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CONSCIENCE

Matters of conscience arise with some frequency in bioethics. A health professional may cite considerations of conscience in declining to perform or participate in a certain procedure. A patient may refuse a particular treatment on grounds of conscience. And new or unanticipated circumstances may create conflicts of conscience for patients and health professionals alike. What do we mean by "conscience" in these and related contexts? Is conscience an internal moral sense sufficient for distinguishing right from wrong? Is the "voice" of conscience simply the echo of parental and social prohibitions? Or does conscience differ in important ways from either of these? How much weight should be given in ethical reflection to claims of conscience? To what extent and for what reasons should health professionals compromise personal convenience, institutional efficiency, or medical effectiveness in order to respect individual conscience, their own or their patients'?

Three conceptions of conscience

The idea of conscience has a long and complex history (D'Arcy, 1961; Mount, 1969). The word "conscience" derives from the Latin *conscientia*, introduced by Christian Scholastics. Most generally, it refers to conscious awareness of the moral quality of some past or contemplated action and the disposition to be so aware (conscientiousness). In what follows we consider three main conceptions: (1) conscience as an inner sense that distinguishes right acts from wrong; (2) conscience as the internalization of parental and social norms; and (3) conscience as the exercise and expression of a reflective sense of integrity.

Moral sense. Conscience is sometimes conceived as an internal moral sense sufficient for distinguishing right from wrong. The reliability of this inner sense is usually attributed to its divine origin, its reflection of our true nature, or some combination of the two. There are, however, difficulties with this conception.

Consider, first, a variation of an argument developed by Plato in his *Euthyphro*. Is what makes an act right the fact that it is endorsed by one's conscience? Or does conscience recommend a certain course of conduct because it is right? If the former, the promptings of conscience appear to be arbitrary. Whatever is urged by a person's conscience would, in this view, be right. There would be no way to assess the deliverances of conscience or to compare the consciences of, say, Hitler and Mother Teresa. If, on the other hand, conscience directs us to perform certain acts because they are right, it cannot be the principal source of moral knowledge. We must, in this event, have prior, independent criteria of rightness and wrongness that allow us to distinguish those acts that should be recommended by conscience from those that should not—in which case conscience is not sufficient to guide conduct.

A related difficulty is the prevalence of conflicts of conscience, both within persons and between them. Such conflicts are especially pronounced in bioethics, where advances in knowledge and technology confront us with unprecedented, consequential choices ranging well beyond our ethical traditions. The limitations of conscience, if it is conceived as a sufficient guide to moral decision making, may not be so noticeable in static, homogenous, insular cultures and subcultures. But where new circumstances require members of pluralistic societies to come to some agreement on bioethical questions, appeals to an internal, self-validating

sense of right and wrong are apt to generate more heat than light.

Internalized social norms. The most plausible explanation for the limitations of conscience in resolving ethical conflicts is that the "voice" of conscience is simply the echo of social and parental admonitions impressed upon the developing psyches of young children (i.e., the Freudian superego). Whatever its psychological and developmental significance, conscience so conceived has little normative import. That we have certain moral compunctions as a result of our socialization does little to establish their validity. We are bound by the voice of conscience only if we can provide independent justification of its dictates. It is the adequacy of the justification, not the persistence of the voice, that carries moral authority. Conceived as internalized social norms, then, conscience plays no direct role in ethical deliberation.

Sense of integrity. "I couldn't live with myself if I were [or were not] to perform the abortion in these circumstances." "I can no longer participate in this treatment plan in good conscience." "How could I continue to think of myself as a Jehovah's Witness if I were to consent to the blood transfusion?" Each of these sentences expresses an appeal to conscience that is neither a deliverance of an internal moral sense nor an internalization of an external social norm. What is expressed in each case is the culmination of *conscientious* reflection about the relationship between a certain course of action and a particular conception of the self. So understood, appeals to conscience are closely connected to reflective concern with one's integrity. The focus is not so much on the objective or universal rightness or wrongness of a particular act as on the consequences for the self of one's performing it.

There is something absurd, Gilbert Ryle has observed, in saying "My conscience says that *you* ought to do this or ought not to have done that" (Ryle, 1940, p. 31). I may be troubled by your wrongdoing, but unless I have advised or assisted you, or culpably failed to prevent you from performing the act in question, my conscience will be clear. The same is not true, however, about those of my acts that I have determined, for one reason or another, were or would be morally wrong. Having judged a certain act to be wrong, an appeal to conscience stresses the added wrongness of my performing it. Appeals to conscience therefore presuppose a prior determination of the rightness or wrongness of an act (Childress, 1979). Moreover, one may or may not extend the standards one employs in making this assessment to others in similar situations. If, for example, the standards are universalizable principles of respect for persons, justice, or beneficence, one will maintain that anyone would do wrong in performing the act in question. But if one's standards are grounded in religious convictions, personal ideals, or a particular worldview and way of life, one may not hold everyone else to them. What is at stake in all such appeals is one's wholeness or integrity as a person.

Integrity

"It would be better for me," Socrates says in the *Gorgias*, "that my lyre or a chorus I directed should be out of tune and loud with discord, and that multitudes of men should disagree with me rather than that I, *being one*, should be out of harmony with myself and contradict me" (Arendt, 1971, p. 439). One cannot lead a good and meaningful life, Socrates suggests, unless the self is reasonably unified or integrated—unless, that is, one's words and deeds cohere with one's basic, identity-conferring, moral, religious, and philosophical convictions. Hence the importance of critical reflection on one's life as a whole. The words, deeds, and convictions of an unexamined life are unlikely to be sufficiently integrated to constitute a singular life—let alone one worth living.

Conscience should not, therefore, be conceived as a faculty or component of the self. It is, rather, the voice of one's self as a whole, understood temporally—as having a beginning, a middle, and an end—as well as at a particular moment. Operating retrospectively, what Christian tradition calls "judicial" conscience makes judgments about past conduct. Operating prospectively, what the same tradition calls "legislative" conscience anticipates whether a prospective utterance or course of action is likely to be at odds with one's most basic ethical convictions (D'Arcy, 1961). In each case, the signal that something is wrong—that one's integrity has been, is currently, or would be compromised—is an actual or anticipatory feeling of guilt, shame, or remorse.

Consider, in this connection, the words of Aleksandr N. Chikunov, a veteran of the 1968 Soviet invasion of Czechoslovakia, as he explains sharing his experience with young soldiers called to Moscow to suppress democratic reforms during the abortive coup of August 1991: "I entered Prague in 1968 and I still have an ill conscience about it. I was a soldier then, like these guys. We were also sent like they are now, to defend the achievements of socialism. Twenty-three years have passed, and I still have an ill conscience" (*New York Times*, August 20, 1991, p. A13). Here Chikunov draws upon the lessons of his "ill" judicial conscience to inform and alert the legislative consciences of the doung soldiers. His motivation, it seems, is not only to spare them the pangs of an ill conscience but also to help heal his own (and thus to heal himself).

The authority and sanctions of conscience are, Mr. Chikunov suggests, self-imposed. No external source can create or directly relieve a troubled conscience. Nor may we easily rationalize or evade its judgments. "Other judges," as D'Arcy points out, "may be venal or partial

or fallible; not so the verdict of conscience" (D'Arcy, 1961, p. 8). The oppressiveness of a guilty conscience is due in part to its identity with the self.

Conscience in bioethics

Three factors contribute to the prevalence of appeals to conscience in bioethics: (1) bioethical decision making often involves our deepest identity-conferring convictions about the nature and meaning of creating, sustaining, and ending life; (2) health-care professionals and patients and their families will occasionally have radically differing beliefs about such matters; and (3) the complexity of modern health care often requires agreement and cooperation on a single course of action.

Conflicts of conscience. Conflicts of conscience arise not only between individuals but also within them. Consider a physician whose patient, suffering greatly from the ravages of the last stages of a terminal illness, is also a longtime friend. The patient requests the physician to provide both the substance and the instruction for taking his own life. The physician finds herself torn. On the one hand, her conception of medicine and professional identity is incompatible with what appears to be physician-assisted suicide. On the other hand, the bonds of friendship and her natural sympathies strongly incline her to accede to her patient's request. The situation has, as a result, precipitated a crisis of conscience, and the physician must engage in what Charles Taylor has called "strong evaluation"—reflection about the self by the self in ways that engage and attempt to restructure one's deepest and most fundamental convictions (Taylor, 1976). Such reflection manifests an admirable concern for wholeness or integrity.

Conscientious refusal. From Socrates to Sir Thomas More to Henry David Thoreau, individuals have appealed to conscience in refusing to comply with a wide range of legal or socially mandated directives. In some cases such noncompliance may be covert and evasive—for example, a physician's providing contraceptive information to married couples in Connecticut before that state's anticontraceptive law was declared unconstitutional (Childress, 1985). In most cases, however, health professionals and patients give reasons of conscience in openly seeking personal exemption from certain standard practices.

Physicians may appeal to conscience in refusing to do procedures that are both legal and performed by their colleagues. Consider an obstetrician's refusal to perform a legal abortion or a pediatrician's refusal to prescribe human growth hormone for short, but normal, children at the behest of their anxious parents. In each case the physician's decision may be based on moral convictions or personal ideals. The obstetrician need not believe that abortion ought to be illegal or that women who request, or physicians who perform, abortions are deeply immoral. The pediatrician may neither urge the legal prohibition of administering human growth hormone to short, but normal, children nor regard parents who request this treatment, or other pediatricians who administer it, as unethical. Both agree, however, that it would be a violation of conscience—a betrayal of their deepest personal convictions about life or the nature of medicine—if they were to perform the act in question.

Similarly, nurses appeal to conscience in seeking exemption from procedures or care plans that threaten their sense of integrity. For example, a nurse may conscientiously refuse to follow a physician's directive to remove medically administered hydration and nutrition from a patient in a persistent vegetative state. Regardless of the act's legality, the family's concurrence, and the physician's directive, given her deepest identity-conferring convictions about the nature and value of life, the nurse may be unable to carry out the action. Her reasoning, she might add, is not strong enough to condemn others who believe differently; but as for herself, she must refrain.

Patients, too, may appeal to conscience in refusing forms of medical treatment. When informed, mentally competent Jehovah's Witnesses refuse blood transfusions on religious grounds, they do not at the same time urge that blood transfusions be legally prohibited, nor do they condemn those who gratefully accept blood transfusions. What they want is not so much respect for the content of their particular convictions as much as respect for their consciences. The same is true of other patients who refuse or request certain forms of treatment on the basis of fundamental moral and religious convictions.

Respect for conscience

Respect for conscience is a corollary of the principle of respect for persons. To respect another as a person is, insofar as possible, to respect the expression and exercise, if not the content, of a person's most fundamental convictions. A society's respect for individual conscience may extend not only to religious toleration but also, for example, to exempting conscripted pacifists from direct participation in war.

In the biomedical context, respect for conscience may be inconvenient, inefficient, or detrimental to medical outcomes. Still, it must always be taken seriously and often should prevail. In some cases, respect for conscience may be balanced with biomedical goals. At a certain level of abstraction, the purpose of health care is strikingly similar to that of protecting individual conscience. Although health care is usually focused on the body, emphasis on informed consent implies that the principal function of medicine is the health or wholeness of the patient as a person. Yet a person's sense of health or wholeness may also be threatened by what the former Soviet soldier, Aleksandr Chikunov, revealingly

called an "ill" conscience. The values underlying appeals to conscience within the health-care system are not, therefore, radically at odds with the values underlying medical and nursing care. In each case the aim is to preserve or restore personal wholeness. Insofar, then, as appeals to conscience and the health-care system share a fundamental commitment to preserving and restoring personal wholeness or integrity, we ought in cases of conflict to seek some sort of balance or accommodation between them.

Health professionals who refuse, withdraw, or dissociate themselves from certain practices or procedures on grounds of conscience may well be among the more thoughtful and effective members of a health-care team. Thus a health-care institution intent on retaining such nurses and physicians has prudential as well as ethical grounds for accommodating their claims of conscience even at the cost of some inconvenience or expense. Respect for conscience requires going to greater lengths for patients, however, than it does for health-care professionals. This is in part because an individual's role as a health-care professional is voluntary in a way that being a patient is not. It is one thing, for example, to respect a Jehovah's Witness patient's conscientious refusal of a blood transfusion; it is quite another to respect the conscientious refusal of a physician who is a Jehovah's Witness to administer blood transfusions. An individual whose moral or religious convictions are incompatible with a common, essential type of health care has no business seeking a position in which such care is a routine expectation.

Problems and limits

At least two important questions remain. First, how do we distinguish genuine claims of conscience from claims serving as smoke screens for laziness, cowardice, distaste for certain procedures, or dislike or prejudice toward certain patients? Second, given that a genuine act of conscience may be morally wrong, should individuals always (or always be permitted to) follow their conscience?

Genuineness. Understanding the nature and justification of conscientious refusal allows us to distinguish genuine from spurious or self-deceived appeals to conscience. In assessing the authenticity of such appeals we may, for example, inquire into (1) the underlying values and the extent to which they constitute a core component of the individual's identity; (2) the depth of the individual's reflective consideration of the issue; and (3) the likelihood that he or she will experience guilt, shame, or a loss of self-respect by performing the act in question. Such criteria have been employed with reasonable success by the U.S. Selective Service System in identifying those whose deep and long-standing moral convictions forbid direct participation in war. They can be used with similar success in identifying genuine appeals to conscience in the health-care setting (Benjamin and Curtis, 1992).

Conscientious but wrong. Conscience is not an infallible guide to conduct. Even those who attend carefully to matters of integrity and who critically examine their basic convictions may, at a later date, judge some of their conscientious acts as wrong. Should one, then, always follow one's conscience? If by "conscience" we mean the exercise and expression of good-faith efforts to integrate conduct with reflective ethical conviction, the answer is "yes." Following conscience is obligatory, even if one's act turns out to be wrong, because one is doing what one reflectively believes to be right. Conversely, deliberately acting contrary to conscience is blameworthy, even if one's act turns out to be right, because one is doing what one reflectively believes to be wrong.

We must therefore distinguish the character of an agent from the rightness of a particular act. That an act is required by conscience entails neither that it is right nor that others must endorse the agent's convictions or permit the act to occur. It is difficult, for example, to question the character of Jehovah's Witness parents when they conscientiously refuse to consent to a life-saving blood transfusion for a young child. Yet if we have good reasons for believing that withholding the transfusion would be seriously wrong, we may try to persuade the parents to consent and, if necessary, seek a court order mandating treatment. Distinguishing the conscientiousness of the parents from our judgment of the act, though not eliminating the difficult question of whether, and if so, how, to intervene, enables us to attend more adequately to its complexity.

MARTIN BENJAMIN

For a further discussion of topics mentioned in this entry, see the entries AUTONOMY; ETHICS, *especially* RELIGION AND MORALITY; PERSON; PROFESSIONAL–PATIENT RELATIONSHIP; RESPONSIBILITY; VALUE AND VALUATION; *and* VIRTUE AND CHARACTER. *This entry will find application in the entries* BIOETHICS; CIVIL DISOBEDIENCE AND HEALTH CARE; CLINICAL ETHICS; MEDICINE, ART OF; *and* NURSING ETHICS.

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THE PHYSICIAN'S CHARACTER

The "new" medical ethics has been dominated by a rights-and-rules approach in which problems are taken one at a time and specific, observable behavior is recommended by way of resolution. What sort of person the physician is, how consistent his views and attitudes are over a lifetime, and the intentions and reflections that accompany his problem-resolving behaviors are all pushed aside as of little ethical interest. As some critics have charged, it is as if we thought we could make medical ethics "doctor-proof" (Smith and Newton 1984).[1]

It has now become more common to include some mention of virtue in medical ethics (Shelp 1985; Brody 1989c).[2] Ethics acquires a dimension of virtue when one is no longer occupied solely with discrete problems and resolutions but also with "practices" as organized, evolving forms of human excellence and with the internal standards that inform such practices (MacIntyre 1981). One can speak of the virtuous person when one views human lives as integrated narratives, from birth to death, and asks what standards of excellence can shape such narratives. One can speak of the

1. "Ethics is practiced by medical ethicists as if neither their own characters nor the character of the physician had anything to do with the enterprise" (Drane 1988, p. 139).

2. An interesting effort to derive a comprehensive medical ethics from virtue is Drane 1988. Drane explains the reluctance of the "new" ethics to consider this option: "The very words, virtue and character, have a religious ring to the secular thinker, which is reason enough to consider them out of place. To be seriously considered, these words would have to be 'laundered' and 'operationalized'" (p. 142). Hence the tendency among analytic philosophers of medical ethics to reduce virtue and character to tendencies to behave or decide in certain ways, and to miss the point that these concepts presuppose standards of excellence, rather than rules for minimally acceptable behavior, and the coherence of one's actions over a lifetime, rather than discrete decisions.

virtuous physician when one looks at medicine as a practice and asks what standards of excellence inform and guide that practice, given its particular goals and its history as a human activity carried out by a defined community. It is therefore fitting here to discuss the physician's character—what sort of person the good physician ought to be, not just what rules the good physician ought to follow.

Any listing of virtues is likely to seem an uninspiring and even pointless task both to analytic philosophers and to scientifically minded physicians. To the philosophers, the problem is that there is no *logical* process to be sure that one has supplied an exhaustive list, whereas in the rules-and-rights mode one seems to be able to demonstrate that X or Y are necessary and sufficient conditions for respect for autonomy or for adequately informed consent or whatever. For the physicians, it appears that one can never measure or evaluate virtuous behavior objectively, and so any discussion of the medical virtues is bound to degenerate into a political or "turf" debate over who gets to be the judge. It is therefore of some interest that the American Board of Internal Medicine, not widely regarded as a bastion of subjectivism, has undertaken the ambitious project of identifying a list of virtues ("humanistic qualities"), insisting that residency directors in their specialties can and should evaluate these rigorously and stating that a resident who lacks these virtues should not be granted board certification. Even if the realities within internal-medicine residencies today do not live up to this idealistic statement of goals, the list and definitions of the virtues are still worth exploring for their own sake (Subcommittee 1983).

The subcommittee of the board suggested that the essential humanistic qualities of the internist are integrity, respect, and compassion, which they defined as follows:

> Integrity is the personal commitment to be honest and trustworthy in evaluating and demonstrating one's own skills and abilities.
>
> Respect is the personal commitment to honor others' choices and rights regarding themselves and their medical care.
>
> Compassion is an appreciation that suffering and illness engender special needs for comfort and help without evoking excessive emotional involvement that could undermine professional responsibility for the patient. (Subcommittee 1983, p. 722)

The fear of "excessive emotional involvement" is a key point to which I shall return later. For now, it is important both to note the substance of the list and the degree of commitment to reform suggested by its official adoption. For example, the board subcommittee not only suggests how residents may be systematically observed to see whether they exhibit these virtues but also lists ways in which their faculty and directors may fail to set the proper tone or the proper example to encourage residents in the pursuit of the virtues. Taken seriously, such a list would call for a wholesale housecleaning in many traditional residency programs.

Even though all three virtues are fully consistent with both a power approach to medical ethics and a preference for a conversation model of moral reasoning, there appears little *direct* link between a power approach and the virtues of integrity and respect. The physician motivated by integrity will feel a strong sense of moral accountability and hence an eagerness to engage candidly and nondefensively in productive moral conversation with peers. She will be less interested in justifying her existing behavior than in becoming aware of new perspectives and potential improvements in her behavior. The physician motivated by respect will desire to follow all the relevant rules and respect the rights of patients. Engagement in moral conversation will be more productive because an attitude of respect will cause her to listen attentively to the opinions of even those with whom she disagrees. Ultimately, both virtues will lead to willingness to label and discuss power disparities and to a deeper awareness of how the unthinking use of power can undermine one's integrity as well as violate the rights of patients.

By contrast, the virtue of compassion occupies a key role in any analysis of the physician's character that grows out of the power approach I have advocated. The reasons for this go beyond the crude observation that compassion is an antidote to power abuse: the irresponsible use of power is often preceded by the relegation of the victim to the status of "other" or even "enemy" (see chapter 3). So long as the other party remains someone with whom the physician can identify and sympathize, she is much more likely to use power responsibly. But to see the full range of linkages between compassion and the various issues surrounding power in the medical encounter will take a deeper and more sophisticated analysis of what compassion entails.

The Virtue of Compassion

Reich (1989) offers just the sort of sophisticated analysis of compassion that I require here. He begins by suggesting that compassion is intimately bound up with another's suffering and by proposing that the experience of suffering can be seen as occurring in three phases, which in turn generate three reciprocal phases of compassion. The phases of suffering are labeled

mute suffering, during which the sufferer is overwhelmed by the immensity of the suffering and is unable to find words to express it; *expressive suffering*, during which the sufferer uses language to try to enhance understanding (and hence ultimately control) of his experience; and *new identity in suffering*, during which the sufferer undergoes a profound change by integrating the new understanding of the meaning of his suffering into a new sense of his own identity as a person. In this third stage, the story he has constructed of his suffering is now fully bound up into the story of his life, and he cannot say who he is without including the suffering and the meaning it has come to have for him (Brody 1987d). Reich adds that this third phase generally requires "solidarity with compassionate others" (1989, p. 91).

Reich proceeds to describe three phases of compassion that reflect his account of suffering. In effect, compassion is defined as a virtue in terms of its relationship to the varying needs of the suffering other. The first phase is *silent compassion* or silent empathy; one shows a commitment to be with the sufferer in his anguish without attempting to control, rationalize, or intellectualize the experience by placing a label on it. This silence, as some clinicians have noted, is not a void; it throws the sufferer back upon himself in the search for words and ultimately helps him move to the second phase. It is one thing to try to find words when one is overwhelmed by a sense of social isolation, quite another to find words when a compassionate companion is standing by in an attitude of openness and receptivity.

Expressive compassion involves more active use of clinical skills, but again without taking charge to the extent of putting one's own language and meaning into the mouth of the sufferer. However one does this, Reich notes, "the role is to make some limited attempt to broaden sufferers' perceptions, so that they become conscious of and connected with a wider spectrum of meaning and value" (1989, p. 94). In its simplest form, and when the suffering is tied directly to physical symptoms, the physician may help most by providing an authoritative diagnosis, giving the sufferer both a socially acceptable name for his misery and a corresponding sense of control over it (Cassell 1976; Brody 1980). In more involved cases, the physician and the sufferer may join in a prolonged project amounting to the construction of the new narrative of the patient's life (Brody 1987d; Kleinman 1988).

There are two critical ingredients of a successful story of suffering in this expressive phase. First, the story must appear coherent and relevant to the sufferer himself. It must be comprehensive enough to take into account the suffering experience in its totality, not just particular features of it (hence the inadequacy of medical diagnosis by itself in cases where the suffering is in large part psychological and spiritual). And it must be sufficiently particularized to be recognizable as the sufferer's own story rather than some mass-produced account. But second, the story must help reconnect the sufferer to the broader society and culture (Cassell 1982, Brody 1987d). It must label the experience in ways that indicate how others have shared similar (if not identical) experiences and in ways that help to promote a fellowship among all humans who have suffered. The compassionate presence and participation of the physician symbolizes this two-directional feature of the successful story. On the one hand, the physician attends to the sufferer as a unique person; on the other hand, the physician represents the broader society and culture, the "normal" people, reminding the sufferer that the suffering has not totally cut him off from the "normal" world.

Berger, in his essay on an English country doctor (Berger and Mohr 1967), describes this feature of the compassionate physician more powerfully. He suggests that many people who visit the physician are simply ill, and almost any moderately skilled and decent response will suffice. But a good number are also deeply unhappy, even anguished. The anguished patient is afflicted not only with an illness but also with a crippling and isolating set of beliefs. He sees his experience as unique, unrecognizable to members of the "normal" human community, and hence feels himself to be an outcast among humankind. This conviction of course seems absurd to the rational onlooker; and this attitude indeed further isolates the anguished person from human companionship. Ultimately, he takes his case to the physician. At this point he has no hope whatever that the physician will recognize him, and reach out to him, as a fellow human being. But perhaps the physician will recognize at least his illness and give it a diagnostic label; that would be some small comfort.

The physician then confronts this anguished and well-nigh hopeless person. If the physician is the right sort of individual, something special may happen. The physician may just manage to appear before the patient as a fellow human being enough like him to be able to comprehend, or even to share, the experience of illness, isolation, and hopelessness. As Berger puts it, the physician *recognizes* the patient, in such a way that the patient feels recognized even in the face of his firm conviction that his sickness and isolation have rendered him unrecognizable. Not only does the physician tell the patient that his illness has a name, that his experience

has been shared by countless others who have managed to rejoin the human community; the patient *feels* human reconnection in the physician's attentive and compassionate presence.

This task is not easy. The anguished person—who is, after all, totally absorbed in his suffering—all too readily engenders in others impatient irritation instead of compassion. The physician must be a strange amalgam of Everyman and his humble self. He must be enough like the patient so that the patient can truly identify with him, even in the patient's present abnormal state; and yet he must still be himself, not a poseur—a solid human being, not just an image in a mirror held up before the patient's face. The physician will fail if he is tired or preoccupied; if he pays too much attention to the disease and not enough to the patient; if he misinterprets a word, a tone of voice, a glance. So it cannot be, Berger concludes, that his doctor is a good doctor because he invariably succeeds in connecting with the patient emotionally. Instead, Berger observes, he is a good doctor because "there is about him the constant will of a man trying to recognize" (Berger and Mohr 1967, p. 71). Berger's account seems to mesh with Reich's notion of what is required in the expressive phase of compassion.

The third phase, *new identity in compassion*, is the most controversial of Reich's arguments and also the most critical for a power analysis of the medical encounter. Many would argue that compassion must have only two phases: is not the job over when one has helped the sufferer find a new voice, a new story, a new identity in his suffering that has reestablished his link with the rest of humanity? But Reich finds it unthinkable that the compassionate person could experience (empathically) the anguish of the sufferer and go through the difficult process of identification with the sufferer necessary to find the appropriate words for the suffering without being fundamentally changed herself. Reich here takes literally what Richard Selzer, in some of his short stories, expresses symbolically as the idea that the surgeon must heal the patient in order to be healed himself (Selzer 1975; Beppu and Tavormina 1981).

Several considerations support Reich's assertion on this point. For one thing, unless the physician has a genuine openness and vulnerability, it is unlikely that the sufferer will experience the encounter as fully healing. It is hard to identify empathically with the anguish of the sufferer and at the same time maintain a strict guard against any impressions or ideas that might threaten one's current sense of identity. So long as the physician responds to the sufferer as a threat, or as a potential threat, to the physician's own composure and sense of self, she represents those who would cast the sufferer out of the human community rather than those who would bridge the chasm of suffering and reestablish human connections. But the only psychologically realistic alternative to a guarded defensiveness is a genuine vulnerability and openness to change and growth. (This and later points suggest a virtue that accompanies compassion, empathic curiosity, which I discuss in the next section.)

Reich notes further that there are special barriers to compassion among physicians. The traditional reliance on benevolent paternalism urges the physician to respond to the sufferer in a "There, there, it's not so bad" manner that immediately imposes the physician's preferred meaning onto the experience of suffering and cuts off the patient's efforts to find his own voice and his own story. The physician trained to fix things may have a hard time demonstrating empathic silence and engaging in a genuinely mutual search for narrative meaning. And the physician trained to be scientific and objective may find it hard to enter the subjective world of somebody else's anguish.

The obvious implication is that the physician must constantly struggle against such obstacles in order to practice compassion. The whole point of calling compassion a virtue instead of an obligation or duty is to note how it must become internalized as a habit of character before it can truly be called compassion at all. But unless the physician adopts an instinctive attitude of openness and vulnerability, it is difficult to see how these barriers to compassion can successfully be overcome. The physician who is closed and defensive in the face of anguish and suffering will magnify these obstacles rather than overcome them.

We are now in a position to see why the virtue of compassion is integrally linked to the ethical use of power in the physician-patient relationship. Surely, being with the sufferer and helping him find his own story to attach meaning to his experience is a prime example of shared power. Few things that the physician can do have the capacity to empower the patient to a similar degree. Disease may threaten bodily function and bodily integrity; suffering threatens one's connections with humanity and one's ability to make sense of one's own life. If the physician attends only to disease and ignores suffering, he may cure but still fail to heal (Cassell 1982). To be compassionate in response to the suffering of the patient is therefore one of the most powerful things a physician can do; but this is possible only to the extent that the physician is willing to adopt a position of relative powerlessness, to acknowledge that the patient's suffering has incredible power over him and that he cannot remain unchanged in the face of it. This is a major irony of the physician-patient relationship, in which

both of one's own healing power and of one's necessary humility forms a synthesis of the apparent contradiction of power and powerlessness.[3]

In chapter 2, I reviewed the story of the healer Snake and discussed the apparent unreality of her lack of charismatic and social power. Her powerlessness seemed an impediment to her carrying out her healing function in the setting in which she found herself. But we can now see a deeper meaning to that aspect of Snake's story. Snake and her teachers seem to have glimpsed the synthesis of power and powerlessness that comes with a proper sense of one's humility as a healer. In a particular social setting, humility and powerlessness may have served Snake poorly. But in the long run, her humility may be her most empowering attribute.

It may be largely out of this dual sense of power and humility that the physician's virtue and character can help insure that power is used responsibly and that its abuses are avoided. Owned, aimed, and shared power each arise naturally from this dual sense of power and humility engendered by the virtue of compassion.

Empathic Curiosity: Not Being Full of Oneself

Are there any additional, specifiable virtues or character traits in the physician that will promote and enhance the exercise of compassion, and thereby the responsible use of power? William Carlos Williams's story "The Use of Force" served earlier as a paradigm case of "the dark side of the force"; so it is fitting that some reflections of Dr. Williams's may help in answering this latest question. Robert Coles has recounted some of Williams's views on medical practice, medical teaching, and medical ethics, taken from tape-recorded interviews of the elder physician when Coles was a medical student:

> Everyone thinks doctors are good people because they help other people who are sick. But if you ask me, the people who are sick are helping us all the time—if we'll let them help us. How many times I've gotten up and felt lousy; [and on starting to hear the patient's story of the illness] the next thing with me is that I've forgotten myself—isn't that an achievement!—because I'm all tied up with someone else. . . . I can't hear a [patient] talk like that and not be sprung—sprung right out of my own damn self-preoccupations. . . .
>
> You can set rules; you can teach lessons; you can give tests; you can pass them . . . but even so, stubborn human nature is out there, threatening to take charge of the intellect. . . . There's a big difference between our high talk, though, and how we behave ourselves when we're out there on our own. . . . It's too damn easy to teach, to preach, then go off and be your own, full-of-yourself self. . . .
>
> Why should we always be told that the alternative is between a doctor who really knows what he's doing, even if he doesn't have much time to be with patients, to talk with them and be understanding of them, and a doctor who has all the time in the world for his patients, but he's a first-class idiot, and could end up being a threat to your favorite relative's health, even life? I'll answer that. It's not a question; it's a rhetorical statement meant to rationalize callousness and egotism!
>
> For crying out loud: who in hell wants a dope hanging around with a stethoscope? But why is this dope conjured up every time some swaggering tyrant or mean, cold son-of-a-bitch, who happens to have an M.D. after his name, shows up and starts bullying people? I guess it's because the rest of us don't want to see him get what he deserves. And why? Hell, we know our own dark side! We rally around others to protect ourselves! . . .
>
> Who are we, a bunch of moral monsters? Maybe we're tempted to be, sometimes. When people are scared as hell, and death's around the next corner, or maybe facing them, right in front of them, they'll grab at anything there is; and we're what there is, what's available. . . . So, we're gods for others—but we know how tinny we can be, or we damn well should know. I guess the raw truth is that the worst of us don't know: the ones who strut and prance and con themselves and everyone else into thinking they are God's hand-picked emissary, if not chosen successor. (Coles 1989, pp. 104, 108–10)

Williams claims sainthood neither for himself nor for even the best of his fellow physicians. There is always human nature to contend with; there are always those days when one feels lousy, totally caught up with oneself and one's petty or not-so-petty concerns. The virtuous physician, in Williams's account, seems to have two particular qualities: first, a readiness to be drawn out of herself through genuine concern for and involvement with her patients; and second, a self-critical humility that allows her better self

3. McCullough (1989) may be referring to a related irony when he states that so long as medical care involves medical language, the physician's sense of control is threatened, since it is ultimately the patient and not the physician who will attach the final meaning and interpretation to the language in the context of his own life: "The physician, as a consequence of using medical language—which he or she was taught was a means to describe and thus control reality—experiences a threat to his or her control and sense of power and authority" (McCullough 1989, p. 122).

to see how silly the "full-of-yourself self" looks. If people seem to worship at the doctor's feet, Williams points out, it is not because of the doctor's divine qualities; it is because the patient is scared and the doctor is "what's available."[4]

Williams warns less of great evils and more of the unavoidable lapses of everyday life. His "dark side," in the above passages, is not the dark side of the force as described in chapters 2 and 3. Using one's power against the patient to enjoy the release that this brings is the cardinal sin. Williams is concerned more with the venial sin of not trying hard enough to shed one's natural self-preoccupations when one is with a patient. In response to venial sin, which is humanly unavoidable, the physician has two characterologic responses. She can chastise herself when she slips, and resolve to try to do better in the future. Or she can adopt the ever-present rationalizations—which would you rather have, me with my flaws, or the idiot with the stethoscope?—and give herself up to self-preoccupation. With that choice invariably comes arrogance. For if she can, day in and day out, be self-preoccupied, and if people nonetheless seek her services and appear grateful, then she must indeed start thinking that she is a superior being, immune to the criticisms that mere mortals earn.

The link between the virtue of compassion, as discussed in the previous section, and Williams's admonition not to be too full of oneself, lies in the way that self-preoccupation distracts the physician from the attitude of humility, of openness and vulnerability, which I have argued is an essential ingredient of compassion. It is worth recalling here Berger's (1967) account of "recognizing," his insistence that the good physician should have "the constant will of a man trying to recognize," even while admitting that he will often fail. He is most likely to fail on those bad days when he is too full of himself and hence unable either to attend carefully to the anguished patient or else too wrapped up in himself to be open to the experience of anguish in the other.

I think that the sort of physician Williams admires is one who would like to have as his epitaph, *There was about him the constant will of a man trying to recognize*. This sentence makes no grandiose claim of success or

4. James Drane (1988) seems to allude to this point: "Physicians are vulnerable to self-ignorance and self-deceit because they are persons of power and prestige. People cater to them and infrequently tell them the truth about themselves. . . . As a result, it is easy for doctors to develop a narrow and conceited view of themselves, frankly to become fools when it comes to their own inner truth" (p. 61). Elsewhere (p. 91) Drane urges upon physicians the virtue of friendliness, which encourages one not to take oneself too seriously and constitutes the opposite of pomposity.

superhuman powers. It displays a frank admission of occasional, even frequent failure. The words in their very simplicity bespeak a human task aspired to by those who are humble in the knowledge of their limits. Even when one succeeds in this task, the words will not permit much self-congratulation. The physician who manages to "recognize" is not thereby a great person; both physician and patient are in the presence of a deep human mystery greater than both of them. As Williams would be the first to point out, "recognizing" can occur only when the patient has been open and candid in laying his story before the physician; and it is the physician, not the patient, who should thereby feel privileged.

As *not being full of oneself* is a rather clumsy label, I propose to call this virtue, which contributes to the greater virtue of compassion, *empathic curiosity*. This phrase is suggested in part by Engel's (1988) discussion of the biologically grounded human needs that play themselves out in the clinical encounter. It is a great mystery that a suffering human being will so readily bare her soul to the physician, even as she feels totally cut off from normal human society. It is even more mysterious that this can often occur when the physician is a stranger whom she has known for only five minutes. Engel proposes that this could happen only if the human organism were hard-wired (as it were) with two reciprocal basic needs: the physician's need to know and the patient's need to be understood. The physician is motivated by scientific curiosity in the best and highest sense, because without this type of science, all of the rest of medical science grinds to a halt. As I showed in chapter 4, all scientific reasoning in medicine requires first an accurate data base, and a thorough medical history requires first a patient who feels at ease with the physician and who feels prompted to tell his own story in appropriate detail and with appropriate insight and candor. The physician's attitude of empathic curiosity is what is required to place the patient in this state; being too full of oneself will confuse, inhibit, or antagonize the patient and virtually insure that one collects unsound and unscientific data from the outset. In this way, the virtue of empathic curiosity is as critical for scientific medicine as it is for ethically optimal medicine.

It seems that the physician who can best be trusted to use power responsibly—the physician who has internalized the responsible use of power as a self-imposed standard of scientific as well as behavioral excellence and who need not be exhorted to use power responsibly by a litany of rules and rights—is the one who possesses the virtue of empathic curiosity as an adjunct to compassion. The physician who is painfully aware of how easy it is to be full of oneself is the one who is most likely to be more

comfortable when power is shared instead of monopolized. The physician who is inclined to be self-reflective and self-critical about such matters, who knows that the easy rationalizations lead to arrogance, will be more likely to own responsibility for the power that is used and to question carefully the goals toward which that power is applied.[5]

Therapeutic Distance and Fear of Powerlessness

What are we to make of the fact that the subcommittee of the Board of Internal Medicine stated the "humanistic qualities" of integrity and respect straightforwardly and robustly but felt compelled in defining compassion to qualify it, "without invoking excessive emotional involvement that could undermine professional responsibility for the patient" (Subcommittee 1983, p. 722)? Is this a legitimate observation on the nature of effective compassion in medicine? Or is it a reversion to Williams's "idiot with the stethoscope," who in this case is reduced to idiocy because he has identified too closely with the patient and thereby allowed his own emotional turmoil to derail his scientific reasoning skills?

The advice, "Be compassionate and empathic but don't get too involved," seems a stock item in the training of physicians. Even Reich feels constrained to observe, "Because compassion is an altruistic virtue, it easily leads to impossible ideals and over-identification with the suffering person, threatening stress and burn-out" (1989, p. 105). One naturally wonders: where are all the cases of medical disasters that gave rise to this warning, that occurred because the physician became too emotionally involved? The larger portion of Reich's argument certainly suggests that the opposite is true. The cemetery is filled not with the corpses of patients who died because their overinvolved physicians became irrational and ineffective, but rather with those of sufferers whose physicians attended to their diseases but failed to heal because of the multiple characterological barriers that cause physicians *not to get close enough*. If the truly prevalent problem is in not getting close enough to hear empathically and to construct mutually a healing narrative, why the ritual advice against getting too close?[6]

5. This further illustrates why virtue cannot be reduced to a mere disposition to behave in a morally correct manner (Childress 1989). We ought to be able, by now, to see clearly the contrast between being disposed to perform healing actions and striving over time to become a healing sort of person.

6. I have seen perhaps two cases in my teaching experience of residents in training who seemed to have such a problem of overinvolvement with patients that it threatened their effectiveness as physicians and caused the patients to develop a dependency that seemed contrary to their own interests. In both cases the overinvolvement seemed to be not an isolated problem but a symptom of a much more global difficulty in carving out an acceptable professional self-image. In Williams's terms, these residents were too preoccupied with themselves rather than with their patients; the overinvolvement was generated more by the residents' internal turmoil than by a genuine receptivity to the patients' suffering. Compare the discussion of the "Rabkin explosion" case in chapter 14. More studies of actual cases that fit this description would be very useful for medical education.

My previous analysis offers an answer: the irony of compassion, the synthesis of power and humility, is a subtle point difficult to grasp and internalize. Faced with the apparent contradiction between power and powerlessness, it is tempting to focus on the powerlessness and to recoil from it in fear rather than go on to the more difficult step of acceptance and synthesis. The warning, "Don't get overinvolved," is a form of reassurance (even if ultimately false) that the physician can hang onto the supreme power to heal while at the same time avoiding the felt powerlessness of vulnerability and change. This amounts to denial of the power that the patient and the patient's suffering hold over the physician. Fundamentally, this denial is a rejection of the concept of shared power by reframing the power issue as a zero-sum game. The possibility that the physician's power to heal in some way depends on his vulnerability—that, ironically, powerlessness can empower—is lost sight of.[7]

Can the narrative approach or metaphor help resolve this problem? I believe that one way to make more sense of the advice against overinvolvement is to see it as confusing emotional distance with esthetic distance. There is a type of distance that is desirable (indeed unavoidable) in effective displays of compassion; but it is esthetic distance rather than emotional distance. It is when the concept of distance is extended inappropriately, to try to turn the fear and rejection of powerlessness into a virtue rather than an obstacle to healing, that the damage is done.

Charon (1989) suggests that the proper model for the sensitive clinician is the esthetic distance that ought to mark the reader's approach to fiction. The skill of reading fiction is to be close enough to the subject of the fiction to feel an emotional identification and to experience, not just know about, what is happening, and at the same time to be just far enough away so as to be able to reflect on that experience with some degree of critical detachment. Often this relative distance ebbs and flows. At one point in the narrative

7. It is also interesting to review a study of psychological testing in first-year medical students (Gilligan and Pollak 1988). Responding to the thematic apperception test, subjects constructed stories that were analyzed for episodes of danger or violence and for themes of intimacy, isolation, success, and failure. While the males were prone to associate danger with intimacy, women were much more likely to associate danger with isolation. If, as other data show, it is a general masculine trait to fear intimacy more than isolation, it is not hard to see how, in the male-dominated world of medicine, the myth of the need to maintain "therapeutic distance" might have arisen.

one is drawn in so close as almost to fuse with the fiction. At another point one looks down from a higher vantage point and is able to see what is going on with more detachment. (Hence the importance of comic relief within tragedy, such as the graveyard scene in *Hamlet*.) Now, when one reads fiction properly, one maintains the same vulnerability, the same openness to personal change and growth, that marks the proper display of compassion. The reader is able to shed the self-preoccupation that would lead to a fear of loss of power if she opened oneself fully to the text. Yet at the same time she must avoid a fusion of identities with the text; if that occurs, narrative ceases to be narrative: it is no longer a way of attaching meaning to experience if all opportunity to reflect on that experience from an outside vantage point has been lost (Churchill and Churchill 1982).

To suggest, as some literary scholars have, that a suffering patient is a text that the sensitive physician must read is therefore not to advocate emotional distance. On the contrary, it calls for intense emotional engagement. But what is essential to "reading the text" is maintaining in one's imagination that separate vantage point from which the experience of the sufferer can be reinterpreted and reconnected to the broader context of culture and society.

This is what is suggested, in part, by naming the virtue that accompanies and stimulates compassion *empathic curiosity* instead of *empathy*. The good physician should be strongly moved to understand the sufferer's anguish, and that requires the ability to occupy a reflective vantage point. But a full understanding will also require a high degree of emotional identification with the sufferer, as well as the willingness to enter into a mutual relationship for the construction of narrative meaning, or else one's so-called understanding will be a flat representation that does not capture the emotional and human depths of the suffering experience.

The physician can adopt the virtues of compassion and of empathic curiosity only by moving beyond the ritual advice against overinvolvement. On an emotional level, this involves accepting the full irony of power and humility in compassion and overcoming the fear of powerlessness in vulnerability. On an intellectual level, this involves distinguishing between emotional and esthetic distance and cultivating the latter instead of the former.

Finally, there is an important interpersonal and social level to compassion. As Reich notes, "Balance in compassion requires that the subject of compassion become the object of compassion: unless we are compassionate with ourselves and receive compassion from others, we are not able to provide compassion" (1989, p. 105). For physicians to adopt and cultivate

compassion as a *professional* virtue requires that they be willing to form themselves into a compassionate community, confident that they will receive empathic compassion and support from each other as they attend to the sufferings of their patients. It is perhaps in this arena that the implicit issues of medical power have most stood in the way of reform. The self-image of the physician as a powerful, scientific, objective individual has worked strongly against the formation of any truly effective peer support system. Given a choice between appearing tough to one's colleagues or entering with them into a network of mutual compassion, toughness usually wins. It is symptomatic that medical educators tell young physicians, "Don't get overinvolved," instead of, "If you find the demands of compassion becoming overwhelming, the rest of us will be here for you, just as you are there for the patient." If medical ethics is to address the physician's character and not only individual actions and rules, then the virtue of compassion will have to become a focus of ethical inquiry. This will in turn require that the professional psychology of power and powerlessness become part of the vocabulary of medical ethics. I believe that substantial progress has been made in recent years; staff support groups in hospice programs and in AIDS clinics are only two examples. Further progress will occur as educators begin to pay more explicit attention to these issues.

TEACHING HUMANITIES IN PRIMARY CARE RESIDENCY PROGRAMS

Laurence B. McCullough

I would like to start with a question that Ron Carson posed for us in his invitation to attend this conference: What is the purpose of teaching the humanities in primary care residencies? The answer to this question it seems to me will be the basis for answering the other questions about who should teach, how the humanities should be taught, and how that teaching is best evaluated.

I take it that the basic purpose of teaching the humanities to primary care residents is threefold: 1) to teach them to reflect in a serious and careful manner on the value dimensions of medicine, particularly the moral responsibilities of physicians; 2) to teach them how to incorporate such reflection into their relationships with their patients; and 3) to develop an understanding of the moral responsibilities and moral character that distinctively characterize the physician in primary care.

1. Teaching rigorous moral reflection. The goal here is a traditional one in both medicine and the humanities: having good reasons for what one does. Physicians are trained to make their judgments and recommendations about patient care in the most rigorous and objective manner possible—this is the heart and soul of diagnostic and therapeutic reasoning. The humanities demand the same discipline in our thinking about value questions, here questions about moral responsibility. From this it would seem to follow that residents need to know how to think clearly and carefully about their moral responsibilities in patient care. To do this they need to have some grasp of the language and basic concepts of moral reasoning, an appreciation for the

intellectual demands of moral reasoning, confidence in their ability to engage in such reasoning, and the ability to apply such reasoning to actual cases.

They also need to understand the moral demands of professional life, something that they seem not to have come to understand well during medical school. Here I mean to emphasize the point that professional life demands that one place one's own interests second to the interests of those one has committed oneself to serve. Any conflict between acting on the best interests of one's patients and acting on one's own self-interest should therefore be resolved by the physician in favor of the former. This feature of the profession of medicine was recognized by Plato: "Surely no physician either, in so far as he is a physician, seeks or orders what is advantageous to himself, but to his patients? For we agreed that the physician in the strict sense of the word is a ruler over bodies and not a moneymaker. Was this not agreed?"[1] More recently in the New England Journal of Medicine, Al Jonsen has called attention to this neglected problem of the conflict between self-interest and obligations to the patient.[2]

Finally, in light of a clear understanding of the moral character and demands of a professional calling, our residents need to develop an account (a theory?) of moral responsibility and moral character in primary care as such.

The grounding for this enterprise is principally in ethical theory insofar as it bears on professional life. That is, one does not start from ethical theory generally, but from the demands of medicine as a professional calling. I am well aware here that I depart from Veatch's claim that medical ethics should be universal in character and not

the language of ethics. So just how to train residents to do this in more than an ad hoc manner has become a major pedagogical concern in my own teaching of our family practice residents.

The residents are much better at thinking about the problems than they are in actually raising them with patients. They tend to fall back on remedies or strategies they have earlier learned, which often glance off problems rather than get at them in an effective way. Helping the teenager with very low self-esteem who is pregnant to think about her responsibilities to the baby she will have is a good example. The tendency is to transfer responsibility to others, e.g., the social worker or community agencies, or simply to give up without really trying to engage the moral awareness of the patient because of the frustrations that such patients almost inevitably engender in the resident.

One way to move from thinking about moral matters to doing something about them is to turn to the virtues: those dispositions or habits to undertake and fulfill one's duties, even and especially when doing so conflicts with self-interest. I see education in so-called human values as essentially concerned with the virtues of the physician. The problem has been that "human values" teaching has lacked an account of what its subject matter and pedagogy should be. I believe that the language of the virtues will suffice for this task, especially the virtues of the moral counselor: patience, sympathy, leadership, and compassion. In other words, human values teaching must be rooted in a prior account of the moral responsibilities of physicians and therefore take its intellectual and pedagogical authority from the humanities in medicine. Such teaching will then be in a position to achieve a focus and rigor that it presently lacks. Without such focus and rigor, human

values teaching should be eliminated from the medical curriculum. In approaching human values teaching in this way, we shall encounter the age-old problem of how to teach virtue. For example, can it best (or only) be done through the role model, perhaps Carleton Chapman's "Cabot-type role model,"[9] or is there not also a didactic component so to speak? That is, it is important to know why one should cultivate particular virtues and not simply--and perhaps blindly--cultivate them.

3. Moral responsibility in primary care. My concern here is that moral issues in primary care have received quite a bit less attention in the literature and in our medical school teaching (e.g., in required medical ethics courses) than have the tertiary-care, "three alarm" issues. I know from my own experience that it took the physical shift to the family medicine center, away from the hospital, to learn that the major, day-to-day issues for the primary care physician were not those of renal dialysis or intensive care, but issues that will never make it to the front page of any newspaper or even a scholarly journal, e.g., managing chronic illness, teenage pregnancy, family "pathology," alcoholism, and responding to the needs of geriatric patients, to name a few.

Working with residents on primary care concerns has led us in our teaching to address repeatedly the following questions:

a. What are the ethical foundations and implications of treating the family as the context/unit of care?

b. What are the limits of the physician's responsibilities regarding other health professionals, and professionals and agencies in social service? Where do the obligations of the physician qua physician legitimately end?

Readings: Session IV

Readings for Session IV