The Notion of Compassion and the Goals of Medicine and Healthcare: A Systematic Analysis

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1. INTRODUCTION

1.1 Overview

Compassionate medical practice, which is herein understood as the sympathetic willingness to enter into the existential suffering\(^1\) of another in order to ameliorate the anguish invoked by disease,\(^2\) rests on the fiduciary relationship shared between physician and patient. On the one hand, without patients, physicians would be incapable of ascertaining the nature of disease and the extent of individual suffering, for these infirmed individuals would not otherwise permit such an invasion of their physical and personal privacy. On the other hand, without physicians, patients could not rightly expect to receive the extra margin of effort that is only the product of a relationship founded on intimate trust. Since suffering is personal and medicine is a personal profession, the physician-patient relationship is one that necessarily transcends ordinary economic, political, and social arenas of life.\(^3\)

Some clinical scholars, such as Eric Cassell, suggest that the healing relationship between physician and patient exists even when the physician is callous, cruel, and ignorant. In other words, the power and meaning of the relationship exists even when the physician ignores it. Hence, the physician-patient relationship can be engendered, exploited, abused, or sabotaged, but it cannot be disowned. It begins to form within moments of the initial encounter, and the relationship deepens as the patient becomes sicker. The painful paradox of the physician-patient relationship is that for it to achieve the fullest possible care of the patient, maximum openness and transparency to the patient must be present, and to be present, in this sense, is to be physically and emotionally endangered. Conversely, if physicians are closed off to patients, they run the risk of inevitably failing both their patients and themselves.\(^4\)

1.2 Analytical Method

An increasingly blurred understanding of the notion of compassion and its place in the context of the goals of medicine and healthcare suggest a critical need to revisit the relationship shared between compassion and the goals of medicine and healthcare in order to uncover its proper moral role and function. To be sure, the issues of immediate import to the conversation over the role and function of compassion in the context of the goals of medicine and healthcare are manifold, and any singular analysis of topics, no matter how sweeping, will unavoidably fall short of adequacy. This essay thus aims to

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1. “Existential suffering” is an intentionally broad term employed herein to include physiological, emotional, psychological, spiritual, and other idiosyncratic manifestations of suffering.
2. Like “existential suffering,” “disease” is an intentionally broad notion herein employed to include the innumerable manifestations of despair and unrest in patients.
briefly address but three: the notion of compassion, the goals of medicine and healthcare, and the notion of compassion vis-à-vis the goals of medicine and healthcare.

The present essay grounds its argument in two, straightforward premises: (i) the extent to which compassion exists within the physician-patient relationship is an indispensable measure of the moral licitness of the fiduciary duties exercised within that relationship; and (ii) the goals of medicine and healthcare are met insofar as they honor and uphold the mandates of licit fiduciary relationships. Drawing from this syllogism, the aim and proposal of this essay is such: to examine the notion of compassion in the context of the goals of medicine and healthcare with the intention of positing the argument that the goals of medicine and healthcare are realized to the extent to which compassion is manifest in the licit fiduciary relationship shared between physician and patient.

To secure the justification of this thesis, the current essay will move in three parts. First, it will address the notion of compassion in medicine and healthcare, including a specific analysis of the nature of suffering in light of morality and the changing concept of the ideal physician. Second, it will address the goals of medicine and healthcare, including a specific analysis of the pursuit of disease and the care of the sick, as well as the amalgam of treating disease, body, and patient simultaneously. Finally, it will address the notion of compassion vis-à-vis the goals of medicine and healthcare, including a specific analysis of nature, death, and meaning, as well as the compassionate care of the suffering patient.

2. THE NOTION OF COMPASSION IN MEDICINE AND HEALTHCARE

2.1 The Nature of Suffering: Living with the Mortal Self

As mentioned above, the notion of compassion in the context of medicine and healthcare concerns the sympathetic willingness to enter into the existential suffering of another in order to ameliorate the anguish invoked by disease. In order to understand compassion, then, it follows that one must first ascertain the nature of suffering. Although the duty of physicians to relieve human suffering dates back to antiquity, little attention has been explicitly devoted to the problem of suffering in medical education, research, or practice. This is particularly troubling considering the fact that patients and the general public often consider the relief of suffering to be the primary end of medicine. At the heart of the intersection between human suffering and the goals of medicine and healthcare lies a haunting paradox, namely, that even in the best settings and with the best physicians, it is not uncommon for suffering to occur not only during the course of a disease, but also as a result of its treatment.

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5. Indeed, the academic literature preceding 2004 hardly mentions the relationship between suffering and the goals of medicine and healthcare. See Cassell, *The Nature of Suffering*, 29-45; see especially p. 31.

6. It is worthy of note that while pain and suffering are not synonymous, physical pain remains a primary cause of human suffering and is the cardinal image formed by most individuals when they think about suffering. See Cassell, *The Nature of Suffering*, 29-45; see especially p. 29-32.

Suffering is an intimately personal matter whose presence and extent can only be known to the sufferer. Although pain and suffering are identified closely in the minds of most people, they are phenomenologically distinct entities. The difficulty of understanding pain and the suffering that accompanies it – indeed, the difficulty of compassion as a moral enterprise that calls on individuals to enter into the chaotic, confusing exercise of sharing in something not immediately experienced – is well known. Physicians encounter numerous difficulties in attempting to provide adequate relief to patients who struggle with morbidity and, ultimately, mortality. As Daniel Callahan notes, human nature fixes no singular response to suffering, and for this reason it is often arduous for physicians to ascertain the behavior it might induce or the meaning it may carry for a particular patient. Hence, compassionate medical care is necessarily idiosyncratic; it must be tailor made to fit the individual in his history, culture, and personal structure of understanding.

2.2 The Changing Concept of the Ideal Physician

Several factors have transformed the modern physician-patient relationship, each of which prove impedimentary to robustly compassionate medical practice. This essay will address but two: the total embrace of science, and the effect of technology. With regard to the former, physicians trained over the past two generations have struggled to disassociate medicine and science. On the one hand, science operates from the belief that it is, and its methods are, essentially value free. On the other hand, medicine has a long tradition in which a hierarchical ordering of values is firmly established. In addition to being value free, a scientific description does not ascribe quality to things. Instead, science ideally deals only with measurable quantities. To be sure, medicine could not do without such quantifiable measures and their significance to adequate healthcare delivery. However, science does not deal with individuals, but with generalities. Thus, although medicine and science are inextricably intertwined, the strains produced by believing them to be one and the same has led to a conception that was bound to fail from the start – that of the ideal physician as a scientist.

8. This notion is supported by the definition of suffering proposed by Cassell: “Suffering occurs when the impending destruction of the person is perceived; it continues until the threat of disintegration has passed or until the integrity of the person can be restored in some other manner.” See Cassell, The Nature of Suffering, 29-45; quotation on p. 32.
9. Unlike other objects in biomedical science, persons cannot be reduced to their parts in order to be understood. See Cassell, The Nature of Suffering, 29-45; see especially pp. 36-41.
12. Other factors include the pressure to procure research and the alteration of medical language. See Cassell, The Nature of Suffering, 16-28; see especially pp. 17-18.
13. That is, that anything that occurs in nature is neither good nor bad, but simply is. See Cassell, The Nature of Suffering, 16-28; see especially p. 17.
14. Patient primacy, nonmaleficence, and beneficence are but three examples.
15. Adjectives like warm, tall, swollen, or painful exist only to characterize individual persons.
16. These include measures such as temperature, dimension, and diameter. See Cassell, The Nature of Suffering, 16-28; see especially p. 17.
17. Cassell, The Nature of Suffering, 16-28; see especially p. 17.
With regard to the latter, in its general senses, technology has altered the character of physician practice in the last sixty years. The full impact of technology is indiscernible in large part because of the mistaken idea that the effects of science and technology on the thinking and behavior of physicians are identical. Due to this confusion, no discussion of the changing concept of physicians can be complete without some reference to the special effect that the simplicity and certainty of technology has had on clinical practice. The intrinsic promise of technology, namely, that it will ameliorate uncertainty and allay doubt, is virtually irresistible considering the fundamental nature of and particular circumstances surrounding medical practice. However, despite the limitless benefits of technology, uncertainty and doubt remain, and attempts to shift or conceal such ambivalence often diminish the capacity for compassion in the presence of human suffering.

3. THE GOALS OF MEDICINE AND HEALTHCARE

3.1 The Pursuit of Disease and the Care of the Sick

It is often troubling to patients to discover that most physicians are not in the first place concerned with discerning what is wrong with them, but rather with discovering what disease is the source of their illness. To laypersons, the two functions of discerning trouble and discovering disease appear to be analogous, yet a vital difference distinguishes them. Discerning trouble and discovering disease become reducible to one another only insofar as the disease is causing the illness. It is an unusual physician who, in absence of discernable disease, continues to search after the diagnosis until the reason for pain becomes clear. The frequent failure of physicians to continue searching for the origin of symptoms where no disease is found is fundamentally grounded in the fact that the signs are detected by another person: the patient himself. Since treatment is directed at a particular disease, it follows that the treatment would be the same no matter which person carried the disease to the physician.

Yet illness is always an idiosyncratic story, and so its pursuit and treatment must mirror such idiosyncrasy. Medical stories are distinct from everyday stories in one critical respect: they always have at least two characters – an individual and that individual’s body. Classical medicine may well contend that it is only concerned with what happens to the body, but it is clear that such a stance is today insufficient because what happens to the body is not identical to what happens to the person. In this sense, understanding illness as a story enables the physician to examine the idea of cause in illness in a manner

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18. It is the burden of physicians to have great responsibility in an arena overflowing with doubt and uncertainty. See Cassell, *The Nature of Suffering*, 16-28; see especially p. 17.
20. Equally unusual is the physician who believes that emotions play a part in the discomfort and continues to probe until he discovers what brings this pain to prominence in this individual at this moment. See Cassell, *The Nature of Suffering*, 88-107; see especially p. 89.
22. While there can be no persons without bodies, there can be bodies without persons, and most people make the distinction between who they are (person) and what they have (body). See Cassell, *The Nature of Suffering*, 88-107; see especially p. 106.
that is dignified. To the extent that employing the physicalist shortcut obscures viewing illness as a process and story that is slowly unfolding, the shortcut does great harm. From the viewpoint of the process that is illness, then, it is artificial and, hence, ultimately immoral, to stop at the boundaries of the body.

3.2 Treating Disease, Body, and Patient

Classically, physicians searched for the specific cause of each disease to find a cure, seeking something that would remove the cause and, thereby, the disease. Particular treatments have been developed that intervene at some point in the process of a specific disease. However, characteristics of the patient, social factors, and even the economic and political setting in which an illness manifests itself may modify an otherwise straightforward course of treatment. Patients often have adverse reactions to certain drugs, suffer from significant comorbidities that prevent standard intervention, and refuse proposed courses of treatment. Each of these circumstances modifies what the physician might consider to be the best medical treatment, yet none is part and parcel of the disease itself. Hence, even in circumstances where a treatment has shown to be appropriate to combat a specific disease, the treatment of a particular patient with that disease cannot be determined by the disease alone.

If each diseased system of the body is treated and supported, then treatment becomes a matter of one interventional event after another, not necessarily related to what the patient may want or what would be best for the patient himself. It is unquestionably difficult for physicians to determine how to adjust the level of treatment to meet the needs of a particular patient. Treatment of disease or therapy determined by pathophysiology must, then, be designed with the needs of the sick individual in mind. In absence of this focus, difficulties ensue. Experienced clinical practitioners typically establish treatment goals and found their therapeutic interventions on those goals. Patients are thus willing to take considerable risks and work toward recovery insofar as these goals become important to and resonate with them. Hence, diagnosing, seeking

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23. In a story, what causes this step in the personal narrative is that which preceded it. See Cassell, *The Nature of Suffering*, 88-107; see especially pp. 105-07.
24. The physicalist shortcut is herein understood as the method of approach that focuses solely on the disease at the cost of excluding the care of person who possesses it. See Cassell, *The Nature of Suffering*, 88-107; see especially pp. 105-07.
26. In this sense, the physician is the nucleolus of therapeutic medicine. Cassell, *The Nature of Suffering*, 108-29; see especially pp. 111-12.
28. This is especially true, for example, of most patients being treated in the intensive care units around the world. See Cassell, *The Nature of Suffering*, 108-29; see especially p. 115.
29. What is good for the patient’s liver or lungs is not necessarily what is good for the patient. See Cassell, *The Nature of Suffering*, 108-29; see especially p. 116.
30. It is relatively simply to begin medical interventions and assuredly difficult to stop them, a fact that has led to current moral problems regarding the licitness of terminating life-sustaining treatment. See Cassell, *The Nature of Suffering*, 108-29; see especially p. 115.
cause, treating, and prognosticating cannot be accomplished in absence of knowledge of both the disease and the sick person.\textsuperscript{32}

\section*{4. THE NOTION OF COMPASSION VIS-À-VIS THE GOALS OF MEDICINE AND HEALTHCARE}

\subsection*{4.1 Nature, Death, and Meaning}

Two conflicting understandings of death brought on by disease have long framed the conversation over the goals of medicine and healthcare. On the one hand, death is believed to be a part of life, to be embraced, at last, with grace and dignity. On the other hand, death is no less frequently repudiated as the enemy of life, to be resisted and rejected with all of one’s might.\textsuperscript{33} The struggle juxtaposes two elemental realities, each possessing an interior logic that leaves no room for the other. One reality is that of one’s impersonal biological nature, shared with all living creatures, and out of which one has been fashioned. It brings life and death, and gives no choice about living with the predetermined order of things. The other reality is one’s innate drive to live,\textsuperscript{34} and to shape biological nature to enable one to do so.\textsuperscript{35} The curbing of this natural drive, and the destruction issued by death on one’s life as both an individual and member of a community, constitute death’s most apparent threat.\textsuperscript{36}

The working premise of modern medicine and healthcare is that there is an answer to this ancient struggle. Such a premise contends that illness and death should be resisted and rejected, fought against at every turn with every imaginable scientific skill. Contemporary scientific medicine contends that nature is more or less malleable, that diseases that cause death can be cured one by one, that the limits of biological nature can be overcome, and that mortality can be placated. The culture that bolsters modern medicine has also issued an idea of no less importance, namely, that the meaning of death in life – the most ancient of human puzzles – can now be put aside.\textsuperscript{37} No effort is any longer needed to comprehend it; it is to be banished, not interpreted. The meaning of death, within which the nature and work of compassion exist and possess meaning, has now become the scientific problem of death, to be assaulted and conquered by the physician.\textsuperscript{38}

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\textsuperscript{32} Cassell, \textit{The Nature of Suffering}, 108-29; see especially pp. 115-29.
\textsuperscript{33} The goals of medicine and healthcare are thus confronted with sorting out the meaning of, and constructing an ultimate solution to, this dilemma.
\textsuperscript{34} While innate, this drive is also thoroughly idiosyncratic. See Callahan, \textit{The Troubled Dream of Life}, 156-86; see especially p. 157.
\textsuperscript{35} That drive is as much a part of human nature as the biological destiny that will bring about one’s end. See Callahan, \textit{The Troubled Dream of Life}, 156-86; see especially p. 157.
\textsuperscript{36} Callahan, \textit{The Troubled Dream of Life}, 156-86; see especially pp. 156-58.
\textsuperscript{37} This misinterpretation of death lies at the core of the struggle to realize the goals of medicine and healthcare while simultaneously providing compassionate care.
\textsuperscript{38} Callahan, \textit{The Troubled Dream of Life}, 156-86; see especially pp. 156-58.
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4.2 The Compassionate Care of the Suffering Patient

It is an unfortunate fact that serious illness is almost always accompanied by sorrow and pain. This essay contends that there are three goals that, if met by the actions of physicians and other caregivers, would promise compassionate care and effect greatly reduced suffering in patients and families. The first aim is that all diagnostic or therapeutic actions be made in terms of the sick person, not the disease. The second involves maximizing the patient’s function, not length of life. The final goal is to minimize the suffering of the patient and family. These aims are interlocking inasmuch as they arise from the fundamental idea that physicians and other caregivers should focus primarily on the best interests of the individual patient rather than on the treatment of the particular disease. Since infirmed persons generally know what is in their best interest, these goals require nothing less than working with and caring compassionately for patients and families.

The physician-patient relationship can thus be viewed as the vehicle through which the relief of suffering – and so the honoring and upholding of the mandates of licit fiduciary relationships – is achieved. Physicians cannot avoid becoming involved with patients and at the same time effectively allaying their suffering. In fact, with patients who are suffering it is essentially impossible to be in their presence and remain indifferent. In its barest sense, to be concerned is to be involved. Every physician fears becoming closer to suffering patients, many of whom will die, because such a relationship is sure to promise pain, sorrow, and loss. Yet it is only through the compassionate connection with the patient that pertinent information flows to inform the physician of what the patient is feeling and even what existential sensations he is experiencing. Through the same compassionate bond, then, the physician can provide the bridge over which the suffering person can return from the isolation of suffering.

39. It is worse when medical care fails to relieve such pain, and worse still when medical care adds to the suffering. See Callahan, The Nature of Suffering, 278-91; see especially p. 282.
40. While axiomatic, they are difficult and often burdensome, particularly for physicians. See Cassell, The Nature of Suffering, 278-91; see especially p. 282.
41. Including which aspects of function matter most to them and when they are experiencing existential suffering. See Cassell, The Nature of Suffering, 278-91; see especially p. 282.
42. Cassell, The Nature of Suffering, 278-91; see especially p. 282.
43. At issue, then, is the degree to which the physician actively participates in that relationship. See Cassell, The Nature of Suffering, 278-91; see especially pp. 290-91.
44. Hence the often unexamined desire to hold back, cover one’s feelings with a white coat, and hide behind incomprehensible language. This is due in large part to the fact that such pain, sorrow, and loss renders useless the technical tools necessary to care for the very sick and suffering. See Cassell, The Nature of Suffering, 278-91; see especially p. 291.
45. This bond enables the endangered, fragile sick person to know that the physician can be trusted, and so begin to reconnect to the world through that relationship. See Cassell, The Nature of Suffering, 278-92; see especially p. 291.
46. Cassell, The Nature of Suffering, 278-91; see especially pp. 290-91.
5. CONCLUSION

The aim and proposal of this essay has been to examine the notion of compassion in the context of the goals of medicine and healthcare with the intention of positing the argument that the goals of medicine and healthcare are realized to the extent to which compassion is manifest in the licit fiduciary relationship shared between physician and patient. To secure the justification of this thesis, it has drawn from the twofold premises that (i) the extent to which compassion exists within the physician-patient relationship is an indispensable measure of the moral licitness of the fiduciary duties exercised within that relationship, and (ii) the goals of medicine and healthcare are met insofar as they honor and uphold the mandates of licit fiduciary relationships. To this syllogistic end, the present essay has been successful.

The implications here are significant. To be sure, the increasingly blurred understanding of the notion of compassion and its place in the context of the goals of medicine and healthcare is a genuine and growing fear. But rather than allowing it to terminate progress, may it instead serve to remind that while realizing the goals of medicine and healthcare are important, how they are realized and the extent to which they exhibit compassion is more important still.

REFERENCES
