PAPER

Suffering, compassion and 'doing good medical ethics'

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ABSTRACT

'Doing good medical ethics' involves attending to both the biomedical and existential aspects of illness. For this, we need to bring in a phenomenological perspective to the clinical encounter, adopt a virtue-based ethic and resolve to re-evaluate the goals of medicine, in particular the alleviation of suffering and the role of compassion in everyday ethics.

A young woman is rushed into hospital by ambulance to the labour ward. She is 28-weeks pregnant and alone. Her waters have broken, and she says she cannot feel the baby moving. The midwives cannot detect a heartbeat. They deliver her baby rapidly and competently. A paediatrician and a medical student are also present. The baby emerges stillborn and grossly deformed, his body bloated and his head misshapen. A dark swelling protrudes from his chest. After rapid delivery of the placenta and checking that the mother is physically stable and comfortable, the baby is whisked away to a side room. The clinical team cluster around the lifeless body, whispering instructions and counter instructions. Horror hangs in the air. Meanwhile, the woman, plump and helpless, lies on the bed—marooned, alone, tears slowly coursing down her cheeks. The student looks up and sees this. She detaches herself from the group and hesitantly approaches the woman. She gently takes the woman's hand lying limply by her side. No words are spoken. The woman squeezes the student's hand in silent gratitude.

INTRODUCTION

This narrative is one of many I partook in as a medical student and junior doctor which showed me the unintended harm that doctors and nurses could do to patients in their emotionally laden responses. I witnessed doctors getting angry, blaming or insulting patients, being cold and callous, lying, failing to explain, being patronising or simply not noticing distress or not listening to what patients were telling them. I also witnessed kindness, tolerance, patience and sensitivity. These observations, perhaps oddly, gave me the strong motivation to study and later to teach medical ethics. At that time ethics was not part of the medical school curriculum. We learnt from our role models, from hearing their deliberations, but above all what they said and how they behaved in their encounters with patients, colleagues and students. In the above narrative, one could perhaps fault the clinicians for not carrying out a specific duty or protocol, but what stood out for me was the lack of attentiveness to the woman's desolation and suffering. The shock—disgust even—generated by the abnormal stillborn baby eclipsed their sensitivity towards her plight. Instead they focused on carrying out correct forensic procedures. I have a recollection of timorously trying to comfort her and of feeling that this was the right thing to do. My teachers did not prescribe it and arguably I was 'stepping out of line'. I certainly was not doing anything 'medical'. I could not bring back her baby from the dead, but I could at least offer a gesture of companionship, of comfort, as a fellow human being.

I give this example precisely because it does not represent a 'challenging ethical dilemma', yet undoubtedly was an event that the woman will never forget—nor, I suspect will she forget how those around her treated her. I would like to think that callous or unkind behaviour in healthcare is something of the past, but alas, the evidence from a variety of sources—anecdotes, the media, as well as from published narratives, formal inquiries and academic papers suggest otherwise. I propose that for the scholarship of medical ethics to translate into good ethical medical practice, it has to attend more closely to everyday ethics and the clear and uncontroversial goal of medicine: the relief of suffering. Furthermore, medical ethics has to be placed within a philosophical framework that 'works' in the context of the lived experience of patients and clinicians. This, I will argue, is best served by the restoration of virtue ethics, bringing in a phenomenological perspective to clinician–patient encounters, including narrative and imagination, and acknowledging the value of emotions in clinical–ethical decisions and responses. We need to remind ourselves constantly what restores or retains human dignity and the potential for the misuse of power in the practice of medicine.[1 2] Without this, medical ethics risks becoming another method for creating alienation, moral disengagement and the reification of humanity, with all the dangers that this entails.[3 4]

MEDICAL ETHICS AND THE GOALS OF MEDICINE

Some ethicists have described the goal of clinical ethics (also known as 'medical ethics') as the improvement of the quality of patient care by identifying, analysing and attempting to resolve the ethical problems that arise in practice, with ethics integral to the practice of medicine.[5] They earlier expressed the hope that clinical ethics 'will have achieved its rightful place at the interstices of relations between patients who are sick and physicians who profess to be able to heal or comfort them'.[6] A review 11 years later led to the conclusion that

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important improvements had been made in ethics processes, but the goal of improved clinical outcomes had not been achieved.[5] Others reached a similar dispiriting conclusion: that there was no firm evidence that medical ethics education led to ethical behaviour in clinical practice.[7] The reason that medical ethics may not be as successful in its outcomes as in its processes—the latter an extensive body of scholarship and vibrant discourse, as shown in this journal—may be due to the neglect of issues discussed below. 'Medical ethics' covers a range of meanings and it is timely to consider which of these are useful guides for fostering healing relationships.

THE MISSING DIMENSIONS IN MEDICAL ETHICS

The need for virtue ethics

The traditional view of medical ethics as a collection of prescriptions and prohibitions, so-called 'code ethics', such as the General Medical Council's guidance *Good Medical Practice*[8] does not describe *how* these rules are to be followed, or even clearly articulate why they should be, apart from creating trust. I do not discount the value of trust,[9] but the deeper question of how such codes promote the goals of medicine remains unexplored. Code ethics is incoherent unless placed within a comprehensive theory of human morality and is described as 'the archeological ruins of a doctrine of medical virtue'.[10] Ethics is also depicted as tools to be picked up or discarded depending on the situation at hand. We now have 'medical ethics for dummies'[11] and 'toolkits' for dealing with ethical dilemmas.[12] These may be valuable and useful to busy clinicians, but they convey the notion that ethics is a simple acquisition of technical skills, rather than a more demanding (and life-long) requirement to develop, hone and practise the virtues, to take responsibility as moral agents and to fully acknowledge the humanity of others. Ethics-as-tools renders moral thought and action extrinsic to individuals' identity.[13] Furthermore, rules and tools simply cannot address core features of clinical ethics—the dynamic relationships between clinicians and patients, the desirable attributes of clinicians or how emotions and reasons are intertwined at the clinical encounter and in clinical–ethical decision making. They ignore the indeterminacy and contingency of life and fail to take into account how institutional culture—'the hidden curriculum'[13]—or the sociopolitical *zeitgei*st can influence ethical humane practice.[14]

Compassion, in brief, cannot be readily accommodated within a utilitarian, Kantian or even rights-based ethical theory. In contrast, it fits naturally within neo-Aristotelian virtue ethics[15] and is gaining support in medical ethics discourse.[16 17] The healing relationship can provide the phenomenological grounding for a normative ethic based on the virtues.[18] Medicine, within this paradigm, represents a social practice with complex cooperative activities that yield goods internal to the practice. These, unlike external goods, enrich the whole community and are achieved by the flowering of the virtues. Personal identity and integrity are founded on a life narrative that we tell ourselves and that we share with others as part of a larger shared tradition.

Moral reasoning and the evasion of emotion

Another oft-stated goal of medical ethics, proficiency at moral reasoning, although important, does not necessarily translate into ethical behaviour.[19] Between the intellectual problem solving in the abstract and facing the concrete reality of persons, there may be a disconnect.[20] Bridging this divide requires a dynamic interplay between detachment and engagement, cognition and emotion and a capacity for self-awareness and honest reflection.[21] Aptitude in moral reasoning may even sometimes correlate with skills in deception.[22] Deliberative decision making can make us less altruistic and compassionate.[23] This leads to another lacuna in much of the discourse and teaching of medical ethics: the emotional dimension.[24] In this context, emotions are often viewed as a hindrance, rather than an aid, to making sound decisions.[25–27] The revival of virtue theory, which incorporates emotions within rational ethical decision making, the inclusion of philosophical emotion theory[28] and neuroscientific knowledge[29] in clinical ethics are thankfully reversing this trend.[30–32]

The neglect of everyday ethics

Medical ethics tends to favour the dramatic or complex 'dilemmas'. While recognising that medical ethics needs a broader canvass,[33] I advocate for a greater focus on the multiple encounters between clinicians and patients (and their families) that form the bulk of medical ethics. 'Microethics' is 'not just the terrain of rare spectacular cases involving heroic decisions', but the field of 'day-to-day communication and structured, complex interactions, of subtle gestures and fine nuances of language.'[34] Ethics emerges from a process of dialogue involving philosophy, personal values, cultural assumptions and political and religious beliefs. Within this dialogue new meanings are created and individuals define who they are. During conversations between doctors and patients, ethical decisions are interwoven with technical decisions in a dynamic iterative process. This perspective shifts the focus from abstract discourse to an exploration of the messy world of intersubjectivity within which moral decisions are made. Clinicians need to connect with the lived experience, the 'lifeworld' of their patients.[35] 'Conversational ethics' values and recognises our social embeddedness and the moral significance of the individual and of reflection.[36 37]

Suffering

It is troubling that patients and laypersons consider the relief of suffering to be one of the primary ends of medicine, yet the medical profession neglects it.[38] This neglect is attributed to the mind–body dichotomy in medical theory and practice. Furthermore, the dichotomy is asymmetrical, with the sciences viewed as 'hard' and the humanities 'soft', creating a 'double-blinded dichotomous clinical gaze'.[39] We are social, embodied creatures and this can predispose us to suffering. Persons suffer from what they have lost of themselves. Cassell's rich multilayered concept of suffering relates this loss to any facet of personhood: one's life story, plans or hidden dreams, relationships, particular roles or spirituality. Suffering is experienced with the lost capability to do enjoyable or routine activities or to participate in the political realm. 'The body is no longer seen as a friend but, rather, as an untrustworthy friend'.[40] The 'latent' role of the clinician is to 'lend strength'—show solidarity—apart from easing the burden of illness with medical or surgical interventions.[41]

Existential neglect

A large empirical study in a hospital setting revealed how the biomedical focus over-rode important existential aspects of the consultation—the personal and human dimensions of the patients' suffering, their feelings and meanings—were systematically excluded. The doctors were courteous, but showed little interest or curiosity about the patients as individuals. Rather, patients were treated as medical objects and often more attention was paid to the computer than to them. The researchers describe this disregard for the patients' humanity as a 'moral offence'.[42] A study in general practice yielded similar findings with the

patients' lifeworld often blocked or ignored.[43] Yet creating 'caring conversations' which recognise the patient as person does not require added time or effort, but greater attentiveness.[44] Patients' narratives describe existential neglect and how this intensifies suffering. Sweeney,[45] faced with a terminal illness, poignantly relates how fellow doctors 'showed a hesitation to be brave' and lacked a 'willingness to accompany him in the kingdom of the sick'. He describes how the transactional aspects of his care were timely and technically impeccable, but that the relational aspects were often sadly lacking, leaving him feeling abandoned. Carel[46] describes a nurse's cold indifference to her distress when discovering that her lung function has undergone a rapid decline. She does not ask for ' feel-good chatting' but wonders if the encounter has to be 'so impersonal, so guarded'—cannot some 'genuine care' be brought in? The lament 'Why am I not treated as a person?' is almost universal. The answer is complex, but suffice to say that we can only claim to be 'doing good medical ethics' by responding well to both medical needs and existential suffering.[47]

COMPASSION AND SUFFERING

Compassion needs to be able to respond to all the dimensions of suffering and to respect the dignity of the person and not slide into pity and condescension. For at the core of the concepts of morality and human dignity is the idea that human beings are not reducible to objects, but are morally valuable and unique.

What do we mean by compassion? Compassion is complex and includes cognitive, affective and motivational elements. It is a capacity that is innate and linked to our evolutionary survival.[48] The two definitions below convey the main elements—noticing, feeling and responding. Also critical is the capacity to tolerate distress (equanimity) such that another person's suffering does not overwhelm and lead to avoidance or denial.

> Compassion refers to a deep awareness of the suffering of another coupled with the wish to relieve it.… Although the process of arriving at compassion can be difficult or complex, showing compassion often flows naturally and can be as quick and as easy as a gentle look or a reassuring touch.[49]

> Compassion is not simply a feeling state but a complex emotional attitude toward another, characteristically involving imaginative dwelling on the condition of the other person, an active regard for his good, a view of him as a fellow human being, and emotional responses of a certain degree of intensity.[50]

Compassion entails empathic imagination—being able enter the worldview of another, while retaining the 'necessary distance'—a sense of separateness.[51] This is not an easy task but one that demands practice and courage. I diverge, however, from Nussbaum's stipulation that the sufferer be deserving of our compassion.[28] 'Undeserving' can segue into harsh judgements and uncaring attitudes towards, say, the obese, drug addicts and immigrants 'who shouldn't be here'.[52]

Some counterarguments

Compassion receives a mixed reception in the context of medical ethics. On the one hand, it is championed as the basis for medical education,[31] but on the other hand, some authors reject it as an obligatory element of ethical clinical practice.[53] Compassion is like a flickering flame: a number of factors, explored in depth elsewhere, can extinguish it.[47] Although we need virtuous organisations for its flourishing that does not mean morality is entirely socially situated or the virtues are fictional.[54] Some argue that etiquette may suffice for good medical practice.[53 55] Certainly, adherence to etiquette could ensure courtesy and may even foster the habituation of some virtues, but will fail to address existential issues, or give guidance for responding to distress.[41 56] Contrary to broadly-held belief, the enactment of compassion is rewarding, not depleting. 'Compassion fatigue' stems from a lack of self-compassion and unbalanced, unreflective emotional empathy (with which it is often confused), not compassion.[57] There is, Aristotle would argue, a 'golden mean'.[58] Compassion alone is insufficient for healing and needs to be unified with the other virtues, particularly discernment, temperance and *phronesis* or practical wisdom.[58]

CONCLUSION

Compassion is a central and necessary element of good medical care and integral to good medical ethics. Compassion is both humble and powerful. It is subversive because it eschews hierarchy and privilege and runs counter to the libertarian, market-orientated industrialised medicine of today. It is embedded in a framework of reciprocity and shared meanings and is underpinned by an ethic of virtue. It demands both the recognition of our common humanity and the honouring of the individual narrative. Compassion views humans as interdependent and vulnerable, with autonomy textured by our milieu and relationships. It responds to, but does not generalise suffering. Above all, it connects with our better selves and what it means to be human.

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