehabilitating or rooting out those faculty who fail or refuse to fulfill these standards of professionalism, no matter how longstanding their tenure in the institution or substantial their contribution to clinical revenue or research productivity.

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Comments on Empathy

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In the 1960s, "telling the truth" and "autonomy" replaced "paternalism" and "equanimity" as the canonical virtues of the medical profession. As respect for authority dissolved in that decade, the notion arose that patients, renamed "clients" or "customers," given some information, should select what they needed or wanted from the cafeteria choices that physicians, renamed "providers," could tell them about. Forgotten was the observation that people in the hospital, patients long-suffering in pain, become child-like in many respects and are very often incapable of making the rational choice that philosopher/ethicists recommend.

Physicians never have caught up with their emotions. One book, *When Doctors Get Sick*, published in the 1987 by H. N. Mandell and myself, made clear how little emotion physicians allow themselves to feel. This was true even when I was sick. It is true of other doctors even when they are dying. Detachment, so praised by Osler, led to distance and numbness so that doctors would not suffer when their patients died.

That compassion has been left out of medicine, to be supplied, one hopes, by the clergy, may not be all bad. For compassion carries an implication of superiority, pity, and an urge to relieve suffering through praying. I prefer the term empathy, for it implies the notion that "I could be you." Empathy, as opposed to compassion, has a ring of equality.

Empathy implies recognizing the patient's humanity or "dignity." Dignity is sometimes ascribed to humans because they are created in the image of God, and sometimes ascribed because of humans' sentience or their ability to communicate and think. But patients and their families are mainly concerned about deference and decorum. That means paying attention to the kinds of issues that physicians have been attending to for a long time, keeping the private parts covered to preserve the illusion of privacy, treating patients as equals regardless of how uneducated, or old, or disagreeable they may be.

Physicians also recognize how different patients are from one another, just as physicians themselves differ from each other. They try to respond to the individual needs of their patients, to relieve suffering and pain as expeditiously as possible. They always try to address each patient as an equal, and choose a topic for conversation that invites the individual patient to talk and be heard.

Henrietta Pratt, 80, Has a Surprise for You

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This poem first appeared in Ragged Edge Online *and is reprinted by permission.*

I seldom go outside my door.
I'm 80 and can barely walk.
The girl upstairs thinks that's so sad,
She's always dropping by to talk.
Her thoughts are shining in her face:
"Poor thing, she's old and all alone
And grateful for the company
She never could get on her own."
She doesn't know that all my friends
Are with me in a better place.
There's neither old nor young nor ill
Nor healthy, here in cyberspace.