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Individualism and Compassion in American Medicine

by

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THESIS

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COWBOYS IN WHITE:

Individualism and Compassion in American Medicine

by

Michael Chunchi Lu

Dedicated to my parents

Ming-Yueh Lu

and

Kun-Tsai Lu

for the simple eloquence of their examples

Dedicated to

Cynthia Thuy Ho

for Always Being There for Me

COWBOYS IN WHITE:

Individualism and Compassion in American Medicine

Executive Summary

Physicians are supposed to embody compassion, but few of us know what that means.

Compassion means to suffer with. That means we suffer with our patients; we participate with compassion in their sorrow.

But that may be too much to ask of us. We show compassion to feel good about ourselves, not sorrow with another. Our compassion gives us self-fulfillment, self-esteem, and self-expression.

That is how most Americans think. That is what most great Western thinkers have thought. Caring for the other is really giving to the self. And so when it does not make us feel good, when it costs us more to give than we get in return, when it ties us down, we care less.

Such self-concerns about our success, self-interest, and freedom make it hard for us to attend to, identify with, and respond to the suffering of others. Our compassion is limited by our individualism.

But don't just blame the individual. Compassion depends on what is in between and around us as much as what is in us. The source of compassion is institutional and ecological as well as individual. Asking individual doctors

to behave with more compassion, without doing something about the institutional and ecological pressures and temptations for self-concern that American medicine puts doctors through, does not get at the root of the problem.

The central argument of my thesis is that our culture of individualism generates a certain kind of compassion in American medicine, one that is limited by our self-concern about our success, self-interest, and freedom.

We are under pressure to succeed in medical education. Our unremitting pursuit of success in becoming a doctor detracts from our joy and compassion in being a doctor. Our preoccupation with success, and our anxiety about failure, make it hard for us to suffer with each other and with our patients. As students, we learn to ignore the sufferings of success and avoid the sufferings of failure. We learn to put up with aggressive competition, isolation, abuse, and stress because they are the price of our success. We learn to avoid or blame our classmates or patients whose sufferings expose our vulnerability to failure. The only sufferings we really attend to are those we can fix. It will take redefining success, practicing commitment, and teaching compassion to make us attend more to our patients, and less to our ambition.

We are tempted with self-interest in medical practice. In a system where compassion has been wed to self-interest, doctors have done well for themselves simply from doing good

for their patients. The patient comes first; so we go the extra mile, do everything for (to) him or her, and get paid fee-for-service. But our self-interested compassion got to be too much, and the system clamped down, making it increasingly harder now for doctors to be either self-interested or compassionate. But we continue to behave as if somehow individual compassions add up to collective compassion; somehow individual self-interests add up to the common good. It does not. It will take renouncing some self-interest, recognizing interdependency, and reappropriating the calling in health care to restore our compassion.

We are bound by freedom in our patient-doctor relationship. Autonomy has given our compassion its rational-legal expression; giving patients their right to informed consent, right to privacy, and right to die can be very compassionate. But its moral vocabulary is limited because human beings are not autonomous; we exist in and through relationships and institutions or we do not exist at all. Autonomy cannot substitute for compassion because of our interdependency. A moral ecology of autonomy cannot generate a social ecology of compassion because of our institutional power. We need an ethic of compassion that pays attention to suffering. We need to make compassion a goal of medicine.

Success, self-interest, and freedom are not only values

of our culture of individualism, they are also values of our marketplace. We are now witnessing the "invasion and colonization" of our caring relationships by the "tide of commercialism," the "coming of the corporation," the "businessfication of medicine." It will only get harder for doctors to be compassionate.

It is hard to be compassionate in an unjust society; compassion and justice are deeply connected. And it is hard to be healthy in a sick society; personal health and social health are deeply connected.

To have a good society, we need more compassionate individuals and compassionate institutions. And a different kind of compassion. But it will take giving up some of the rewards that come with our success. It will take doing things that are not always in our best interest. It will take commiting ourselves to less "freedom from" so others can have more "freedom to." It will take losing a little of ourselves to find our larger self.

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I thank the twenty-seven physicians, students, and faculty for our conversations. I wish I could recognize them by name, but in order to keep their confidence, I will not. The greatest joy I found in doing my thesis has been to learn from each of them.

And I thank my advisors, Robert Bellah, Thomasine Kushner, and Sheldon Margen, for their help and inspiration. They are great teachers, in the sense of William Wordsworth's words:

> What we have loved.
> Others will love, and we will teach them how.

Thanks for teaching me how.

Michael Chunchi Lu
Berkeley
May, 1992

I

Compassion Means To Suffer With

Compassion means to suffer with.[1]

But how do I suffer with my patients?

Take Sam, for example. How would you suffer with Sam? Sam's doctor told his story like this:

> Sam, at the time I met him, he was around seventy-two years old. He was a long-standing diabetic; he was a man who lived in the Tenderloin in San Francisco with very low funds. And he used to pride himself in the fact that he would play poker for three days when all his Medicare checks and his social security checks arrived and basically tripled his checks just through these winnings.
>
> Sam was a man of independence. Sam first recognized his need for independence when he killed a man in Cleveland and spent ten years in jail before he was released and came to San Francisco. He always referred to that as a learning that he never wanted to be in an institution again. It is certainly understandable why he held tightly to his small hotel room in San Francisco Tenderloin.
>
> But Sam was also not a well man. Over the next five years that I was caring for him his diabetes began gradually to ravage his body. His eyesight began to go. But what was most disturbing to him was that he began to lose feelings in his fingers. It was disturbing to him because he could no longer feel the cards with the same degree of accuracy as he did before -- which could result in potential loss of income.
>
> Initially with his diabetes and his progressive neuropathy, he began to develop ulcers on his legs; ulcers that would not heal because the blood flow would never be adequately returned to those areas. About five years into his illness he lost his left leg. He thought this was the end. He thought he was going to die. He ended up in the nursing home,

and he went into a major depression. But we were actually able to get him into a rehabilitation center for about a month, get him a prosthesis, Sam hobbled out, returning to himself, to the people that he knew, and to situation that he felt most comfortable, still holding steadfast to the fact that he never wants to be institutionalized.

But unfortunately as diabetes tends to do, once it has taken one leg it'll go after the other. And sure enough Sam developed an ulcer and lost three toes on his right leg this time, and his heel began to become necrotic. We tried everything we could to control his diabetes, but it was an inexorable process and it became apparent to us that Sam was soon going to lose his other leg. And Sam recognized that as well. When that happens, he wasn't going to be able to continue to live in the Tenderloin and continue to live independently. And this was the focus of our discussion when he would come and see me at the clinic when I was an intern and later at my private practice after I finished.

So that takes me to one Saturday night in early October, about seven years ago. I had guests over for dinner and I was serving the wine when the telephone rang. I have since learned that as a physician you don't pick up the telephone, but I picked it up. It was Sam.

"Bill, I am just calling to say good-bye."

"Where you going, Sam?"

"I'm going to die."

"Oh?"

"Yep, I've been thinking about it. I just shot myself up with a whole bottle of insulin, and the way I figure it, I'll be dead in about forty-five minutes or so. But, there are just about three people in this world whom I really care about and I feel it's necessary for me to say good-bye. I've already called the first two and they said 'good-bye.' Now I'm calling you. And don't worry, I made clear there is no record of this phone call; I looked you up in the phone book and got your number and just dialed you up. I had a little trouble seeing it and a little trouble thinking clearly...."

I could tell. His blood sugar was probably twenty at that point and he was kind of going in and out. "This way, there is really no record of this call. I really just want to say good-bye. And there is nothing you can do about it anyway. You don't know where I live. And if you are really my friend, I just don't want you to feel bad about it."

What kept going through my mind was: "Sam, why the hell didn't you send me a letter!"

So we talked .... It turned out that I had to fill out some kind of health care form for him just a couple days ago. I knew where he lived. I knew his address. I knew his apartment number.

"Well, Sam, I don't know what I'm going to do."

"There is nothing you can do and don't try anything. Good-bye!" and he hung up.

I poured myself another glass of wine. I sat down and began a discussion about Sam with my guests. I was the only physician. Everyone of them said: "You've got to do something!" "This is a cry for help!" "He really needs your help. He wouldn't have called you." I thought to myself: "How come the other two guys didn't see it that way?"

I really, deep down in my heart, believe that Sam was trying to say good-bye. I really do. But listening to them and mulling it over in my mind, I basically had to come to the feeling that "Sam, if I wasn't your doctor, I probably would've just said good-bye. But somehow you've involved me in this so that I cannot just say good-bye. I am very sad for you; I should've listened to you...," and I called 911. They banged down the door and hauled him out and took him to the emergency room.

I left the party with the cheers of my friends and somewhat feeling like I really let somebody down. Walked on out there and, this is about an hour and half later, you know he should've been dead by now.

And he's still up there, ranting and screaming and cursing: "God dammit! God dammit! You know I've been a diabetic all these years; I should've known better. I used NPH when I should've used regular."

"Yes you should've," I said. "And you should've sent me a letter, too."

Did Sam's doctor act with compassion? What was the compassionate thing to do, or not to do? Did he suffer with Sam? From what did Sam suffer? How would you suffer with Sam?

Physicians are supposed to embody compassion. Yet few of us know what that means. Most doctors I interviewed were at a loss for words when I asked them what is compassion. "It's a kind of feeling," one doctor tried to elucidate. "Something touchy-feely." Some doctors characterized compassion as something indefinable and inscrutable and would rather keep it that way. One doctor put it this way:

> You can say that its feet are standing in the realm of mystery, its head or something like that is in the realm of being nice, golden rule, being civil, behaving in a way that is socially congenial. But down at its roots compassion, I feel, is sufficiently deep that it's a mystery.

Another doctor told me simply, "I'm not that philosophical."

These doctors did better at describing how they would show compassion. "Listening to her, holding her hand," one doctor who works in an emergency room reflected on how he might have shown more compassion to one of his patients. "Just being there, making eye-contact, telling her 'I know you are hurting.'"

Listening, explaining, acknowledging, reassuring, hand-holding, making eye-contact, and being there. But is that compassion? Is that what it takes to be a compassionate doctor?

But often it takes less. "It takes seconds to be compassionate," one doctor pointed out to me, "to acknowledge somebody's emotional pain." "Just tell them," he taught me his repertoire, "'I know you are hurting,' 'I know you are frightened,' or 'I know what you are going through.'"

"Mrs. Jones," one surgeon reenacted his compassion, looking into my eyes intently and putting my hand to his heart, "the doctor will be with you until the cows come home."

Medical students take it a little slower. "[I]t only takes one or two minutes to be compassionate," one Harvard medical student said, "to put patients at ease."[2] Compassion in a minute or two? Compassion in a second or two? Is that enough compassion? Is that all it takes to "suffer with" your patient?

You probably think I am taking compassion too literally. Do I really have to **suffer with** my patient in order to be a compassionate doctor? What does it take to suffer with someone? What does it mean to suffer?

II.

THE NATURE OF SUFFERING

All Life is Sorrowful

The king, having learned of the wish of his son, ordered a pleasure party prepared, with extreme precautions taken that no afflicted person should appear along the way to unsettle his son's protected mind....

The gods, however, in their pure abodes, having recognized the moment, sent forth an old man to walk along the road.

"Who is that man there with the white hair, feeble hand gripping a staff, eyes lost beneath his brows, limbs bent and hanging loose? Has something happened to alter him, or is that his natural state?"

"That is old age," said the charioteer, "the ravisher of beauty, the ruin of vigor, the cause of sorrow, destroyer of delights, the bane of memories and the enemy of the senses. In his childhood, that one too drank milk and learned to creep along the floor, came step by step to vigourous youth, and he has now, step by step, in the same way, gone on to old age."

The charioteer thus revealed in his simplicity what was to have been hidden from the king's son, who exclaimed, "What! And will this evil come to me too?"

"Without doubt, by the force of time," said the charioteer.

And the great-souled one whose mind, through many lives, had become possessed of a store of merits, was agitated when he heard of old age -- like a bull who has heard close by the crash of a thunderbolt. He asked to be driven home.

A second day, another outing; and the gods sent a man afflicted by disease.

The prince said, "Yonder man, pale and thin, with swollen belly, heavily breathing, arms and shoulders hanging loose and his whole frame shaking, uttering plaintively the word 'mother' when he embraces there a stranger: who is that?"

"My gentle lord," said the charioteer, "that is disease."

"And is this evil peculiar to him, or are all beings alike threatened by disease?"

"It is an evil common to all," said the charioteer.

And a second time the prince, trembling, desired to be driven home.

There came a third time, another outing, and the deities sent forth a dead man.

Said the prince, "But what is that, borne along there by four men, adorned but no longer breathing, and with a following of mourners?"

The charioteer, having his pure mind overpowered by the gods, told the truth. "This, my gentle lord," he said, "is the final end of all living beings."

Said the youth, "How can a rational being, knowing these things, remain heedless here in the hour of calamity? Turn back our chariot, charioteer. This is no time or place for pleasure."

The driver, this time, however, in obedience to the youth's father, continued to the festival of women in the groves.... But that best of youths ... only pondered in his agitated mind: "Do these women not know that old age one day will take away their beauty? Not observing disease, they are joyous here in a world of pain. And, to judge from the way they are laughing at their play, they know nothing at all of death."....

And the call of the young prince Gautama to that end came to him on his next departure from the nest, when he beheld the fourth and last of the Four Signs.

He was riding his white steed, Kanthaka, across a field that was being plowed, when he saw its young grass not only torn and scattered, but also covered with the eggs and young of insects, killed. Then filled with a deep sorrow, as for his own kindred slaughtered, he alighted from his horse, going over the ground slowly, pondering birth and destruction .... Pondering the origin of the world and destruction of the world, he laid hold there of the path to firmness of mind. And released therewith from all such sorrows as attach to desire for the objects of the world, he attained the first stage of contemplation. He was calm, and full of thought.

Where upon he saw standing before him an ascetic mendicant. "What art thou?" he asked. To which the other answered, "Terrified by birth and death, desiring liberation, I became an ascetic. As a beggar, wandering without family and without hope, accepting any fare, I live now for nothing but the highest good." Where upon he rose into the sky and disappeared; for he had been a god.[1]

Seeing old age, disease and death led the Buddha Gautama to the first two of his "Four Noble Truths": all life is sorrowful and the cause of suffering is ignorant craving (trsna).[2] He was awakened to the causal chain of suffering: "From 1. ignorance, there proceed in series: 2. acts, 3. new inclinations, 4. incipient consciousness (portending further life), 5. an organism, 6. organs of sense, 7. contact, 8. perception, 9. desire, 10. attachment, 11. rebirth, and 12. old age, disease, and death."[3]

On seeing old age, disease and death, what do our physicians see? What differential diagnoses for the etiology of suffering do they generate?

Despite the universality of the experience, particularly among patients, suffering has received little attention from the medical profession.[4] Eric Cassell attributes this negligence to the Cartesian mind-body dichotomy in medical theory and practice. For most Western-trained physicians treating organic diseases, suffering is pain and pain is suffering. The relief of suffering is the relief of pain. Everything else is in the head.

Eric Cassell observes that suffering is experienced by neither the mind nor the body alone, but by the person. "Suffering occurs when an impending destruction of the person is perceived," he argues, "it continues until the threat of disintegration has passed or until the integrity

of the person can be restored in some other manner."[5]

What I find most insightful in his observation is that "suffering can occur in relation to any aspect of the person": "the lived past, the family's lived past, culture and body, the unconscious mind, the political being, the secret life, the perceived future, and the transcendent-being dimension" are all susceptible to damage and loss.[6]

People in pain suffer from pain "when they feel out of control, when the pain is overwhelming, when the source of the pain is unknown, when the meaning of the pain is dire, or when the pain is apparently without end." Suffering can also be generated from pain when "physicians do not validate the patient's pain" -- as when the pain is diagnosed as imagined, faked, psychological (in the sense that it is not real).[7] Alternatively, pain may be dissociated from suffering if it is validated, suffused with meaning. Cassell cautions that "people are often said to have suffered greatly, in a religious context, when we know only that they were injured, tortured, or in pain, not whether they suffered."[8]

In chronic illness, suffering of a different sort may be experienced -- the suffering of self-conflict:[9]

> Suffering arises in chronic illness because of the conflicts within the person that are generated by the simultaneous need to respond to the demands and limitations of the body and to the forces of society and group life. These struggles to meet opposing needs become internalized, and suffering occurs as the integrity of the person is threatened by the dissension.

An example is someone with a handicap attempting to get on a bus "like everyone else" -- the "person has committed two breaches of the social rules: attracting stares and slowing everybody down."[10]

Becoming dependent on others is a breach of another venerated social rule: self-sufficiency and independence. A patient became depressed after a pacemaker implant that led to the suspension of his drivers license. He had to rely on his wife to drive him everywhere. "I isolated myself," like many persons with chronic illness, "I'd close off and not talk."[11] The "conflict between the desire to live in society and the need to retreat" causes the suffering of chronic illness. The conflict is also between the social desirability of independence and the personal need for dependency.

I will not (cannot) try to say the last word on the nature of suffering and its relation to illness. Suffice to say that much of life is suffering and the cause of suffering is beyond pain. Let us first turn our attention to suffering of a very different sort, in a very different culture.

This is Somebody's Child

A wailing father brought his ten-year old boy to the ER. On examination, the patient showed no respiration or pulse, a protruding right eye with periorbital ecchymoses, and pupillary dilation.

> I learned from the father that the boy had been helping him out at the store all day. Around nine o'clock this evening, he gave the boy some money to get some noodles for dinner. As the boy was going across the street to the noodle stand on his bike, a car hit him and sped away.
>
> As the father recounted what happened, I saw him took out a soiled hankerchief and tried to put the child's eye back in place. He kept calling out his boy's name, trying to wake him up. All of a sudden, as if he had just remembered something, the father reached into his pocket and took out a handful of money. "Here's seven hundred yuan," the father pleaded. "Please, doctor, please help my child. Please save him." Then he started to kneel. I picked him up, took a deep breath, and told him that his son had passed away.
>
> The father reacted as one might imagine. This is, after all, a father. I put my hand on his shoulder, wishing to share his sorrow, his regret, his anger.... The father knelt down before his child, his fists still clenching the money. All the hard work, all the hopes (his tells me that his son always comes in first in his class), were drowned out in his quiet sobbing.[12]

This story was recounted in the diary of a medical intern in Taiwan. What struck me about this account, as with most entries in the diary, was the intern's attention to the sufferings that were generated within relationships, mostly familial. The sorrow of a father for the loss of his child; the sorrow of a son for the loss of his father:

> A patient arrived last night, brought in by three family members. The attending started him on mechanical ventilation, and his son began to pump the bag. Four, five more senior family members arrived later, amongst them a woman who started wailing: "If you are going to die, wait until we get home," she cried.
>
> The other family members stood around, looking at each other, helpless. One of them finally spoke, "I think it's hopeless. Let's bring him home...."

> Before he finished his sentence, he was silenced by the stern stares of his elders. Meanwhile, the son kept pumping the oxygen bag, as if he were playing a dirge from a bagpipe....
>
> The family finally decided to take turn on the bag. When I woke up this morning, his son was still playing the dirge.
>
> I went over to the patient. His face was cold to my touch. On auscultation, his heart had stopped beating. But his son sat next to him, still pumping.
>
> "The patient has passed away, a while ago ...," I announced.
>
> The bag fell from the son's hand. His exhausted body falling on top of his deceased father, he began to sob quietly.[13]

Unlike accounts of similar tragedies by health professionals in the West[14], here the physician played no role on the centerstage. No heroic measures; just compassionate observation.[15] The compassion was more for the living than for the dead. No questions about when is the dead dead or whether the dead suffers.[16] The deaths were social deaths, and the suffering shared suffering, suffered together.

Compare these stories to those of Sam that I recounted earlier. Where was Sam's family? Who mourned for his death? Who suffered with him? These stories serve to illustrate two important differences in the experience of suffering between the culture of my nativity in Taiwan and the culture of my acculturation in the U.S.. First, suffering is largely a personal experience in the U.S., experienced by the person as an individual. In contrast,

suffering is largely a relational experience in Taiwan, experienced within the roles and obligations of the relation. In the U.S., suffering is the damage to or loss of personality; in Taiwan suffering is the damage to or loss of relationships.

Second, as a personal experience, suffering is unique to the individual American sufferer. To suffer with her, we need to know her as a person. But as a relational experience, suffering is determined by the roles and obligations of the Taiwanese sufferer. To suffer with him, we only need to know that he is a father, and suffer as any father would the loss of his child.

Compassion, as embodied in the Taiwanese medical intern, is to suffer with someone as one would with one's own parent, spouse, or child:

> When I see patients who are suffering, I often remind myself: this is somebody's father, or this is somebody's mother, or this is somebody's husband, or this is somebody's wife. As such, the patient becomes more than symptoms and signs, lab values and imaging findings. In illness, as in health, conscious or unconscious, the person continues to participate in the joy and sorrow of a larger life.[17]

I may be overstating the differences; there are, no doubt, relational implications to the American experience of suffering and compassion; just as there are personal qualities to the Taiwanese experience. But, by and large, to know Sam's suffering is harder than to know "any father's" suffering. It takes knowing Sam as a person.

But that may be too much to ask in our culture of individualism.

The Suffering of Individualism

Our experience of suffering is generated from, and limited by, our individualism.

Individualism lies at the core of American culture. It is "a belief in the inherent dignity and, indeed, sacredness of the human person."[18] A human person is more than his or her roles or position, we hold; a person is a person unto himself or herself, with a personality, an individuality of his or her own. To suffer with a person takes knowing more than how a person, any person, in his or her roles or position would suffer; it takes knowing the person as a person. It takes knowing Sam to suffer with Sam.

There have been several traditions of individualism which followed from that belief, as described by the co-authors of Habits of the Heart.[19] Our individualism extols the success, self-interest and freedom of the individual.[20]

Success means to "be all that I can be." It means to "com[e] out ahead in a fair competition with other individuals."[21] We compete to see "who can be king of the mountain, who can get the most attention, who can be the most envied."[22] We suffer when we lose. But we also suffer when we win. Success takes hard work. It takes suffering

stress, isolation, and delayed gratification. But it's worth it, we tell ourselves, success has its rewards. Our accumulation and consumption relieve the sufferings of success.

If success is my reward, failure is your punishment. Failure means you did not work hard enough. It is your fault. Success by the grace of God implies failure by the disgrace of man -- the "have's" are more saved than the "have-not's" by virtue of their work.[23] Sociologist Robert Wuthnow found in a national survey that while four in five Americans agree that "I can do anything I want to, if I just try hard enough," more than half (54%) also agree that "people generally bring suffering on themselves."[24] Success does not need our compassion, and failure does not deserve it.

Self-interest means "looking out for ourselves: getting the most for our money, making wise investments, driving the hardest bargain we can."[25] It is the central tenet of utilitarian individualism[26] and classical economics[27]. We suffer when we are cheated, duped, taken advantage of, when we come out on the short end of a bargain. But it is partly our fault; we should have known better. It is assumed that people are self-interested and, in a system constrived on a harmony of self-interest, they ought to be.

Self-interest also means taking care of ourselves, our

health and physical fitness, our bodily pleasures and material comforts. Increasingly, Wuthnow observes, "self-interest also means taking care of ourseves psychologically, emotionally." And so we learn "how to relax, giving ourselves positive messages, knowing what we need at any particular moment, and learning how to get what we need." This is what is referred to as expressive individualism.[28] Self-interest means "knowing the inner recesses of our selves, finding ways to express our selves, and making sure nobody else tells us what our selves want and need."[29] We suffer when we do not know oursleves, when we do not know what we want, when we do not take care of ourselves, when we cannot feel good about ourselves. The singular importance of feeling good about ourselves is demonstrated in a survey which found that while 44% of Americans thought "fear of failure" to be "very important ... in motivating a person to work hard and succeed," twice as many thought "self-esteem/the way people feel about themselves" to be "very important."[30]

Freedom is our most cherished value. It is how we like to think of our political institutions; we pride ourselves in being the leader of the free world. It is also how we like to think of our economic institutions: free enterprise, free market, free trade, consumer sovereignty....[31] At the personal level, freedom means to be "left alone by others."[32] It means "not having anyone

tell us what to do, not having to listen if they do, not having to conform."[33] It means to do as we please, to decide for ourselves, to march to the beat of a different drum. It also means to be out on our own, to stand on our own two feet, to be our own boss. Freedom implies autonomy, independence, and self-sufficiency. We suffer when we are not free, when we cannot do what we want,[34] when we cannot decide for ourselves, when we have to depend on somebody else.

We suffer to the extent our success, self-interest, and freedom are limited. But our sufferings are limited by the extent of our success, self-interest, and freedom. Take isolation, for example. Success, self-interest, and freedom can be isolating. To be all that I can be is to come out ahead of you, to look out for myself is to watch out against you, to be left alone to do as I please is not to need you and not to get tied down by you. It is hard for me to have a relationship with you, to forge a bond with you, except in those terms. Relationship between you and me is often undertaken for utilitarian or therapeutic motives -- "what's in it for me" or "how does it make me feel" becomes the test of its endurance and dependability. Little wonder why many Americans do not feel that they could count on their friends or neighbors. Nearly four in ten (37 percent) in Wuthnow's survey feel they could not count on their immediate neighbor. Almost as many (36 percent) think they could not

depend on church or synagogue members for help. One person in three doubts it would be possible to count on relatives outside the immediate family[35]. Isolation is the price we pay for our success, self-interest, and freedom.

But we try not to let isolation bother us. We learn to take care of ourselves. We learn to stand on our own. We learn to love ourselves. It is only when old age,[36] disease,[37] or death and dying[38] expose our dependency that we suffer most from our isolation. It is only when we cannot care for ourselves that we realize no one is there to care for us, when we cannot stand on our own that we find no one around to stand by us, when we cannot love ourselves that we feel unloved.

But not when we are doing okay. There is, in our culture of individualism, a collective denial of isolation and loneliness, for admission of suffering would detract from our enjoyment of success, self-interest and freedom, or at least the pursuit thereof.

Now we know how we suffer alone. Let us see how we suffer together, with each other. Not only is our suffering generated from and limited by our individualism, I will argue; so is our compassion.

III.

THE NATURE OF COMPASSION

The GOOD SAMARITAN COWBOY

> A certain man was going down from Jerusalem to Jericho; and he fell among robbers, who both stripped him and beat him, and departed, leaving him half-dead. And by chance a certain priest was going down that way: and when he saw him, he passed by on the other side. And in like manner a Levite also, when he came to the place, and saw him, passed by on the other side. But a certain Samaritan, as he journeyed, came where he was: and when he saw him, he was moved to compassion, and came to him, and bound up his wounds, pouring on them oil and wine, and he set him on his own beast, and brought him to an inn, and took care of him. And on the morrow he took out two shillings, and gave them to the host, and said, "Take care of him; and whatsoever thou spendest more, I, when I come back again, will repay thee.[1]

The Good Samaritan embodies compassion, as we know it. A national survey found that the strongest predictor for becoming involved in charitable activities is the knowledge or experience of the story of the Good Samaritan.[2] But how we know or experience the story is telling about who we are. Take the following rendition, for example:

> A man was going from Atlanta to Albany and some gangsters held him up on the way. They robbed him of his wallet and his brand new suit; then they beat him up and left him unconscious on the side of the highway. Passing by in his car, a preacher saw him, turned away, stepped on the gas, and went back to thinking about a sermon he was going to give his congregation. Later a gospel singer drove past without stopping because he was late for a rehearsal. Finally, a poor old black man came up to the site in his car and saw the man on the side of the road. He was struck with pity, tears came to his eyes and he stopped. He got out of his car

> and helped the man as much as he could; in spite of his age, he managed to lift the man into his car and took him to some place that could help him further, a hospital of some sort. When he was leaving, he gave the nurses and medics some money and said, 'If this doesn't cover it, I'll be back later when I get my next check.' The moral of the story is: 'Help your neighbor and stop being so apathetic!'[3]

This is how we might retell the story. This rendition was created by a priest to "show how we ordinarily alter the story ever so slightly to fit better with the way our culture thinks about such things." He went on to tell the story "the way it was told by the church fathers from earliest times through the Middle Ages":

> The man who was beaten while going from Jerusalem to Jericho represents mankind descending from the conscious paradisal state of Jerusalem to the materially-minded state of Jericho, a very worldly city.... The robbers are the fallen spirits playing on the unchecked passions within us. The man left wounded and bleeding represents the state of all mankind, wounded in soul by the Fall and by sin at work in us. A priest ... and a Levite [as] representatives of the old covenant passed by not only out of their hard-heartedness, but because of their inability to render effective help to the man.... But the Good Samaritan who came riding on his donkey had compassion on this stranger.
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> The Good Samaritan ... is Christ Himself, who even to the Jews was a stranger. He came to heal the soul of man deadened by sin by pouring in the oil of gladness, the oil of chrismation or of regeneration.... He also poured into the wounds wine, the symbol of fruitfulness, the wine of the Eucharist. Then he put the man on his donkey, symbolizing man's lower nature which Christ has mastered and uses for God's work, and he took him to the inn.... The inn is the Church, and it provides the place where a man who has been beaten and healed can regenerate until Christ comes again. The two denarii given to the inn-keeper for the care of the man are the two great commandments given ...: love the Lord your God, and love your

> neighbor. In this you can clearly see the symbolism of the Church and the Second Coming of Christ, and of Christ Himself, the great gift and minister to humanity.[4]

Sociologist Robert Wuthnow pointed out that in this medieval reading of the allegory, the listener is asked to identify not with the Good Samaritan, but rather with the injured person saved by the Christ in the figure of the Good Samaritan. The inn cannot be substituted by "a hospital of some sort" - it represents the church. Wuthnow points out that

> this teaching was emphasized especially by St. Bede, who saw the church as the place where the injured man could recover from the worldly passions that had led him into harm's way in the first place. It was not that the listener simply resolved to follow the example of the Good Samaritan; instead, the listener was encouraged to become part of a supportive communty that would provide daily guidance, instruction, and opportunities to practice a new set of values. Moreover, as St. Maximus taught, the two denarii or shillings were the two great commandments: to love God and one's neighbor. These were the way to overcome one's selfish instincts. They were not simply admonitions such as, help your neighbor and stop being so apathetic. They were teachings given in the context of the inn, the church, the supportive community. As the injured man recuperated at the inn, these were the teachings that would gradually enable him to become more compassionate. The story was thus not so much a moral tale that worked by playing on the sentiments of the isolated individual, but a parable about community and social support. It was in fact this meaning that still struck Rembrandt when he painted his great interpretation of the Good Samaritan: his portrayal is not set along the road, as most contemporary sketches are, but in the warm light of the inn.[5]

Wuthnow argued that "this allegorical reading is possible because of the institutional authority of the medieval

church."[6]

In contrast, in our reading of the parable as a moral tale, we recognize no such institutional authority. As such it "place[s] the entire burden of doing good on the choice, the willpower, the moral fortitude of the individual." That so much of our charitable behavior is institutionalized in the so-called voluntary sector, Wuthnow observed, grows from our society's emphasis on freedom, individual autonomy, and willpower. "Showing compassion is also a way of setting ourselves off from the crowd," Wuthnow argued, "of showing our nonconformity, our commitment to doing our own thing."[7] If I think everyone else is self-absorbed with success and self-interests, than my compassion sets me apart and sets me free. Compassion "dramatizes our freedom to choose."[8]

But why would I choose to express myself by caring for others? Caring for others makes me feel good. Wuthnow cites an advertisement of an international relief agency whose appeal for sponsorship consisted of repeating the message "It'll Make You Feel Good"[9]:

> At the top was the familiar face of a needy child, dark-skinned, with large, sad eyes. Beside her picture in bold, black underlined letters half an inch high was the word SPONSORSHIP. Below, this, filling up nearly a quarter of the page in equally huge letters, were the words It'll Make You Feel Good.... Three times in quarter inch bold section headings the message was repeated. "You'll Feel Good ... knowing that you can help stop her hunger. You'll Feel Good ... knowing that Jesus' love for children has been demonstrated through your compassion. You'll Feel Good ... knowing that you're touching this hurting world." "please become a sponsor today," it concluded: "You'll

feel good about it.

"It is hard to imagine Jesus saying to his disciples," Wuthnow quibbed, "'Take up your cross and follow me - it'll make you feel good.'"

The emphasis we place on good feeling concerns thoughtful observers. "When we have to express everything that's loving and caring and socially responsible in terms of 'what it does for me,'" sociologist Robert N. Bellah worries, "that begins to undercut the very nature of those practices."[10] Theorist Daniel Bell sees our pursuit of emotional gratification as symptomatic of our loss of faith in objective truth[11]:

> The collapse of our confidence in absolutes results in personal insecurity -- a crisis of self-identity. To escape, we attempt to dissolve the boundaries between ourselves and others. We frantically pursue intimacy among friends and family, all the time in hopes of making ourselves feel better. We may do the same in our fleeting efforts to help strangers ... but the underlying problem is how we feel about ourselves. We desperately want to be fulfilled, much more so than we desire to be of help.

Feeling good is not the only way we derive fulfillment from our "compassion." Caring for others also lets me be "all that I can be." It makes me feel successful. It gives me self-esteem. It rounds out my personality. It promotes my personal growth. One respondent in Wuthnow's survey compared caring to muscle-building. "Each time you care you become a little stronger, a little more capable, a little better at helping others."[12] And our growth in self-

sufficiency, self-confidence and self-esteem, in turn, strengthens us to help other people. As John Stuart Mill put it, "In proportion to the development of his individuality, each person becomes more valuable to himself, and is, therefore, capable of being more valuable to others."[13]

"Our emphasis on fulfillment consists ultimately of a gift we give ourselves," Wuthnow observes, "rather than a true gift that forges social bonds through its exchange." In contrast to true gifts the fulfillment of which, according to sociologist Alvin Gouldner, depends on the reciprocation of gift from the recipient[14], our fulfillment from caring "is instant gratification." Compassion by this account becomes "cheap, overly psychological, utilitarian, focused on the needs and interests of the giver."[15] But this criticism speaks more to the nature of our society. Wuthnow argues that "getting fulfillment from those we help fits very well with the anonymous, segmented society in which we live. It is the perfect arrangement for a society of strangers."[16]

The emphasis on fulfillment from feeling good about and rounding out the self, what Wuthnow calls the "therapeutic motif," puts the needs of the caregiver before those of the cared-for. Sixty-six percent of respondents in Wuthnow's national survey agreed that "you have to take care of yourself first, and if you have any energy left over, then

help others".[17] That is, I can choose to care, but I am also free to quit -- if it gets to be too much for me. Our individualism motivates compassion of a certain kind, but also limits it. We bind our compassion in order to free ourselves. Caring too much violates the self-boundaries of the caregiver and the cared-for; it weakens self-sufficiency and therapeutic efficacy for both. We call it obsession. We call it co-dependency. The central message of the therapeutic motif is to take care of ourselves before we can take care of others. Burnout results from giving too much of ourselves. Self-sacrifice is too much to ask. While 42 percent of the public in Wuthnow's survey agreed that "I want to give of myself for the benefit of others" was a major reason for them to be kind and caring people, only 15 percent in a subset of the survey agreed when the question was reworded as "I want to sacrifice myself for the benefit of others."

We also limit our compassion by creating a distinction between our roles and our selves; that is, by confining it to institutionalized roles rather than embodying it as a whole way of life. We see compassion as what we do but not who we are. "[A] role is always bounded, whereas a self is not," Wuthnow illustrates the distinction. "I can take a vacation from my roles; I cannot take a vacation from myself."[18] It is easier to discharge the requirements of a compassionate role than practice the commitments of a

compassionate self. "[W]e help out at the senior citizens' center one evening a week," Wuthnow observes, "rather than simply trying to be do-gooders in everything we do."[19] Being a caring volunteer, or a caring doctor, does not commit myself to being a caring person in my everyday life. It leaves me room for non-caring activities.

Not only do we limit our compassion individually, we also limit our compassion collectively. Caring rests, first and foremost, on the volition of the individual; only when individual charity fails do we look to collective compassion for help -- but a compassion that is preferably voluntary, private, and decentralized. So what if it doesn't solve our problems -- more than half (57%) of the public agrees that "charities provide 'Band-Aids' instead of really solving our problems"[20]; that does not matter -- we are still making a difference, one person at a time. Wuthnow's survey found that 72 percent of the public agreed that "[p]rivate charities are generally more effective than government programs". While one in two believes that "getting everyone who could to donate five hours a week to volunteer organization" would help a lot in the making of a better American society, only one in five thinks that "spending more money on government welfare programs" would and 42 percent of the public think it would not help at all.[21] But even our confidence in voluntary associations is belied by our mistrust of institutions. While charities beat

business, organized labor and the U.S. Congress by a margin of two to one (46% versus 21%, 22%, and 28%, respectively) in the vote of public confidence,[22] 75 percent of the public agreed that "many charities fatten the pockets of their administrators instead of really helping the needy."[23]

In sum, our individualism is not at odds with our compassion at all. Indeed, it is our individualism that motivates our compassion. Our compassion is not about helping the other; it is really about giving to ourselves. It is about our freedom, in that it expresses our autonomy and non-conformity; it is about our success, in that it gives us self-esteem, lets us be "all that I can be"; and it is about our self-interest, in that it makes us feel good about ourselves. But we also set limits to our compassion, lest we get burnt out, become co-dependent, or lose our selves or our freedom. We will see later that American doctors' compassion is like this; individualism generates a certain kind of compassion in American medicine, but also limits it.

Let us look first at a compassion of a very different sort to see how ours is limited.

Moon in Hundred Bowls of Water[24]

The Bodhisattva Avalokitesvara looked down into the many hells and saw that they were filled with suffering beings.

A great vow spontaneously arose in his heart. "I will liberate all beings from the sufferings of the hells," he said. And so through countless ages he labored, descending into and emptying hell after hell, until the unimaginable task was at last done.

The great Bodhisattva ceased then from his eons of heroic exertion. He wiped the glistening diamonds of beaded sweat from his brow, and looking down into the now empty, silent hells, smiled. It was done. Here and there a curling wisp of smoke still rose up. Now and then, in some vast cavern far below, faint echoes sounded as a loose brick shifted on a pile of rubble. But the raging fires had been quenched and the great iron cauldrons were quiet. Sweet silence flowed through the dark halls. Even the demons were gone for they too, in the end, had been released, liberated to the heavens, by the mighty efforts of the Compassionate One.

But what was this? Suddenly, there came a wailing scream, then another, and another. Flames leapt, clouds of smoke whirled, blood-filled cauldrons bubbled madly. The radiant smile faded from the Bodhisattva's face. Once again the hells were entirely filled. In less than an instant all was exactly as before.

The heart of the Bodhisattva Avalokitesvara filled with sorrow. Suddenly his head split into many heads. His arms shattered into many arms. The one thousand heads looked in all directions to see the sufferings of every being. The one thousand arms were enough to reach into any realm, to save those in need.

Rolling up his one thousand sleeves, the great Bodhisattva settled down once more to the unending task.[25]

Avalokitesvara is worshipped throughout traditional Mahayana countries as the embodiment of compassion. As Lama Govinda explained the iconography, "in the palm of each hand an eye appeared; because the compassion of a Bodhisattva is not blind emotion but love combined with wisdom. It is the spontaneous urge to help others flowing from the knowledge of inner oneness." An American student of Buddhism takes it to signify "dependent co-arising": no one is saved until all are saved. There is no independent liberation; there is only interdependent salvation.[26]

Buddhism is prolific on compassion. And the compassion it teaches is very different from the compassion we know. Take the following jataka, for example:

> Once, long, long ago, the Buddha came to life as a noble prince named Mahasattva, in a land where the country of Nepal exists today.
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> One day, when he was grown, he went walking in a wild forest with his two older brothers. The land was dry and the leaves brittle. The sky seemed alight with flames.
>
> Suddenly, they saw a tigress. The brothers turned to flee, but the tigress stumbled and fell. She was starving, and her cubs were starving too. She eyed her cubs miserably and, in that dark glance, the prince sensed her long months of hunger and pain. He saw, too, that unless she found food soon, she might even by driven to devour her own cubs. He was moved to compassion by the extreme hardness of her lives.
>
> "What, after all, is this life for?" he thought.
>
> Stepping forward, he calmly removed his outer garments and lay down before her. He tore his skin with a stone and let the starving tigress smell the blood. Mahasattva's brothers fled.

> Hungrily, the tigress devoured the prince's body and chewed the bones. She and her cubs lived on, and for many years, the forest was filled with a golden light.
>
> Centuries later, a mighty king raised a pillar of carved stone on this spot, and pilgrims still go there to make offerings even today.
>
> Deeds of compassion live forever.[27]

What, after all, is this life for? Prince Mahasattva's compassion is generated from certain presuppositions about life that are radically different from our own. All life is sorrowful and the cause of suffering is the ignorant craving of sentient beings. This enlightenment makes it easier to offer one's own flesh in self-sacrifice. All life is connected and compassion (karuna) arises from our Buddha-nature (sunyata). This enlightenment makes it easier to identify with the suffering of the other.[28]

Compassion for What? Compassion for Whom?

A life lived for the self, in contrast, gives of itself less freely. And when it gives, it is really giving to the self. Man is selfish, the preponderant Western view goes, and so is his compassion.[29]

Niccolo de Bernardo Machiavelli found man to be "ungrateful, fickle, false, cowards, covetous."[30] "All society ... is either for gain, or for glory," Thomas Hobbes[31] believed that "[n]o man giveth but with intention of good to himself, because gift is voluntary; and of all voluntary acts, the object is to every man his own good."

"The most disinterested love is ... a kind of bargain," La Rouchefoucauld[32] observed, "in which the dear love of our own selves always proposes to be the gainer some way or other." "Pity and compassion ... is an ingenious foresight of the disasters that may fall upon us hereafter," he argued. "We relieve others, that they may return the like." His argument merely extended Thomas Aquinas' account of mercy, which Aquinas attributed to Aristotle, that "men pity such as are akin to them, and the like, because it makes them realize that the same may happen to themselves."[33] Bernard Mandeville[34] claimed that our natural state is one of self-interest, and a man's noble action is "enjoyed in self-love, whilst he is thinking on the applause of others." Jeremy Bentham[35] thought "the greatest happiness for the greatest number" could be attained by contriving "a harmony of selfish interests."[36] John Stuart Mill[37] professed that the "utilitarian morality does recognize in human beings the power of sacrificing their own greatest good for the good of others. It only refuses to admit that the sacrifice is itself good." We care for the happiness of others "in the hope of favor and the fear of displeasure" or from "a pain ... attendant on violation of duty." And Friedrich Nietzsche[38] declared the "morality of unselfing" immoral: "all so-called 'selfless' tendencies, in regard to the whole 'love of one's neighbor' ... are signs of weakness.... The overcoming of pity I reckon among the noble virtues."

There were notable exceptions to the "selfish hypothesis" of compassion. Jesus commanded us to "[l]ove your enemies, and do good, and lend, expecting nothing in return."[39] In early Christianity, the notion of agape referred to "self-sacrificial or selfless loving kindness, a giving of self to others."[40] Abelard interpreted the crucifixion as "an act of atonement, at-one-ment, ... to evoke in man's heart the sentiment of compassion for the suffering of life, and so to remove man's mind from blind commitment to the goods of this world."[41] Rousseau spoke of "l'impulsion interieure de la compassion" (the internal compulsion of compassion), derived from "la repugnance naturelle" (a natural repugnance) to see the suffering of others.[42] We feel pity for the suffering in our midst much as cows lowed in anguish for a fallen comrade.[43] This "natural sense of pity," however, can become subverted by the drive for self-preservation ("la conservation de soi-meme") and, worse yet, subdued by self-love in civilization.[44] David Hume[45] argued against the "selfish hypothesis" by positing that compassion is obvious: "A man that grieves for a valuable friend ... how can we suppose that his passionate tenderness arises from some metaphysical regards to a self-interest, which has no foundation or reality?" Adam Smith also recognized a "pity or compassion, the emotion which we feel for the misery of others."[46] "How selfish soever man may be supposed," Smith contended, "there

are evidently some principles in his nature, which interest him in the fortune of others ... though he derives nothing from it except the pleasure of seeing it."[47] Why would a human being, spontaneously, without thought, sacrifice his own life to the other? Arthur Schopenhauer asked.[48] His answer was that this "represents the breakthrough of a metaphysical realization, which is that you and the other are one, that you are two aspects of the one life, and that your apparent separateness is but an effect of the way we experience forms under the conditions of space and time." Schopenhauer, whose philosophy was much influenced by Buddhism, took this sense to be the driving force ("Triebfeder") of ethics.[49]

So are we really just doing ourselves a favor when we do good for others? Or are we naturally compelled by pity or compassion to help, untouched by our self-interest? Are we, by nature, egoists or altruists?[50] Compassion for whom? Compassion for what? Is our compassion for the other, or is it really for ourselves?

That depends on what you mean by the self -- how much of the other is the self, how much of the self is the other. The dichotomy between egoism and altruism disappears when the self and the other converges, becomes one. When we realize that "the other is no other than myself," the

other's suffering becomes my suffering which is compassion. Yasutani Roshi points out that the fundamental delusion of humanity is to suppose that I am here and you are out there.

But that is how most of us think. I am here and you are out there. There is a space in between us. We are connected to each other by that space, but we are also separated from each other by that space. What compassion there is between us depends on what is in the space between us. That is, **our compassion may depend on what is in between us as much as what is in us.**

Neurophysiological research has localized compassion to the amygdala and its reciprocal interconnections with the hypothalamus and temporo-parietal association cortex.[51] This pathway is also the neural substrate for fight or flight, which makes compassion just about as natural as aggression. The amygdala is said to be

> strategically located for generating rapid and specific autonomic and endocrine patterns in response to complex social signals. The survival value of such a system is obvious: the perception of another individual's approach should give rise to a specific pattern of cardiac output and respiration -- and very quickly -- tailored to whether the intent is to bite, to have a quiet grooming session, or to copulate.[52]

So our drive for self-preservation, to fight or to flight, and our internal compulsion for compassion may share a common pathway. We have it in us to be compassionate toward

each other, but we have it in us to be aggressive and destructive toward each other as well. Whether I am compassionate or aggressive to you depends on whether I see you as one of us or one of them. It depends on what is in between us, a connection or a separation.

On seeing the hungry tigress, Mahasattva's brothers fled for their lives while he offered his own. Which is more natural -- their drive for self-preservation or his compulsion for compassion?

Both are natural, from their points of view.

Mahasattva's brothers saw the tigress as an aggressor, a predator to whom their natural response was to fight or to flight. In between them and the tigress were the laws of the jungle, of selection, of survival of the fittest. The natural thing to do was to separate themselves from the tigress as far as possible, to increase the space in between.

Mahasattva saw it differently. He saw the tigress as an extension of himself in space and time. He saw her suffering as his own. In between them were not the laws of the jungle, but certain truths about life. Life is suffering, caused by holding on to what we have and craving for what we do not have. By giving himself to the tigress, he relieved the sufferings of both. Decreasing the space in between makes less room for suffering.

Now you may still think that Mahasattva's brothers' flight was more natural than his pity, that self-preservation is more innate to us than compassion. Let me give you another example. A mother or a father loves a child. The child becomes ill. The mother or the father suffers with the child. That seems natural enough. After all, our "deepest and most central joy," self-psychologist Heinz Kohut affirms, is "that of being a link in the chain of generations."

Not so, Sigmund Freud argues, parental love is "nothing but the parents' narcissism born again." The child is but "an external object that is part of their genetic 'flesh and blood' and whose well being and success enhances the parents' self." Because we are inherently driven by our libidinal and aggressive drives for our own survival, any "feelings of compassion ... necessitate the notion of a reaction-formation," even feelings for our own children.[53]

So which is it -- is compassion a natural extension of parental love or a reaction formation against inter-generational strife? It may very well depend on what is in between the parent and the child. D. W. Winnicott argues that the development of the capacity for concern in a child depends on a stable and dependable mother-child relationship.[54] Heinz Kohut points out that "it is in response to ... a flawed parental self which cannot resonate with the child's experience in empathic identification that

the newly constituted assertive-affectionate self of the child disintegrates." He reminds us that "[i]s it not the most significant dynamic-genetic feature of the Oedipus story that Oedipus was a rejected child?"

We know that abused children are less likely to respond with empathy, and more likely to respond with aggression, to other children in distress, and they are also more likely to become abusive parents when they grow up.[55] We think that narcissistic personality disorder may be caused, in part, by the absence of empathic support from caretakers during child development.[56] Narcissism and aggression may be the only natural response to neglect and abuse in childhood, just as empathy and compassion may be part of normal development only with caring and nurturing. The reactive cry of a neonate on hearing other neonates cry has been interpreted as manifest of our innate capacity for empathy.[57] But whether or not the newborn will grow up to be compassionate still depends on what will come between it and its caregiver, more than what is in it already.

Evolutionary biologist Daniel Kriegman tells us that reciprocal altruism may confer selective advantage: "People who can trade such acts will have a significant advantage over nonaltruists or those excluded from reciprocal arrangements." This is no new insight; he merely restated Aristotle, Aquinas and La Rouchefoucauld in evolutionary terms. "The obligation to bring assistance to one's fellow,

or brotherly love," Max Weber observed, "was derived ... from the primordial organization of the neighborhood group. The nearest person helps the neighbor because he may one day require the neighbor's help in turn."[58] Kriegman cites as an example the reciprocal acts of compassion amongst the residents of a Calcutta leper colony, documented in Dominique Lapierre's City of Joy,[59] which inspired my investigation into the nature of compassion.

The new insight that Kriegman gives is his attention to the context of reciprocal altruism -- the space in between. He argues that reciprocal altruism has three prerequisites: "(1) high frequency of association, (2) reliability of association over time, and (3) the ability of two organisms to behave in ways that benefit the other."[60] In other words, reciprocal altruism evolves from dependable interdependency. But not from independence or unreliability. Konrad Lorenz accounts for the love of neighbor as "a matter of course if he is your best friend and has saved your [life] a number of times: you [reciprocate] without even thinking."[61] But if I helped my neighbor when he was in need, and when I needed help he gave me none, I think twice about helping him next time he is in need. It has even been suggested that "man's swollen brain, ... evolved as a mechanism of ever more devious cheating, and ever more penetrating detection of cheating in others."[62] Compassion may be natural in the City of Joy

because that is the kind of people they are and the way of life they live, but it can be unnatural elsewhere where people are less dependable or less interdependent.

Social psychologists have found that "[h]elping is more likely when people share a sense of common fate."[63] "This sense of interdependence is easily disregarded in our society," Elliot Aaronson worries, recalling the murder of a woman in New York City that was witnessed by thirty-eight of her neighbors, none of whom came to her aid, "the predominant explanation given by the 38 on-lookers to the Genovese murder was, 'I didn't want to get involved.'"[64] I am here and she is out there.

Social psychologists have also found that "people help less when the costs of their assistance are high." In one experiment in which subjects enlisted from Princeton Theological Seminary were to deliver a speech, over half of the students stopped to help a "victim" along the road when they were told that they were on time, while only 10 percent offered help when told that they were late for the speech, even when the speech they were to deliver involved the parable of the Good Samaritan![65]

In another experiment,[66] researchers found that subjects who were made to feel high level of empathy toward an accomplice of the experimenter found in distress from electric shocks were significantly more willing to take the shocks for her than subjects who were made to feel less

empathy. High-empathy subjects were just as likely to help even when given a easy way out of feeling bad or guilty about not helping. So far so good -- we help others not only to reduce our own empathic distress or avoid punishment, as behavioralists suggest.[67] But researchers also found that when subjects were informed that the shock was to be "[c]learly painful but not harmful," even high-empathy subjects took the easy way out if they could. This led the researchers to conclude that "any altruistic motivation that blossoms from feeling empathy may be a fragile flower, easily crushed by overriding egoistic concerns."[68]

The Anatomy of Compassion
and
The Ecology of Compassion

I mentioned earlier that compassion means to suffer with. But how does one person suffer with another? How does a doctor suffer with his or her patient?

I have identified three moments of compassion, drawing inspirations from a variety of works reviewed above.[69] To suffer with the other requires us to

1. **Pay Attention to the Suffering**
2. **Identify with the Sufferer**
3. **Respond to the Suffering**

Compassion takes attention, identification, and responsibility. Did Sam's doctor paid attention to his suffering? Did he identified with Sam in what he was going through? Did he respond to Sam's suffering with compassion?

Attention. In the first moment of compassion, we attend to suffering. We do not turn away. We do not pass by on the other side. We pay attention to what is going on[70]:

> When we are giving our full attention to something, when we are really attending, we are calling on all our resources of intelligence, feeling, and moral sensitivity. This can happen at work, at play, in interaction with people we care about. At such moments we are not thinking about ourselves, because we are completely absorbed in what we are doing ... it is in such moments that we are most likely to be genuinely happy.

"There is something overlapping about being present and compassion," one physician who is also a Zen practitioner explained. "Being more fully there is another way of saying being compassionate." In Japanese Buddhism the phrase "mono no aware wo shiru" means "to be aware of the pity [sigh] of things."[71] Aware is described as "an echo, very gentle, of the deep pang of the young Prince Gautama in his own palace period of the realization of death," and it is being mindful of these gentle echoes that our compassion is awakened.

But we are easily distracted by our self-absorption. It is hard to really pay attention to someone else when we are thinking about ourselves. But it is "me" that we are told to attend to. Economists like Milton Friedman tell us

we are self-interest maximizers. "Psychology and psychiatry ... not only describe man as selfishly motivated," psychologist Donald Campbell points out, "but implicitly or explicitly teach that he ought to be so."[72] All the self-theories in the past decade -- "self-awareness," "self-monitoring," "self-presentation," "self-evaluation maintenance," "symbolic self-completion," "self-affirmation," "self-expansion," and various "self-esteem" theories, to name a few, as well as social exchange theories and even communal relationship theories, "all seems to come back to looking out for 'Number One.'"[73] In a culture of utilitarian and expressive individualism, our self-absorption with self-esteem, self-interest, and self-expression makes it difficult for us to pay attention to anyone but ourselves.

Identification -- In the second moment of compassion, we identify with the other in his or her suffering. Paying attention is not enough to generate compassion if we cannot see the suffering from the other's point of view. Piaget describes empathy as the "ability to put oneself in the place of another's experience and view the world through that person's eyes."[74] But "perspective-taking" is not enough to generate compassion if we cannot identify with the other in some way. Psychologists found that such "connection can be superficial": demonstrators at an anti-Nixon rally offered more assistance to an accomplice

carrying "Dump Nixon" placard than one carrying "Support Nixon" placard.[75] A more enduring connection, as I mentioned, is generated from a sense of interdependency. Identity of suffering is generated from a sense that the self and the other are one.

But the process of identification can also divide "us" from "them". Compassion can be used, by reinforcing solidarity within the in-group, to sensitize prejudice against the out-group. "It is a fault," John Donne admonished his congregation in a sermon, "to bee too compassionate of an Heretique"[76]; the same John Donne who is remembered for "any man's death diminishes me,/ because I am involved in Mankind;/ And therefore never send to know for whom/ the bell tolls; It tolls for thee." How compassionate you are depends on how large the group with which you identify: yourself, your clan, your class, your race, your country, your religion, your species, your genus, ... your kingdom, your planet.

Responsibility. In the third moment of compassion, we respond to the other's suffering. That may take stopping along the road to help a victim, offering your flesh to a hungry tigress, descending into and emptying hell after hell, or doing nothing but to suffer with. The important thing is that you respond to the suffering of the other with your own, that you suffer with. Now you might wonder why you yourself have to suffer and how your suffering might

help the other. You just do; you respond to suffering with suffering and expect suffering in response to your suffering.

That may be too much to ask of you. Compassion is supposed to make us feel good, not sorrow. We forget that "[r]eal love is always painful and hurts," as Mother Teresa knew, "then it is real and pure."[77] "Anyone who experiences the woes of this world within his heart," Albert Schweitzer learned, "can never again feel the surface happiness that human nature desires."[78] "To say that it does not require time and energy, to deny that one can become worn out in doing good, to obscure the fact that real dangers and risks may be necessitated," Robert Wuthnow warns us about compassion[79], "is simply to lure people into a false understanding of caring that is unlikely to prove enduring." Compassion has costs. Responsibility has costs. I mentioned earlier that compassion is "a fragile flower, easily crushed by self-concern." Our self-concern make us less responsible to the suffering of others, especially if responsibility is going to cost us some of our success, self-interest, and freedom.

A Transition

Compassion is not, as one doctor suggested, "something you either have or you don't so don't worry about it." Compassion depends on what is in between and around us as much as what is in us. The source of compassion is not only individual, but it is institutional and ecological as well. So asking individual doctors to be more compassionate, without doing something about the institutional pressures and temptations for self-concern that American medicine puts doctors through, does not help us get at the root of the problem.

We are under pressure to succeed in medical school. We are tempted by self-interest in practice. We are bound by freedom in our relationship with our patients. Compassion is important to us, but so are our success, self-interest, and freedom. We want to be compassionate doctors, but in our culture of individualism our compassion is limited.

Let us turn our attention now to how individualism generates and limits our compassion in American medicine.

IV.

COMPASSION AND SUCCESS:

The Limits of Our Medical Education

If "two of the most basic components of a good life are success in one's work and the joy that comes from serving one's community,"[1] then American doctors have it made. They do well for themselves from doing good for their patients.

Americans want success. But we all know that "a selfish seeker after purely individual success could not live a good, happy, joyful life."[2] So we want to do good for others, too. Our problem arises when the "individual's need to be successful in work becomes the enemy of the need to find the meaning of one's work in service to others."[3] Doctors have no such problem, supposedly.

But many doctors do have problems. The data on physician impairment belie the supposed joy of success and compassion[4]:

> suicide rate of physicians is two to three times that of the general population, equal in number to the loss of about two medical-school classes yearly. Alcoholism is at least as prevalent among physicians as in the general population, and underreporting of physician-alcoholics is likely. Drug addiction may be 30 to 100 times more common among physicians than in the general population; a controlled study showed that heavy drug use, including use of alcohol, was 1.6 times more frequent among doctors than in a comparable group of nonphysicians. Physicians are also more likely to have had 10 or more visits to a psychiatrist

than are controls."

What went wrong? Doctors are envied for their success and joy, but these doctors seem to get neither.

And their problems may have begun early in medical training. Studies have found that 30 to 40 percent of interns had experienced at least one major depressive episode, 7% had abused alcohol, 9% had abused illicit drugs.[5] Even earlier on, up to half of medical students are shown to need psychotherapy, suicides are second in number only to accidents as a cause of death among medical students, and drug abuse is common.[6]

Even without psychopathology, most medical students do not seem to enjoy their success. One study found that three-fourths of students reported that they were more "cynical about academic life and the medical profession than when they started out" and more than half of students would not recommend that their friends or children go into the medical profession.[7] So much for success and joy.

In this chapter, I will argue that our unremitting pursuit of success in becoming a doctor detracts from the joy of compassion in being a doctor. Our preoccupation with success, and our anxiety about failure, institutionalized in our medical training, make it hard for us to be compassionate to each other and to our patients. We ignore the sufferings of success and avoid the sufferings of failure. The only sufferings we let ourselves suffer with are those we can successfully relieve. That is,

success generates a limited compassion, limited by our success and failure in becoming a doctor.

Pre-medical Education

Jessica had wanted to be a brain surgeon ever since she was in the fourth grade. She dropped out at the end of her sophomore year in college.

Her reasons for dropping out? "O[rganic] Chem[istry] had a lot to do with it." She did poorly in it, and she knew friends with higher grade point average who were not getting into medical school.

"A lot of people around me were very ambitious," Jessica added. "I could never achieve that level of competitive drive." "There are some people for whom it's a game to get in [medical school] at all costs. The only object is to win, no matter what gets in the way." She cited examples of classmates who kissed up to the professor, slept with the teaching assistant, or cheated on midterms in order to get ahead, to get an A.

"You never feel secure," recalled Sanjeev, a college senior now applying to medical school. "Always doubting yourself. Always comparing yourself with someone else. I did lousy in some courses my freshman year. While I seemed happy on the outside, I was not all that happy when I got my midterms back. And when you did bad, inside you feel the pressure of someone who did better than you."

The competition depressed Jessica. "The first year I said to

myself: 'I'll work harder!' The second year I became suicidal. I came home one day and turned on the gas stove, but I couldn't go through with it." She felt as if she were "falling through a hole." "I couldn't change the world," she realized. "People wanted, demanded, expected things done in a certain way, and I just couldn't do it."

She also felt isolated. "Everyone was too busy." "The typical premed," she observed, "spends the entire weekend studying." "Freshman year I was isolated," Sanjeev confessed. "I never did anything on weekends but study." Even when he was around friends, he felt isolated. "We are all going to med school; we are all competing so hanging out is superficial."

Jessica wanted to be a brain surgeon because she thought a brain surgeon is "someone who knows how to fix things; someone who could totally control things; someone who is not a weak person." Now she worries about "having someone's life in [her] hand and not knowing what to do." She saw her predisposition for uncertainty and hesitation unfit for medicine.

Pre-clinical Education

"In medical school, medical students are viewed by how well they memorize, how fast they can recall a list of differential diagnoses," Nicole deplores. "Personality they show are not important any more."

"I was feeling low self-esteem," Nicole, now a third-year medical student, recalled her sufferings during her first two

years. "Standard is set by what is worthy of praise, not standard I'm used to. So either you get punished all the time, or you balance it with a few pats on your back."

"I had to develop an inner confidence to buffer myself from feeling inadequate, as viewed by my professors," Nicole told me how she had coped. "You've got to make sure you're doing okay because nobody else is going to make sure you are doing okay."

Not her professors (with a few exceptions). One told her that "life is tough so go do your work." That same professor told me that "not condon[ing] unacceptable behavior of the teaching faculty" would go a long way in making doctors more compassionate.

And not her classmates. "I didn't feel supported. I can't really say someone made me suffer, but my classmates being more compassionate would have reduced my pain." But she is not bitter. "I've become more tolerant of others. All of us have less energy and so less compassion with the suffering of each other.... I have become more realistic with my expectations of others and their limitations."

But she has become more realistic with herself, too. "I've also become more self-protective. At first I was reaching out constantly. But when again and again, I was feeling down and nobody notices or cares, then I thought to myself maybe it's not realistic to expect others will do the same for me." "I feel a little sad I don't reach out anymore, but I also feel more compassionate when other people don't reach out."

She was not alone in her isolation. Many medical students I spoke with, including some of her classmates, shared her isolation. "Each person has to make a definition of his or her own life," Rajeev confided in me, "I don't have a strong relationship with another human being ... my life is not defined. So it has to be defined through my work. I found the only way to put meaning in my life is through scientific discovery." Contributing to his sense of isolation is "living in a culture away from [his] own."

But just studying alone can be isolating. "You have more and more amount of studying to do and less and less time with human beings," Nicole bemoaned. "It's an alienating sort of thing, spending time focused on studying more, more, and more until you get to a point that you don't feel any more. You feel unfeeling, dull, and down." Nicole said she spends "three-fourths of [her] life studying" and feels really "out of balance."

Clerkship

"If you don't have a good sense of who you are, they'll try to break you," Diana taught me two cardinal rules for surviving the third-year clerkship, which she took from an essay advising sponge divers on "how to swim with sharks"[8]:

"Do not bleed."

"Get out if someone is bleeding."

"When they criticize you, don't take it personally. You can't take things personally. Just roll with it. Be flexible."

She agrees with the author's observation that "bleeding prompts an even more aggressive attack." Surgical house-officers are notorious for their blood-thirst. "The game that surgeons like to play is to ask you 'are you sure about that?' If they sense you are unsure, they'll try to break you. So even if you don't know it, you have to say you don't know in a certain way .... You almost have to have a certain arrogance to survive."

Despite the analogy, she attributes benign intentionality to the attacks by the house officers. "I think the thing is you want people to gain confidence," she comes to their defense. "At this point, [medical students] need to learn to put their foot down and take a stand. You don't want a wishy-washy doctor."

A corollary to "don't bleed" is "don't whine." Although most medical schools have set up formal grievance process for students, one never knows "well, are they going to believe me or [the house officer]?" Also, one fears retribution: "once [the house officer] hears, is that going to affect my evaluation?" "Are they going to see me as a complainer?" And for women harrassed by "a lot of sexual jokes and innuendos," especially in surgery, Diana just accepted that "you can't do anything about it because if you do, they'll say you are a straight lace." Most medical students end up not doing anything about their problems.

But "most medical students don't have problems with their house officers," Diana reassured me. Wanting to be "part of the team" was more her overriding concern. "You want to be a part of everything; it's kind of like a herd mentality." Indeed, what

bothered her most during her third year was the sense of "not knowing what my role was," feeling like an "extraneous and excess baggage."

"A lot of times they do things without telling you." She remembered "waiting around the whole afternoon for them to call [her] in to the evening round for surgery and they don't call. When I run in, they tell me they've rounded already." But again, Diana attributed benign intentionality to the house officers. "They are just too busy. They would like to be home, so they let you go home for them vicariously. Soon enough you stopped caring, too. You just want to get your work done and get out of there."

Scott knows what "team" pressure is like. He wanted to cover up a patient exposed from the waist down and forgotten by his attendings and residents during a work round. But he hesitated. He did not want to show up his team. "The old man was just lying there, the abscess in his groin exposed to everyone [in a large, open ward], and the chief resident just talked over him to the students, as if he weren't there." Eventually, Scott summoned his courage and pulled the bedsheet up for the patient. "I decided that they [house officers] are just human anyway -- and some of them are jerks. I didn't care what they thought of me anymore."

Diana was lucky; she has had attendings and residents who expected "medical students ... be more caring than the interns than the residents." She explains the division of labor for

caring, "The attitude is that [medical students] still have the time and the desire to care. They are still early on in their training -- they still care about patients. It's all fresh and new; with more workload it's easy to lose it." Some attendings have admonished her to never forget to cover the patient up when they forget to do so themselves.

Although most of her attendings and house officers tolerated her spending time with the patient, they were less patient with her wasting their time. "If you spend a lot of time on the patient's social history, they'll tell you to cut it out or say that it is typical of a med student presentation.'" The patient's social history is "something that goes out the window if you are in a hurry." She usually reports only the patient's marital status and occupation, occassionally adding "what is vital for the patient's present illness."

She, in turn, expects nurses to spend more time with the patients. Diana found that "the more time I spend with patients, the more they think I am a nurse." Being perceived as a nurse by her patients bothers her. She admitted she did not consider nurses part of the "team". "They know a lot about the patient; they are good about telling you how the patient is doing," she remarks, "but they don't know what to do." For that reason, she and her house officers usually found it unnecessary for nurses to go on work rounds with them.

Diana said that approval from her house-officer was more important than appreciation from her patients during her third

year. "Approval from your residents shows up in your evaluation," she distinguishes the two sources of motivation. "Approval from your patients is what keeps you going." She then reveals what was more important to her. "Sometimes you do all these things for the patient and no one seems to appreciate or care what you've done for her. So you tell yourself, 'why waste time?'"

How her house officers treated her patients rubbed off on her. "You see them not spending time with patients, so you learn not to spend too much time with patients. You hear them writing off a patient -- 'she's pain in the neck,' and you learn to write them off too." Don also told me that "as a medical student you look up to interns and residents." He found that "often times they don't exhibit compassion." But nonetheless "you try to emulate them ... their ways of being efficient." "Often times efficiency and compassion are not compatible," he concluded.

Diana, now finishing her fourth year in medical school, is going into pathology because "pathologist knows the most." "In pathology you get answers." In contrast, in medicine "you keep treating and comforting, but treatment don't always work. [You] don't heal; [you] just palliate." She became cynical about becoming a doctor during her clerkship. "A lot of time you can't do good. I want to help people, but some people you just can't help."

Who are they?

"People with self-inflicted diseases," she names them.

"Smokers, chronic alcohol abusers, IVDU's, homosexuals, promiscuous heterosexuals, AIDS patients, teenage pregnancy...."

Residency

"I think the main thing this year is the physical demand that's put on you," Alex reflected on his first year of residency in ENT (ear, nose, and throat). "It is harder to be nice to people when you are tired."

On an average week, Alex worked 113 hours a week in the hospital, fourteen hours a day when he was not on call. He was on call every third day (which usually means you stay up all night) and had one day off every three weeks.

"You want to spend more time with your patients," Alex regrets, "but there are so much demands on your time. You have to keep minimum responsibility for each patient and draw your line." On some services, Alex was responsible for twenty-five to thirty patients. "So you say to them: 'I'd love to spend more time with you, but I gotta go.' ... It's the time factor. It's really frustrating."

This was especially true in the emergency room, where Alex spent much of his first year. "The ER is a brief encounter, and some of [the patients'] background are not what you can relate to .... You really feel for these people. The compassionate thing to do would be to take them and go over their concerns with them." But, Alex realized, "you have a job to do and that's to

get them in and out of the hospital. You are not going to solve their problems."

Would he like to have had more time with each patient? "That's ideal.... It's harder to get to know your patients when you don't know what issues concern them." Alex remarked, "but it's hard to think of ways that are possible."

Why not?

"That's the question," Alex was amused. "It's economic. Hospitals like to have lots of interns and residents ... and pay them less than minimum wage. But there's a secondary effect which is the loss of connecting with your patients.... Why can't they hire more people? Because they are not going to put more money into it."

At an annual salary of $29,700, Alex was making $5.05 an hour. Five years ago his salary would have been less than $3 an hour.

"But you don't look at it that way," Alex quickly pointed out to me. "In general you just try to enjoy what you are doing ... try to know some patients. That's what makes the whole rigmarole meaningful. Otherwise it's assembly line medicine. Anyone can get burnt out."

"I may not connect with every patient, but you just try to do something nice for them, like getting a cup of water or a bedpan. That's one way of attending to their needs. Sometimes you just sit down and talk with them even if you have to be somewhere else and just absorb the penalty for being late."

In contrast, Alex observed that for many of his peers,

medicine is an "intellectually challenging career." "Patient contact is not necessary for a lot of people. You are still a doctor."

"I ...," here Alex paused, perhaps embarrassed by the contrast he was about to draw. "I don't know," he continued hesitantly, "I want to have fun, too."

"It's an individual decision they have to make," to be or not to be compassionate. "I see compassion as an inherent quality of people that gets stretched by the demands that are put on them.... If someone don't see himself as compassionate, give him more time will not make him more compassionate." Some people have it, and some people don't. Therefore, residency reform, such as that in New York, will not make residents more compassionate. "You give him more time, he might not spend it with patients. He might go wind-surfing instead."

Some attendings have it, and some attendings don't. "I learn from both." "It's not necessary that they spend a lot of time with a patient to show compassion. An attending can come in and spend a few minutes, and in a few minutes a great bond is formed." Alex spoke admirably of one surgeon who came in and told his patient, 'I want you to be able to trust me. I wouldn't do anything for you that I wouldn't do for my father.' "You can see [compassion] in his face," Alex observed. "The pateint really felt very good about it though he was going to be operated on by this person he has never met. It's a skill."

Alex is also getting better at showing his compassion.

"During third and fourth year, you do not feel very comfortable about your caretaking ability; I spent last year just getting comfortable with the doctor role," Alex reflected. "Now I don't have to spend that much time proving I'm a competent doctor. Now I tell my patient, 'I am going to do a few things with you first, but after that I like to get to know you as a person.'"

What Success and Failure Do to Our Compassion

What do these students have in common?

They speak the language of success and failure. They share a vocabulary of success and failure. So much of what they go through in becoming a doctor is experienced in terms of success and failure.

Suffering, for example, depends on how they are doing.

There are the sufferings that come with success. Competition during premedical years, isolation during preclinical years, abuse during clerkship, and work overload during residency all cause the sufferings of success. We put up with them because they are the price we know we have to pay for success. Often we do not even see these as sufferings, as long as we are doing well.

Take abuse, for example. Three out of four students surveyed at two medical schools reported at least one abusive experience during their four years of medical training.[9] Another study found consistency in the patterns of abuse across ten medical

schools.[10] Most commonly the students were yelled, shouted, or sworned at by faculty, residents or staff, but sexual harassment and discrimination, psychological mistreatment, and even physical abuse were not infrequent.[11] Half of the students of color in one study reported experiencing racial or ethnic slurs, and less-masculine male students and less-feminine female students were more likely to experience abuse, provoked perhaps by homophobia.[12] Abuse was significantly related to psychopathological outcomes, mostly depression and escapist drinking, controlling for pre-existing psychopathology.[13] Most students also felt that the abuse interfered with their emotional health, family life, and physical health.[14] One student summed up her experience as "constant abuse and humiliation ... a sacrifice of 4 years of my life in order to be able to achieve my dream of becoming a caring, compassionate physician."[15]

Despite its frequency, abuse is infrequently reported. Only 16% of abused students in one study had gone to the authorities to complain.[16] Why do medical students put up with the abuse? One-third to one-half of students have observed ethical or professional misconduct in their training, such as alcohol or substance abuse, sexual misconduct, mistreatment of patients, and cover up of mistreatment; but, again, few have spoken up.[17] Why? It is the price you pay for success[18]:

> Because medical students hold the lowest position in the hierarchy of medicine, a fear of challenging authority pervades all aspects of their education. Those who abuse students know they can do so with impunity. Because most students go through medical school, especially the clinical years, without a

> clear idea of the criteria by which they are being graded, they tend to feel that all their actions are scrutinized and strive to minimize conflicts with house staff and faculty.

Diana points to the fear of retribution: "is that going to affect my evaluation? Are they going to see me as a complainer?" She rationalizes their behavior instead. "I think the thing is you want people to gain confidence .... You don't want a wishy-washy doctor."

The third-year of medical school is the "first of total clinical immersion."[19] It is also considered the "year in which the most important phase of socialization is largely completed, when the adoption of the values of physicians is effected." The socialization takes place largely between the medical students and the house officers - the interns and the residents - by a process of identification

> not merely because what [the house officers] can do (always the first word in this world, the second being know) is so prodigiously impressive, but because the immediate goal is not to become a physician in some general sense but - in less than two years - to become a house officer and to learn as quickly as possible the strategies for survival under the inhuman regimes to which house officers are subjected and subject themselves.

Diana identified with their confidence in her rationalization. Don rationalized the lack of compassion among some house officers in terms of the need for efficiency. Confidence and efficiency are the secrets of success, and abuse the initiation into the secret fraternity. One learns how to be a successful doctor by going through the initiation.

I mentioned earlier the importance of the "team" to Diana and Scott. Anthropologist Melvin Konner offers an explanation of his own dependency on the team:[20]

> I have been absorbed into the "teamness" of medical training. During my last few months on the wards I tried to be decent to the patients, but my bonds, my emotional energy - what the psychoanalysts call cathexes - were all with doctors and medical students and, to a lesser extent, nurses. Authentic human feelings flow among members of a team, and these create and stabilize the social organization. It is the job of this organization to deal with the patients, but the patients are outside of it. Relations with them should be smooth, cordial, and efficient, but they are certainly not personal. And increasingly as one's training goes on, one feels quite protected by the fact that their dependency, their frightening, unpredictable involvement with you, is dispersed among the team members. In Martin Buber's terms, the relationship with a fellow team member may be an "I-Thou" involvement, but the relationship with a patient is at best "I-You" or, to be precise, "We-You."
>
> Disloyalty to the team is always dangerous, and it can be remarkably subtle. Too great an involvement with patients can in itself be sufficient to suggest it. This works not because you have "gone over to the enemy," to put it crudely -- after all, the patients are not the enemy -- but rather through an implied accusation leveled against the other team members: I care more than you do for patients, therefore you do not care enough. Avoiding this implication helps to suppress at least some nurturing impulses toward patients.

One depends on the "team" for protection from the "frightening, unpredictable involvement" with a patient, frightening and unpredictable because one is vulnerable to failure (see below). More importantly, the "team" doles out reward to the loyal and punishment to the disloyal. Scott risked his success by covering up the patient, by caring more than the "team" did.

Take sleep deprivation, for another example. While almost all students, according to one survey,[21] agreed that "[s]leep deprivation has little direct value in training me to be a good physician," three-fourths of these students agreed that "[s]leep deprivation was worth it because of what I learned." For what do they learn if not to be a good physician? Almost all students agreed that "doing without sleep has sometimes impaired my ability to care for patients," but two-thirds felt that "sleep deprivation is an unfortunate but necessary part of medical training." Necessary for whom if not to care for the patient? Alex tells me that "it's economic. "Why can't they hire more people? Because they are not going to put any more money into it." Some students reported going without sleep for as many as 100 hours on surgical rotations and 50 for ob/gyn and medicine rotations![22]

Why do students put up with sleep deprivation? One survey found that only 30 percent of first-year surgical residents in New York State were keeping within the 80-hour work week requirement. A student advocate points out that

> Surgery has always had ... a strong macho mentality. Many surgeons believe in the myth that they prove themselves by working superhuman hours, and this myth is perpetuated through the residency program.... many surgery residents would welcome scheduling changes but are hesitant to push for change because they are afraid to make waves. Most surgery program operate on a pyramid system. Each year residents considered unfit are weeded out and only a small number of those initially accepted actually complete surgical training.[23]

"Because of this atmosphere of fear," she contends, "few surgical

residents are choosing to blow the whistle on their programs." So many residents just work hard, do their time, and wait for their turn. Success has its price.

Then there are sufferings that come with failure. Self-doubt, guilt, anxiety and depression are all caused by our vulnerability to failure. "You never feel secure," Sanjeev admitted. "Always doubting yourself.... And when you did bad, inside you feel the pressure of someone who did better than you." Jessica almost killed herself because she was doing poorly. "People wanted, demanded, expected things done in a certain way, and I just couldn't do it."

Over time we learn to cope with our sense of failure, mostly by avoiding it, denying it, and projecting it. We learn to give ourselves positive messages, pats on the back. "You got to make sure you are doing okay because no one else is going to," Nicole said. We also develop a certain compulsiveness for certainty to cover up our vulnerability to feelings of self-doubt and "impotence in the face of disease and death."[24] Jessica wanted to become a brain surgeon because a brain surgeon is someone who "knows how to fix things, someone who could totally control things, someone who is not a weak person." Diana wants to go into pathology because "pathologist knows the most." In pathology "you get answers"; in medicine "you don't heal, you just palliate."

Isolation comes with both success and failure. Most students I spoke with reported often feeling isolated. Simply having too little time for too much work can be isolating. One study of "dysfunctional stress" in the medical school environment found the "shortage of time for family and friends" to be most problematic for students.[25] As Nicole put it, she is spending "more and more amount [of time] studying and less and less time with human beings." "It's an alienating sort of thing," she laments. Success takes time -- away from meaningful involvement with our family, friends, patients, and community.

Even when one gets involved, the involvement is often instrumental, calculated to maximize one's chance for success. I have often been asked by pre-medical students: "what kind of activities should I get involved with in order to get into medical school?" Such involvement is likely to prove unenduring, as the cost-benefit ratio of involvement is often unfavorable.

Most pre-medical and medical students have too little time for themselves, and even less for others. We want to succeed, and occassionally we want to feel good. So we have friends -- to study with, to party with, and to talk to. But, as Sanjeev recognized, "we are all competing so hanging out is superficial." It has been reported that sometimes "the emotional and physical demands of medical school are met through selection of a spouse who will not make great demands on the student." Once training is over, the "couple finds they really do not have much in common," or "spouses who were chosen to provide financial and

emotional support during training feel unneeded after graduation."[26] The relationships of premeds and medical students are often unenduring because they are limited to their utilitarian or therapeutic lifespans. Many successful premedical and medical students thus fail in their developmental task of achieving intimacy in young adulthood, intimacy defined by Erik Erikson as "the capacity to commit [one]self to concrete affiliations and partnerships and to develop the ethical strength to abide by such commitments, event though they may call for significant sacrifices and compromises."[27]

If success is isolating, failure is even more so. Nicole said that she no longer reached out to others because when she was feeling down, no one reached out to her. Why?

I know. I've been there.

You are sitting there in class, feeling isolated. You feel that people are around you but not with you. You need attention, but no one seems to notice or care. You start thinking that people are just out for themselves. All it takes now is for somebody to reach out to you, or for you to reach out to somebody. The cure for isolation is compassion. But it does not happen. Not enough. Why?

"Because you don't want to appear weak and vulnerable," Sanjeev explains to me. "And because I don't want to imply that you are weak and vulnerable." So you don't ask for help and I don't give you help, as if needing help is an admission of failure. Besides, I have got enough problems of my own. I have

to take care of myself first, and if I have any energy left over, then I'll help you.[28] "I cannot give bread when I have only crumbs," Nicole tells herself. So "do not bleed," and "get out if someone is bleeding."

How we attend to the sufferings amongst us may carry over to how we attend to our patients' sufferings. A 1983 New York Times article which asked "Can Doctors Learn Warmth" reported that

> some experts believe students can be dehumanized, and even brutalized, by the [medical education] experience. Medical students are often physically and mentally overwhelmed by the demands placed on them. They sometimes observe inhumane treatment of patients, and they themselves are not infrequently treated as ciphers by those above them in the medical hierarchy. As a result, these young would-be doctors begin, in turn, to view troublesome patients as ciphers.[29]

Diana tells me that "it is hard to care for others when no one seems to care for you." Don admits to being clinically depressed after an abusive experience during his third-year clerkship. "I had the most dramatic mood swings. Sometimes I felt really sad, and I just didn't want to come back to see patients." He did, because that was the price he, and his patients, had to pay for his success. But if abuse makes children less empathic to their peers in distress and more abusive when they grow up, what does abuse do to our medical students?

If we do not pay enough attention to our patients, it may be because attention is inversely proportional to responsibility. The more responsible we become for patient care as we move up the

hierarchy, we learn, the less attention we can give to care of the patient. If we do not pay enough attention to isolation as a source of suffering for our patients, it may be that we ourselves are isolated. If we discount the patient's experience of malaise and fatigue, it may be that we disregard our own.

But we have the most difficulty attending to the suffering of those patients who expose our vulnerability to failure. These include "dying patients or those demonstrating repeated suicide attempts; burn patients; quadriplegics or those with several congenital malformations; sociopathic and dangerous patients; abused children; and those patients who were excessively demanding or communicated a feeling of entitlement,"[30] to name a few. Diana had her own list: "smokers, chronic alcohol abusers, IVDU's, homosexuals, promiscuous heterosexuals, AIDS patients, teenage pregnancy...." Most of these patients we can do little for. We may project our own sense of failure onto them. We may see them as one of "them," or one less than human: We call them gomer (acronym for Get Out of My Emrgency Room), crock (referring to a hypochodriac or somatizer, short for "crock of shit"), PIA (officiallly, preganancy-induced anxiety; unfofficially, pain in the ass), dirtball (a street person), worm (a hateful, threatening or dishonest patient), M.U.O (marginal undesirable organism), and the objectification of our failure goes on.[31]

The ultimate failure is death. As Elisabeth Kubler-Ross asked about our avoidance of our dying patient[32]:

> Is the reason for this increasingly mechanical, depersonalized approach our own defensiveness? Is this approach our own way to cope with and repress the anxieties that a terminally or critically ill patient evokes in us? Is our concentration on equipment, on blood pressure our desperate attempt to deny the impending death which is so frightening and discomforting to us that we displace all our knowledge onto machines, since they are less close to us than the suffering face of another human being which would remind us once more of our lack of omnipotence, our own limits and failures, and last but not least perhaps our own mortality?

The problem with a compassion driven by success is that from time to time, we are going to "fail". It is paying attention to suffering when there is nothing else I can do but to suffer with that is the real compassion. Here I am reminded of what Dr. J. Englebert Dunphy said once: "the patient is not afraid of death, but he is terribly afraid of being abandoned by his physician in the face of death."[33]

So our compassion really depends on our success. Now that Alex does "not have to spend that much time proving [he is] a competent doctor," he could spend more time being a compassionate doctor. Unfortunately for many students, the unremitting pursuit for success in becoming a doctor has forever deprived them the joy of compassion in being a doctor.

Recommendations

We cannot expect students to come out of eleven to fifteen years of institutionalized self-absorption with personal success and, all of a sudden, become compassionate doctors whose attention to their patients is not distracted by self-concern. We cannot teach students to be compassionate toward patients who "fail" them if we are uncompassionate toward them when they fail us (teachers). We need to change our medical education -- by redefining success, by practicing commitment, by teaching compassion -- or else our doctors will have neither success nor joy, and our patients will not get enough compassion.

1. Redefine Success. When thirty senior students in the class of 1956 at the University of Kansas Medical School were asked "what is your idea of a successful physician," thirteen thought of "one who really helped his patients, as a man who had worked hard and acquired all the skill and knowledge necessary to give such help." Six considered respect by patients and community; four, comfortable living; four, personal satisfaction; and three, large practice as the measure of success. Curiously, none thought "get[ting] along with patients" or "participation in the community" were important to being a successful physician.[34] The researchers in this well-known study concluded thereby that although medical students became more cynical as they go through medical school, their idealism is maintained "throughout school .... When they leave medical school it again comes to the fore."[35] In other words, medical

school did not have any long-term effect on the students' idealism about being a doctor.

But is a hard-working doctor, with all the skill and knowledge necessary to help his patient, the ideal doctor? Hard work is essential to the Protestant ideal of success. But is hard-work all there is to being a successful doctor?

But at least most of them did not measure personal success in terms of large income, large practice, comfortable life, etc.. I wonder what medical students nowadays consider success. The most competitive residency programs tend to be those subspecialties which offer better income or more comfortable lifestyle. Diana thinks that prestige has a lot to do with students' choice of specialties. "I came close to choosing ophthalmology," she confesses. "It is one of the most glamourous specialty, more difficult to get into, nicer lifestyle, a lot of money." But she did not choose it. It is not her idea of "success".

The co-authors of Habits of the Heart speak to the "lack of certainty about what the 'best' we are supposed to make of ourselves is"[36]:

> Schneider and Smith note that "there are no fixed standards of behavior which serve to mark status. The only clearly defined cultural standards against which status can be measured are the gross standards of income and consumption, and conformity to rational procedures for attaining ends." Middle-class individuals are thus motivated to enter a highly autonomous and demanding quest for achievement and then left with no standard against which achievement is to be measured except the income and consumption levels of their neighbors, exhibiting anew the clash between autonomy and conformity that seems to be the fate of American individualism.

Perhaps for middle-class professionals, like doctors, whose "occupation involves the application of technical rationality to the solution of new problems ... in the service of the public good," their "'success' [could] have intrinsic validity." But when such technical competence is enclosed in a "career" and within bureaucracy, "concern for rational problem solving (not to speak of social contribution) becomes subordinated to standards of success measured only by income and consumption."[37]

We find "rational procedures for attaining ends" the exclusive concern of the Flexner report, on which the curriculum of U.S. medical schools have been grounded for the past eighty-two years. In his "exclusive, indeed obsessive concern with scientific training," Flexner failed to ask: "How do we ensure that the medical student becomes a caring and compassionate physician?"[38] Moreover, as Seymour Sarason criticizes:

> If Flexner can be faulted for anything, it is his failure to take seriously something that he notes and indicts: the commercialization of medicine.... That we are a capitalist society ... in which in countless ways the desire for individual material gain, indeed aggrandizement, is stimulated and reinforced, in which success is too often equated with what Veblen termed conspicuous consumption, in which striving for upward social mobility is a socially accepted goal is a fact the implications of which Flexner did not confront. Possessed as he was by the concept of the "educated man," which in his day referred to a relatively small elite in terms of socioeconomic status, Flexner assumed that such individuals were somehow devoid of the seamy apsects of the motivation for pecuniary gain.

Success in a capitalistic society is largely measured by accumulation and consumption, and individuals may be driven by

those pursuits in becoming a doctor.

So if we want to teach doctors-to-be to be more compassionate doctors, we need to redefine our notion of success. A successful premedical student is not one who gets the highest grades on midterms, scores fourteens and fifteens on the MCAT's, and gets into the "best" medical schools. A successful medical student is not one who memorizes the most and recalls the fastest, out-smarts and out-scores his classmates most often, and gets into the most competitive residency programs. A successful doctor is not one who has the largest practice with the highest income at the nicest location with the most comfortable lifestyle and most conspicuous consumption. A successful premed, medical student, doctor, citizen, or society, is one who cares, one who is compassionate.

That may take restructuring our medical education so that less emphasis is put on competition and more on compassion, less on individualistic success and more on interdependent success. That may also take giving up some of the rewards that come with our success in individual competition, and in so doing alleviate some of the sufferings that come with success and failure as well. It may take, in Christopher Jenck's words, reducing the "punishments of failure and the rewards of success"[39]:

> Reducing the inordinate rewards of ambition and our inordinate fears of ending up as losers would offer the possibility of a great change in the meaning of work in our society and all that would go with such a change. To make a real differnce, such a shift in rewards would have to be a part of a reappropriation of the idea of vocation or calling, a return in a new way to the idea of work as a

> contribution to the good of all and not merely as a means to one's own advancement.

To reappropriate the idea of calling in medicine, we need to make practicing compassion a goal of medicine, and teaching compassion a goal of medical education.

2. Practice Commitment. Compassion takes practice. Here I speak of what the co-authors of Habits of the Heart refer to as "practices of commitment." These are "shared activities that are not undertaken as means to an end but are ethically good in themselves (thus close to praxis in Aristotle's sense)."[40] As they explain[41]:

> People growing up in communities of memory not only hear the stories that tell how the community came to be, what its hopes and fears are, and how its ideals are exemplified in outstanding men and women; they also participate in the practices - ritual, aesthetic, ethical - that define the community as a way of life. We call these "practices of commitment" for they define the patterns of loyalty and obligation that keep the community alive.

In contrast, many practices of medical students and, more importantly, their teachers, are "practices of separation." These are activities which are "undertaken in the interest of the self at the expense of commitments to others."[42] When premedical students kiss up to the professor, sleep with the teaching assistant, cheat on midterms, destroy class notes on reserve, they practice separation rather than commitment. When medical students compete to see "who can be king of the mountain, who can get the most attention, who can be the most envied,"[43] when they do not reach out to their classmates who need their help, when

they study more and more and care less and less, they practice separation rather than commitment. When attendings or house officers abuse medical students, when they neglect or abandon patients who expose their vulnerability to failure, when they lose sleep over their success rather than for their patients, they practice separation rather than commitment. "Medicine is practiced humaneness and compassion[44]," and it takes practice to become a good doctor.

3. Teach Compassion. But students cannot redefine success by themselves. They cannot practice commitment on their own. Their teachers can help.

Teachers frequently raise two objections, or at least concerns, about teaching compassion. First, **can we teach compassion?** How do you teach compassion to medical students?

"You can't," one veteran educator professes.

"Have you ever fallen in love?" He asks me.

"Yes."

"Did someone have to teach you how to love?"

This analogy between compassion and love is telling about our expressive individualism. Like true love, genuine compassion comes to us naturally and spontaneously. No need for lessons. No need for practices. It is in my core already; it is just who I am.[45]

But who I am is also none of your business. Who are you to tell me how to show my compassion? Is a laboratory researcher working on a cure for AIDS any less compassionate than a

clinician taking care of patients with AIDS? How about a a stockbroker on Wall Street -- can he show compassion doing what he does?[46] We allow pluralism and relativism in what is compassion to avoid being judgmental or judged. "The important thing is not so much what we do but the spirit in which we do it." Compassion is not what we do but how we feel; the "feeling is what counts." And the feeling is mine; it cannot be taught by you.

These two reactions against being taught compassion -- I don't need to be taught how to feel, and who are you to teach me how I should feel -- make teaching compassion to cowboys by cowboys difficult. We forget that compassion depends on what is in between us and around us as much as what is in us. We forget that compassion needs nurturance and cultivation. We forget Plato's observation: "If you would know virtue, observe the virtuous man."[47] We forget Wordsworth's words[48]:

> What we have loved,
> Others will love, and we will teach them how.

We can teach compassion, even to cowboys in white.

But, second, **do we want to teach compassion?** Medical students have traditionally been taught **equanimitas** with respect to their patients[49].

> The doctor's emotional bond with his patient also had its own unique perplexities. The "excess of sensibility" that some physicians felt for the suffering of their patients, Dr. S. Weir Mitchell thought, endangered the effectiveness of medical treatment; yet the opposite, too little sensibility, he believed was worse. Osler's recommendation of "equanimity" was not easily

> maintained. In order to act as a protector, the doctor often diminished his awareness of his own vulnerability. He could not honorably avoid treating the many infectious diseases of that era, and many doctors succumbed. Yet this lowering of awareness made it more difficult to understand the feelings, thoughts, and motives of patients. Instead of empathy, many doctors more readily linked their own sense of worth to their success in curing their patients.

But equanimity has its drawbacks. "Don't you hate it, sir," the famous Dr. Samuel Gross once blurted out to a colleague, "to spend a life like yours and mine, and be beaten-puzzled-licked, sir -- by a miserable lump in a woman's breast." Dr. S. Weir Mitchell confessed that "he never saw a death or a serious failure to cure that did not hurt him personally."[50] Equanimity was often achieved by treating the disease and not the patient; by closing in on the disease we can safely distance ourselves from the suffering of our patients, as Elisabeth Kubler-Ross has observed. We can do war with diseases; it is more difficult to make peace with our patients, and ourselves.

I believe compassion has real limits, but I also believe that our doctors are nowhere close to the real limits of compassion. We stop at the limits of our success, self-interest, and freedom and call it "burnout," "compassion fatigue," "excess of sensibility." We ride in for a high-noon showdown with villainous diseases, and ride off into the sunset after a glorious victory and with the admiration of our patients. But what if we lose the showdown? What if we cannot ride off into the sunset victorious? Staying detached in our equanimity is one response. But compassion is more healing, for our patients and

ourselves.

But compassion takes more than the individual heroism of the cowboys in white; it takes a community of memory for nurturance and sustenance. It takes people who will suffer with you when you suffer with your patients, who will practice commitment to, and not separation from, patients and each other, who will remember and teach what medicine is all about.

A doctor is, literally, a teacher, and there is nothing more central than to teach students compassion -- because that is what medicine is all about.

V.

COMPASSION AND SELF-INTEREST:
The Limits of Our Medical Care

Doctors are supposed to put their patients' interest above their own. They are not supposed to care much for money -- not more than they care for their patients anyway. "The idea of my attaching money to medicine," one doctor tells me, "is an insult to the profession."

His discomfort about the profit motive seems so out of place in our market economy. Human beings are exclusively self-interest maximizers, we are told by Milton Friedman and Chicago school economists, and "the one moral code all modern people can understand is self-interest."[1] From that perspective, "there is no behavior that is **not** interpretable as economic, however altruistic, emotional, disinterested, and compassionate it may seem to others."[2] In addition, self-interest is a cornerstone of our culture of individualism.[3]

Yet the doctor is believable. If he were an investment banker, a used-car salesman, or a lawyer, he might seem less credible, or even a little odd. But I believe most doctors genuinely **think** that they are not in it for the money. And most doctors would tell aspiring doctors-to-be to go somewhere else if they want to make money. Two recent studies indicate that potential income is not among the top

ten considerations influencing medical students' choice of residency subspecialties.[4 5] And when money is a consideration, it is often mentioned in the same breath with student loan indebtedness.[6 7] One doctor tells me that he is embarrassed every time he hands a bill to his patient and feels that "money should be taken out of patient-doctor interaction." Others go so far as to "socially withdraw to avoid having their financial success observed by their patients":[8]

> The physician is expected to place patients' interests before his or her own. Although most physicians do this, Americans are clearly a self-oriented people, and it is difficult for American physicians to behave totally differently. Patients seek out busy and successful physicians, yet they are jealous of their prosperity and accuse the successful physician of practicing medicine for its financial rewards. Furthermore, nobody is entirely comfortable with a piecework fee-for-service system that compensates a physician approximately in proportion to patients' suffering and misfortune.

The physician's ambivalence about self-interest is evident in this piece by a physician.

The physician has always taken pride in being above self-interest. From the early days of medical professionalization, the physician has seen himself, and made the publics see him, as

> neither a capitalist nor a worker, rather that he stood in some third position with an outlook arising from that standing. He was not a capitalist because his authority and honor were not derived from wealth and the dollar was not the best indication of his achievement. He was not a worker, though he was employed, because he worked from a position of command, guided in part by his science, and was therefore never wholly at the

> bidding of those who employed him.... The professional by contrast maintained precapitalist presumptions. He was not self-denying, but his self-interest was directed and constrained by the requirements of his vocation. For him, duty guided self-interest; and duty arose out of an abiding relationship between persons and entailed action that one's position or station required.[9]

Called to work by duty and honor, he shared with his colleagues "a high sense of purpose [and] a vigorous and durable sense of community," which neither capitalism nor democracy provided. And that "kind of solidarity, a source of meaning in work, and a system of regulating beliefs" contributed to the unparalleled success of medical professionalization.[10]

It is "unprofessional," the American Medical Association (AMA) declared in its code of ethics in 1934, for a physician to permit "a direct profit" to be made from his work.[11]

> The making of a profit from medical work "is benath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy."

No commercialism in medicine was tolerated. Many physicians I spoke with deplore the "tide of commercialism," the "coming of the corporation," the "businessfication of medicine." To "run medicine like a business," to "make it into a corporate structure," to "process patients like widgets," is something many doctors feel uncomfortable doing. "Conflicts between the altruistic ideals of medicine

and the financial imperatives of business," Arnold Relman worries in his editorial in the New England Journal of Medicine[12], "will almost certainly be resolved in favor of the latter by corporate managers whose jobs and financial advancement are at stake." It is feared that "economic imperatives may weaken what should be a strong fiduciary relationship between doctor and patient." A "physician cannot easily serve his patients as trusted counselor and agent," Relman argues, "when he has economic ties to profit-seeking businesses that regard those patients as customers."[13]

The justification given by the Council on Ethical and Judicial Affairs of the American Medical Association for its guideline against physician self-referral evinces again the profession's ambivalence toward self-interest.[14] The Council recommends that "physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility." The guideline is intended to "remind physicians that the profession of medicine is unique and that physicians are expected to put their patients' interests first." "[W]hen a physician's financial interest may conflict with the best interests of the patient," the Council "assumed that the physician will not take advantage of the patient":

> however others may see the profession, physicians are not simply businesspeople with high standards. Physicians are engaged in the special calling of healing, and, in that calling, they are the fiduciaries of their patients. They have different higher duties than even the most ethical businessperson. This is the teaching of the Hippocratic oath and of the great modern teachers of ethical behavior.

"As professionals," the Council asserts, "physicians are expected to devote their energy, attention, and loyalty fully to the service of their patients." The patient comes first. And just in case I missed the point, a surgeon sent me an article following our interview with this sentence highlighted: "a surgeon's primary interest is the individual patient."[15]

With so much evidence to the contrary, how can anyone still accuse American doctors of being self-interested?

In his study on the history of professionalization in the United States, Samuel Haber argues that the "medical profession was not self-abnegating with regard to its authority or its honor, and it was unlikely to be self-abnegating with regard to its econmic welfare." The fee bills (which recommended minimum charges for various medical services adopted by local medical associations), for example, "were overt attempts to ensure comfortable incomes for all practitioners." But Haber also calls attention to the fact that "it is significant that doctors did not make straightforward economic claims or rely upon direct economic inducements"[16]:

> Even the fee bills were not justified in terms of maximizing income but rather as providing a "competence," sufficient means for the comfortable existence that would allow the doctor to carry his work. This was closer to the precapitalist notions of just price than to capitalist notions of market price. As indicated, fee bill charges often became customary charges unresponsive to market conditions, and most physicians never relinquished their traditional practice of varying fees with the ostensible income of the patient and treating the poor gratis. Fee bills were probably more important in fostering a general collaborative spirit and collegial solidarity than in raising doctors' incomes.

The notion of "competence" was used to justify the fee-for-service private practice to me by the doctor who found it insulting to the profession to attach money to medicine. "Doctors should be paid well," he contended, "so that they can be divorced from economic vicissitudes ... [and] not have to worry about money." But how much competence is competent?

And when the AMA declared in 1934 that it was "unprofessional" for a physician to permit 'a direct profit' to be made from his work, Paul Starr argues in his sociohistorical study on the transformation of American medicine[17] that it was "not that the AMA believed it was wrong for doctors to make a profit from their work." Organized medicine just "wanted to prevent the emergence of any intermediary or third party that might keep for itself the profits potentially available in the practice of medicine."

But organized medicine would have had a harder time

defending its self-interest had doctors appeared self-interested. "The basis of [the medical profession's] high income and status," Paul Starr argues, "is its authority, which arises from lay deference and institutionalized forms of dependence"[18]:

> The strength of classes, as Polanyi has written, depends "upon their ability to win support from outside their own membership, which again will depend upon their fulfilment of tasks set by interests wider than their own."... This was exactly so for physicians, ... physicians were able to see social interests defined so as to conform with their own.

Patients, and the publics, came to defer to and depend on organized medicine because doctors appeared to put patient interest ahead of their self-interest. Physicians' "cultural authority" won for the profession its legitimate power to self-regulate, which a critic describes as a "booby-trap" for the patients and the publics.[19]

The AMA's guideline on self-referral renews the call for self-regulation. "Physician, police thyself," or else be policed by the state.[20] The guideline was intended to provide a "level of 'flexibility' that recognize[s] gray areas and individual exceptions, a flexibility absent in most legal statues." "We are the AMA, not the [Health and Human Services inspector general]," AMA general counsel Kirk Johnson said in its defense. "We have to respect the exceptions and accept the good-faith motivations of our members." The guideline ensued reports of excessive self-referrals which spurred more restrictive legislative

initiatives in several states.[21] But critics worry about physician compliance. "Doctors are saying 'screw you' to the AMA, because money talks louder than ethics."[22] The guideline is part of "a professionalism push" for more self-regulation by organized medicine, and less antitrust enforcement by the governments, that includes proposals for peer review of patient complaints concerning physician fees and collective bargaining by physician groups with dominant payers.[23] Paul Starr points out that organized medicine had used self-regulation to advance its economic interests in the past.[24]

Are American doctors more interested in their patients or in themselves? Are they compassionate, or are they really self-interested?

It is difficult to tell because American doctors' compassion has been wed to their self-interest. They had contrived a system where what was good for the patient was also very good to the doctor. They did not have to choose between compassion and self-interest; they got both. In this chapter I will argue that American doctors' compassion is generated from, **and limited by**, in part, their self-interest. It is difficult to validate such a claim, for that takes attributing ulterior, self-interested motives to the exalted self-justifications of doctors whom I chose to interview because of their reputed compassion. But there are, nevertheless, real limits to American doctors'

compassion which may also be the limits of their self-interest. Let us start at these limits.

The Limits of Compassion

I started out by asking doctors what makes it hard for them to be more compassionate to their patients. Not enough time, it doesn't pay, and it's their fault are frequent chief complaints.

Not Enough Time

A family practitioner at Kaiser illustrated the problem of the lack of time:

> You see somebody in the midst of a very, very busy morning. At Kaiser, for example, you are budgeted fifteen minutes to see somebody. And you've just gone over with your last patient by seven minutes because they were medically complicated; so really you only have eight minutes. And then the person is elderly and so maybe they have some problem with their gait; it takes them a couple minutes to get into the room so you've got [six] minutes left to deal with them. And then they tell you something or start crying about the death of somebody in their family or something ... So whatever you are able to bring to bear in those situations are also condition by what you are able to do given those constraints.

And an internist in a private group practice explained:

> In my office we schedule one patient every fifteen minutes. This is often not enough. Often the patient is crying out for more attention, yet I have to adhere to asking questions about problems that are real. I saw a fifty-year-old man today who is pathologically devoted to his eighty-year-old mother with Alzheimer's. He dropped in to ask a few quick questions. I only spent three to four minutes reassuring him, but I know he needed at least half an hour.

It Doesn't Pay

> It doesn't pay to be a compassionate physician. Compassion isn't rewarded. Talking to patients is not compensated. Cognitive services are not compensated in the U.S.. You'll get ridiculed. Others see your effort as girlish, soft, not scientific. They'll assume you are gay. They won't promote you. They will criticize you. In the workplace, others want to get product. Compassion is useless unless you can be briskly compassionate.

It's Their Fault

> A 35 year-old woman who weighs 500 pounds came in to the ER for asthma and congestive heart failure. Two things came to my mind immediately. Her situation got worse because she is fat; that decreased my desire to be compassionate. Her situation got worse also because she did not keep her appointments. So even before I talked to her, I already saw her as a fat, non-compliant woman who was now sick.
>
> A fifteen year old kid of Italian descent came in for STD [sexually transmitted disease]. When I hear young kids getting STD these days, one of my reaction is a surge of anger. I feel like taking them by the neck, ... I mean what can I do, I get really nasty and I ask them in a real passive-aggressive way: "Have you ever heard of AIDS?" That's clearly an expression of my own anger that kids are growing up in such relative cultural deprivation that they are not prepared to deal with their own sexuality.... But there is a real tension between being tough with him that's helpful to him and my sense of irritation because in the background is that I feel really rushed. I may not have slept well last night; its condition may not have anything to do with him -- why is it that I'm susceptible to such irritation? Is it really for his benefit or am I projecting upon the situation my own incompleteness around such issues? My own ability to be irresponsible? When I see it in somebody else it's easy to pick on him for it ...

I should also mention that a few doctors identified the distraction of technology and the fear of burn-out or co-

dependency as limiting their compassion, though most doctors consider these red herrings.

Time is Money

Time is consistently recognized as a limiting factor by every doctor I interviewed, and often **the** limiting factor. So let us look at time for now. When asked how they could have been more compassionate with their patients, many doctors said they wished they had talked and listened to their patients more, but there just is not enough time. Compassion takes time -- time that they do not have.

The question that naturally follows is "why is there not enough time?" In managed-care settings like HMO's, PPO's or IPA's, doctors are under pressure to produce, often measured by patients processed per unit of time. I was therfore more interested to see whether doctors who work for themselves -- in private practice -- might have a easier time with time.

They do not. One editorial in the New England Journal of Medicine points out that for internists entering solo private practice:

> the overhead for an office frequently consumes 60 percent or more of their fees, and it is a struggle to maintain a satisfactory income while giving each patient the kind of personal care they are trained to provide. To make ends meet, they emphasize procedures, such as electrocardiogram, x-ray studies, and laboratory work done in the office because otherwise they could not afford to spend more time with patients.[25]

As I mentioned, a few doctors identified technology -- doing procedures -- as a source of distraction.

Doctors in private group practice do not have it easier either. Despite having partners to share their work and risk, they cannot take their time with patients. Young doctors are kept busy with night calls and scud work because they are often employees of their senior "partners" who own the practice.[26] They are also under financial pressure to do more and talk less in order to pay back their loans and support their families. Once they become established, they often have more patients than they have time for. As one established internist explained:

> You have a large group of patients who want to see you as their doctor. Very quickly your practice can get out of control. You want to be there for your patients. In my [group] practice we allow fifteen minutes per visit. We can allow twenty minutes. But then we will have to cut back on the number of patients we can see in a day. So we try to be there the vast majority of time for vast majority of patients. Your availability is the most important thing. If your patient has pneumonia, the hell with compassion. He wants to know "can you see me," so you try to be available.

But another physician frames the problem of time in terms of money: "Do we accept a lower income but take on another partner so we can take more time with our patients and have more time with our families?"[27] No one has enough time for compassion.

And it is possible that money may have something to do with it. Clearly, for these doctors compassion means spending more time with the patient, listening, explaining,

acknowledging, reassuring, hand-holding, making eye-contact, and being there. This kind of compassion does not pay. What pays is doing procedures, at least for doctors in private fee-for-service practice, which explains in part why technology is distracting.[28] For example, a doctor can spend eighteen minutes in the office taking the history and doing a physical examination on a patient with gastrointestinal complaint and get reimbursed $35 by Medicare, or she could do a fifteen-minute gastroscopy with biopsy procedure and get reimbursed $337, or a thirty-minute colonoscopy procedure get reimbursed $608.[29] A gastroenterologist makes, on the average, $74 an hour, because he can do more (expensive) procedures than an internist or a family practitioner, who makes about $40 an hour.[30] Between 1985 and 1988, the total amount of Medicare allowed charges for gastrointestinal endoscopy procedures grew by nearly 20 percent annually.[31]

If doctors feel that they do not have enough time for compassion or that compassion does not pay, why has organized medicine insisted on a system that pays doctors by piecework rather than by the hour? It is because compassion by piecework pays, fee-for-service.

The Limits of Self-Interest

This kind of compassion says **"the patient comes first."** One retired surgeon told me that he does not apologize for a nickle he made from surgery. And why should he? He did everything he could for the individual patient. He went the extra mile. He stayed with "Mrs. Jones until the cows come home."[32] I believe that he was a compassionate surgeon. I bet his patients thought so, too.

But what was good for his patients was also very gocd to him. He did well for himself simply from doing good for his patients. "Patient comes first" meant that compassion should not be constrained by money, that patient care must not be compromised by cost considerations. Under a fee-for-service arrangement, he was paid for every extra mile he went and everything he did for his patient, and mostly by somebody else, the so-called "third-party" payer.

A historical review of the evolution of the fee-for-service system and monopolistic pricing by physicians is beyond the scope of this discussion[33]; suffice to say that the reimbursement system arranged a happy marriage between the physician's self-interest and compassion. Most patients were "unconscious" of the cost of their doctors' compassion if they were insured. And private insurers passed the cost of compassion onto employers; employers' contribution to their employees' health insurance premium increased by 300 percent between 1976 and 1984, from $598 to $1,770 per

employee.[34] Employers, in turn, passed the cost on to the government in tax exclusion, and to employees in lower real wages and labor substitution. The estimated revenue loss from tax exclusion from employees' taxable income was $3.2 billion in 1970 and $45.8 billion in 1987.[35] For patients who did not have private insurance, doctors (and hospitals) often cross-subsidized the costs of charity care by charging their privately-insured patients a higher fee, which then got passed on. For the aged, the disabled, and the poor, that is, the untouchables in the world of private insurance, doctors managed to charge the governments what the customary, prevailing and reasonable fee that they had been charging private insurers, at least through Medicare. Everyone seemed happy and doctors' compassion paid, for a while.

Third-party payment for physician services increased from 16.8% in 1950 to 81.3% in 1990.[36] That means whereas patients paid their doctors 83 cents out of every dollar from their own pocket in 1950, by 1990 they paid only 19 cents out-of-pocket, as shown in the following table[37]:

		By Source of Reimbursement (%)		
Year	Total	Direct	Private	Public
1950	$ 2.7	83.2	11.4	5.2
1960	5.7	65.4	28.0	6.4
1970	14.3	45.1	33.9	20.9
1980	46.6	37.3	36.3	26.4
1990	125.7	18.7	46.3	35.0

What was good for the patient was also good to the doctor.

Total health care expenditure on physician services, as shown in the table above, increased from $2.7 billion in 1950 to $125.7 billion in 1990. Physician income more than doubled between 1965 and 1975[38], and nearly doubled again between 1975 and 1984.[39] By 1976, it was estimated that doctors made twice as much as dentists or lawyers in income, following perhaps the most rapid decennial rise in income amongst all professionals.[40]

The increase in physician income can be accounted largely by the increase in fees and volume of physician services provided. With some exceptions, physician fees have generally risen more rapidly than the consumer price index.[41] Physician fees have been shown to be unrelated to the costs of providing physician services, as they increased more rapidly than the government index of physician expenses, and continued to grow rapidly even after the increase in malpractice premiums has been levelling off.[42] Physician fee also had little to do with time or intensity of work. Even after complicated and time-consuming procedures had been simplified, Mark Blumberg points out in his historical analysis of doctors' fees, their prices remained high.[43] "As a result, some services, like cataract surgery, are financial 'winners' because they pay much more than they cost to produce," Paul Starr remarks, "while other services, like talking to a patient," are "losers" because they pay less than they cost. In times of fee freeze or

general price control, physicians have been able to make up for deflated real price by increasing the volume of services provided.[44]

Some economists have suggested that "the extent of the demand the physician will 'create' and the price that will be established are based upon what target income the physician desires."[45] One researcher found that as the number of surgeons or ophthalmologists increased, per capita utilization also increased. More interestingly, contrary to the prediction of classical economic analysis, the price of service increased rather than decreased with increased supply.[46] By doing more and charging more, doctors got paid more.

Two physicians accounted for the lack of time in terms of "target income." The target income is said to be determined by what other doctors or professionals in the area are making.[47] As one doctor pointed out, "You are a doctor. Your professional colleagues are always comparing income. You've got to refer [patients] back and forth and you know how much each other is making." Another doctor blamed the spouse for setting the target. "Your wife goes down the block to the house of your high school classmate who is now the president of Safeway and finds a new washer and a dryer and she is still doing your laundry at the laundry mat," he explained. "She complaines: 'where's my washer and dryer?'" So you have to do more and make more

money to please her.

I mentioned earlier that success for middle-class Americans is ambiguous because "there are no fixed standards of behavior which serve to mark status."[48] "The only clearly defined cultural standards against which status can be measured," Schneider and Smith argued, "are the gross standards of income, consumption, and conformity to rational procedures for attaining ends." Target income, washer and dryer are such measures of status. While doctors are said to derive intrinsically valid "success" from application of technical rationality to the solution of a problem, Robert N. Bellah and his co-authors observed that "to the extent that technical competence is enclosed in ... 'career,' concern for rational problem solving (not to speak of social contribution) becomes subordinated to standards of success measured only by income and consumption." "When this happens, as it often does to doctors" they concluded, "it raises doubts about the intrinsic value of the work itself."[49] We will return to this concern at the end of the chapter.

Doctors' compassion was generated, in part, by their self-interst, but it was also limited by their self-interest. They overdrew on their compassion. We spent 4.6 percent of our gross national product on health care in 1950; by 1990, our national health care spending absorbed 12.2 percent of our GNP.[50] In the decade between 1981 and

1991 alone, our national health care expenditure escalated from $290 billion to $738 billion (estimated $817 million in 1992). Most of the cost inflation can be attributed to price inflation and intensified service, as I described earlier.[51]

Expenditures for physician services accounted for $125.7 billion in 1990, or a little less than one-fifth of the total health care bill. But it is estimated that physicians direct or prescribe the provision of services that account for more than 70 percent of the bill. This is because of the "gatekeeping authority" of doctors, which gives them great economic power.[52] At least half of the 40 million tests doctors ordered each day "do not really contribute to a patient's diagnosis or therapy"; more than $155 billion, or 25% of our national health expenditure in 1989, were said to be wasted on "tests and treatments that will have little or no impact on the patients invovled."[53] But for most doctors few tests and treatments are ever wasted on their patients. The patient still comes first.

The rising cost of compassion made it increasingly unaffordable. Businesses are finding it increasingly hard to provide insurance coverage to their employees, especially small businesses in service, retail trade and construction industries where most of our working uninsured work.[54] Under the provision of the Employee Retirement Income Security Act of 1974 (ERISA), many large businesses became

self-insured in order to avoid state insurance premium taxes and mandated benefits. The withdrawal of large groups of young, healthy workers from community pools made the traditional insurance practice of community rating of risk impracticable because of adverse selection. Private insurers began to rate individuals or groups according to their experience or risk and discriminate against and exclude from coverage those whose prior illness or lifestyle predicted high medical costs.[55] Experience-rating made insurance unaffordable for many who need it the most.[56] Even when self-insured, businesses are finding it hard to be competitive when, for example, Chrysler spends $700 on employee health care for each vehicle manufactured -- twice as much as French and West German automakers and three times as much as the Japanese.[57] The cost of Medicaid more than doubled from 1981 to 1988, to $55 billion ($66 billion in 1991).[58] Total Medicare expenditure grew by five times between 1970 and 1980, from $7.4 billion in 1970 to $36.8 billion, and tripled between 1980 and 1990, to $113 billion.[59]

And the system clamped down. Some payers tried to control cost with micromanagement and fee regulations. In came administrators. Between 1970 and 1982, the number of health care administrators increased 171 percent, in contrast to a 48 percent increase in the number of doctors. The total cost for health care administration in 1983 was

$77.7 billion, $29.2 billion of which could have been saved if we had a Canadian single-payor system.[60] They scrutinized over doctors' charges with such cost-containment measures as pre-certification (PRO), concurrent utilization reveiw, retrospective audit, and case management, in some cases requiring physicians to consult with non-physician administrators at some out-of-state central office for approval of procedures to be undertaken. In 1982, over 80 percent of physician bills to Medicare were partially disallowed. Medicare informed these doctors that out of every dollar they had charged Medicare, 25 cents were "unreasonable" and Medicare would not pay for it. (Some doctors then turned around and billed their patients for the balance, averaging $35 to $40 per bill.)[61] Private insurers often followed suit, as one doctor describes:

> Young doctors are becoming more mercenary today because the system put them under so much pressure. For example, private insurance learns that Medicare has been paying you 80 percent of what you charge, and they come to you and say, "if the government can pay you X amount we think we can pay you X amount. If you don't like it, we know somebody coming out of Albert Einstein and Bangledesh who would be happy to practice in Berkeley.

To go an extra mile for their patient (or for themselves), some doctors started gaming with the system. Certain gaming practices have been so widespread that they have produced a nomenclature of their own: unbundling, upcoding, pingponging, family ganging, and churning.[62] Medicare fraud is estimated at $50 billion a year; Medicaid fraud at $7 to

$17 billion a year.[63]

Doctors who were sanctioned for Medicaid fraud typically saw themselves as "sacrificial lambs hung out to dry" mostly because of "stupid laws [and] bureaucratic nonsense."[64] They found Medicaid regulations "onerous and mercilessly nitpicking, ... standing in the way of important and humane service demands." As one doctor criticizes:

> They've built in systems that either ask for somebody to cheat, you know, or to cheat the patients on the type of care that's provided. You put somebody in the position where lying is the most reasonable course, and they will lie.

"Doctors will always bill [Medicaid] the maximum amount because that maximum amount is actually less than we charge our private patients," one doctor rationalizes. "I would say that form of abuse exists in 90% to 100% of doctors that I know who take Medicaid." These doctors tended to see themselves as "autonomous provider who needs to have unquestioned independence ... from controls imposed by government regulations."

The alternative to regulation is market competition. The idea is to drive down prices, and thereby providing access, through managed competition.[65] Both the Bush Administration and, reluctantly, the American Medical Association support the use of market competition to contain costs and provide access.[66] But competition has its costs. The proportion of premiums devoted to overhead, including marketing costs, in our competitive, risk-rated insurance is

3.7 times greater than for overhead in Medicare and Medicaid, and 13 times greater than in the Canadian national health system. Administrative cost for private insurance range between 5.5% for large groups and 40% for small groups.[67] Between 1983 and 1987, our competitive health insurance increased administrative costs by 37%.[68] Uwe Reinhardt claims that "we pay fifteen percent more in this country [on health insurance] so we can say that we have pluralism."[69] In other words, so we can say we have free choice. And still we do not have cost-containment, universal access, or more compassion.

Market competition has also given impetus for the rise of the for-profit sector in medicine, what many doctors deplore as the "tide of commercialism," the "coming of the corporation,"[70] the "businessfication of medicine." Not that medicine was never for-profit, but that the profit motive is now explicit and pervasive. Bradford Gray reports that 14 percent of community hospitals, 34 percent of psychiatric hospitals, 81 percent of nursing homes, 66 percent of HMO's, 57 percent of PPO's, 90 percent of freestanding surgery centers, 93 percent of primary care centers, 42 percent of dialysis facilities, and 63 percent of blood banks, and at least 25 percent of health care dollars are for-profit.[71] But even in the non-profit sector, in response to the increasingly competitive health care market, there is increasing attention to the bottom-

line. One Kaiser doctor who is considering leaving Kaiser for private practice deplores the transformation of Kaiser:

> I came to Kaiser [so I can] take care of the community from a systems point of view; now, ... some of the spirit is that not present. There's a sense "delivering health care resource" to a large number of people which is to say that it's a business proposition and doctors are in some sense ... employees. You go you do your work and you get paid; you don't have control over your schedule. You have a certain number of patients you have to see and you have to demonstrate you are practicing in a cost-effective way.

"My sense is that young doctors can't avoid being involved in a very difficult period in medical history," he concludes, "where it's not at all clear who are the good guys, who are the bad guys, what is the right thing to do, what is the wrong thing to do."

And when the system clamped down, it is not only doctors who got squeezed. The number of uninsured increased from 28.4 million in 1979 to 36.8 million by 1984, an increase of 8.4 million Americans.[72] Of the uninsured in 1985, one-half are working adults and one-third are childrean age 18 or less; one-third are poor and nearly another one-third near poor. The number of poor children increased by 3.5 million (from 10 million to 13.5 million) between 1979 and 1983, and yet children receiving Medicaid increased only by 1 million (from 9 million to 10 million). In 1980, Medicaid covered only about 32 percent of the poor, and 10 percent of the near poor. But things got worse. Federal Medicaid grants to states were reduced by 3 percent

in 1982, 4 percent in 1983, and 4.5 percent in 1984. Along with the changes in Medicaid rules in 1981, these budget cuts "saved" $3.9 billion at the expense of 750,000 recipient disqualified from eligibility.[73] Under President Reagan's vision of the New Federalism, federal categorial grants to the states were replaced with block grants to the counties, a substantial proportion of which were then never funded. California state devolved the responsibility for financing and providing Medicaid to the counties in 1983. In passing the buck, its block grants to the counties were funded at 70 percent of what the state would have spent had the Medicaid program for its 270,000 medically-indigent adults remained in place. Six months later, one study reported a significant decline in the health status and access to care of disenrolled recipients.[74] An increasingly competitive market also squeezes out the underserved. For-profit health care organizations, by their nature, are not in it to provide access for those who cannot pay. Some 10 to 15 percent of physicians in public hospitals, 20% in private non-profit hospitals, and 50% in for-profit hospitals reported that their hospital had attempted to discourage access for the uninsured. But under competition, non-profit health care organizations are becoming more reluctant to cross-subsidize charity care.

And it all started with the "patient comes first" But "patient comes first" also meant that no one comes in

between. "No third party must be permitted to come between the patient and his physician in any medical relation," declared the AMA in its code of ethics in 1934. It was intended to put the patient first "by eliminating any mixed loyalties, especially loyalty to institutional requirements," but it had the effect of justifying the practice of fee-for-service and excluding any organized buyer from exercising countervailing monopsomist power.[75]

Especially the government. The AMA has, until recently, opposed all attempts to establish a universal health care system by the government. In 1950, the AMA spent $2.25 million in its "national educational campaign" against national health insurance, more than $1 million in just two weeks before the 1950 congressional elections, in contrast to the $36,000 spent by the Committee for the Nation's Health in support of a national health insurance. Its campaign stigmatized national health insurance as "socialized medicine." In one of its pamphlets, it asked: "Would socialized medicine lead to socialization of other phases of American life?" And it answered: "Lenin thought so. He declared: 'Socialized medicine is the keystone to the arch of the Socialist State.'"[76] Paul Starr remarks that the Library of Congress could not locate this quotation in Lenin's writings. Interestingly, during the Great Depression, the AMA labelled national health insurance "fascist medicine" because the first national system of

compulsory sickness insurance was established in Bismark Germany in 1883. As a result, one in eight American remains uninsured, deprived of what all industrialized societies (except South Africa) guarantee to all its citizens as a birthright.

The surgeon who stayed with his patients "until the cows come home" vehemently opposed the "governmentalization of medicine." He marked the day Medicare got enacted "the beginning of the end of compassionate medicine." The doctor who found it insulting to attach money to medicine supports "socialized medicine." But when asked to comment on the role of organized medicine in its opposition, he came to its defense, though he has resisted joining. "The AMA shouldn't be blamed," he argues. "It was just doing its job to protect the interests of its members." To these doctors, individual compassion somehow adds up to collective compassion; individual self-interest somehow adds up to the common good.

Recommendations

In this chapter, I have argued that American doctors' self-interested compassion has given impetus to the transformation of a system that is making it increasingly difficult for doctors to be compassionate or self-interested. And the harder doctors try, the harder it gets. Some rethinking about our self-interest, interdependency, and health care is indicated if we are to revitalize our doctors' compassion.

1. Renounce Some Self-Interest. If doctors are above self-interest, this should not be too much to ask. Give a little more time to your patients for a little less "competence." Give a little more care to a few more patients who cannot pay. Go into primary care even if it pays a little less.

I expect to be asked: "Where do you draw the line?" One can always give a little more of oneself. I expect to be reminded that physicians have always offered free health care to the needy.[77] I expect to be told that I, too, will have to pay off my loans, my mortgages, my children's tuitions. These concerns are real enough, but then not really. A Chinese proverb tells us that we have "never enough sizing up, always plenty sizing down."[78] It depends on with whom I am comparing myself. Most hard-working Americans would consider themselves doing well with an

income of a little less than $91,200 (median income for a family practitioner), and certainly at $219,000 (median income for an orthopedic surgeon). How much "competence" is competent? How much compassion is compassionate?

2. Recognize Interdependency. I mentioned earlier that compassion is increased when people share a common fate, a sense of interdependency. American doctors do not share that sense. They do not see doing more for their patients, and for themselves, as taking away from other patients. Conversely, doing less for their patients, and for themselves, might not save it for other patients. Norman Daniels argues that saying no to patients (and to themselves,) is so hard for American doctors because the resources saved may not be redistributed justly within the system[79]:

> American physicians cannot make this appeal to the justice of saying no. They have no assurance that the resources they save will be put to better use elsewhere in the health care system. Reducing a Medicare expenditure may mean only that there is less pressure on pubic budgets in general, and thus more opportunity to invest the savings in weapons. Even if the savings will be freed for use by other Medicare patients, American physicians have no assurance that the resources will be used to meet the greater needs of other patients.... In a for-profit hospital, the profit made by denying beneficial treatment may be returned to investors.

This is because "[o]ur system is not closed," Daniels points out, "the opportunity costs of a treatment or procedure are not kept internal to it." Unlike physicians in the British National Health Service, saying no to our patients does not

take place within a system of universal access, with regionally-centralized budget and explicit priorities for resource allocation. And our health planners cannot say: "Justice requires that we forgo this procedure because the resources it requires will be better spent elsewhere in the system. It is fair to say no to this procedure because we can thereby provide more important treatments to other patients."[80]

Closing the system might help to increase our sense of interdependency. A global budget, expenditure target (limit) and explicit rationing of health care resources might sensitize doctors to the facts of a lifeboat rather than an open checkbook system. Reimbursing physicians by salary or capitation rather than by fee-for-service might take away the perverse incentive to do more. Reducing administrative waste, employer tax exclusion, and profiteering by proprietary medicine might make resource reallocation more fair. A national health care system might symbolically link "all classes, races, regions, and age groups" in an "effort to ensure all citizens equal opportunity to develop and use their capacities consistent with their aspirations."[81]

But we must also rethink our self-interest in a larger context. "Our individualistic heritage taught us that there is no such thing as the common good," Robert Bellah and his co-authors observe, "but only the sum of individual goods."

They warn that the sum of individual goods in our complex, interdependent world often produces not a common good but a "common bad."[82]

But we still like to think that "each man from selfish motives will promote the greatest happiness of the greatest number," that we can "contrive a harmony of selfish interests."[83] For examples, our individualistic culture of "everyman for himself" and "look out for number one" and our libertarian ethic that holds it "unjust to force one person or group to pay for the needs or burdens of another" rationalize the practice of experience rating, at the expense of those who are excluded from insurance because of such practice.[84] We also thought that if each doctor gave the best care possible to each patient that they would add up to a best health care system, forgetting that not every patient comes first. Many patients never come because they cannot pay. The doctor who supported universal health care excused the AMA on the ground that it "was just doing its job to protect the interests of its members," ignoring that not all interests receive or deserve equal protection.

Uwe Reinhardt remarks that "[i]n fact, few, if any, countries in the industrialized world can rival the United States in the best parts of its health care system, and few, if any, match it or would want to match it in its worst":[85]

> To guarantee access to human services on equal terms to rich and poor alike inevitably implies that the well-to-do forgo some of the quality,

> freedom of choice, and other superior amenities that a more inegalitarian distribution would offer them. In a society that views success and poverty as primarily the products of free choice rather than of mere fortune, the well-to-do are not easily moved to make that sacrifice .... That refusal can be defended also with appeals to the loftier goal of economic efficiency.... Thus it can be argued, as this nation's haves often do, that enforcement of greater equality in the distribution of human services would come at the expense of technical progress in the production and delivery of these services.

If we are ever going to have a national health care system, each of us, especially the privileged, must be willing to give up something -- some amenities of first-class health care, a tithe of our "competence," a piece of tax exclusion, a bit of our self-interest -- to get something greater for all.

3. Reappropriate the Essence of Health Care. Health care is about **health** and **care.** Under present institutional arrangements, we deliver neither very well. To make the work of health care more intrinsically rewarding, we need to pay greater attention to making health and giving care. We need to reappropriate the idea of calling to health care.

Health is "not merely the absence of disease or infirmity." Health is, as defined in the Preamble to the Constitution of the World Health Organization, "a state of complete physical, mental, and social well-being."[86] Health care is not only or primarily medical care.[87] The factors that affect health, according to Dr. Henrik Blum, professor of public health at University of California, Berkeley, include heredity, environment, life styles, and medical care services, which depend on population, natural

resources, ecologic balance, human satisfactions, and cultural systems.[88] "If you don't pay attention to factors that affect health," Blum asserts, "you are not going to have compassionate health care."[89] For example, the unavailability or unaffordability of many essential human services prevents American doctors from providing the health care that their patients need. In countries like Sweden or U.K., Blum observes, such services are provided free of charge and in the home of the patients. "Doctors in U.K. are more compassionate," Blum contends, "they are not penalized for it."

Now we see why minutes, or seconds, of listening, explaining, acknowledging, reassuring, hand-holding, making eye-contact, or being there is not enough compassion. More time or more pay for doctors will not make our health care more caring if we do not pay more attention to what make health.

Or to what is care. Our caring is bounded by our freedom, I will argue in the next chapter. Compassion is giving patients their autonomy, or simply leaving them alone. But is it autonomy, or compassion, that our patients want from us?

VI.

COMPASSION AND FREEDOM:
The Limits of Our Medical Ethics

Autonomy, more than compassion, is what our patients want from us. So one is led to infer from our preoccupation with autonomy, and our inattention to compassion, in our deliberation of ethical issues in health and medical care.

High Noon

A twenty-two-year-old woman lies "debilitated and allegedly moribund" after two periods of anoxia left her in a persistent vegetative state. Her parents sought court authorization to remove her from a ventilator, overriding what her doctor considered to be "medical standards, practice and ethics."[1]

A nineteen-year old man with back pain underwent laminectomy which left him in a condition such that he "required crutches to walk, still suffered from urinal incontinence and paralysis of the bowels, and wore a penile clamp." He sued his doctor for, among other things, failure to inform him beforehand of the risk involved in the operation.[2]

A single woman who wished to terminate her pregnancy by

an abortion "performed by a competent, licensed physician, under safe, clinical conditions" was unable to do so under Texas Penal Code, which made it a crime to procure an abortion, "except for the purpose of saving the life of the mother." She sought a declaratory judgment that the Texas criminal abortion statutes were unconstitutional.[3]

All three cases pitted patient autonomy against medical paternalism and state interest, and in all three landmark cases the principle of autonomy was upheld.

Karen Anne Quinlan was finally allowed to be removed from her ventilator with respect to her right to privacy:[4]

> Presumably this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy .... we believe Karen's choice, if she were able to make it, would be vindicated by the law. Our affirmation of Karen's independent right of choice ... may be asserted on her behalf by her guardian under the peculiar circumstances here present.

The New Jersey Supreme Court decided that "the State's interest [in the preservation and sanctity of human life and defense of the right of the physician to administer medical treatment according to his best judgment] contra weakens and the individual's right to privacy grows," as Justice Hughes formulated, "as the degree of bodily invasion increases and the prognosis dims." At the time of the decision, Ms. Quinlan was described as "emaciated, having suffered a weight loss of at least 40 pounds, and undergoing a

continuing deteriorative process. Her posture is described as fetal-like and grotesque; there is extreme flexion-rigidity of the arms, legs and related muscles and her joints are severely rigid and deformed."[5]

Mr. Canterbury also won his case on the principle of autonomy. The court found the neurosurgeon who performed the laminectomy at fault for failing to disclose the risk that "the reasonable person, in what the physician knows or should know to be the patient's position" would want to know. Judge Robinson grounded his decision in Canterbury v. Spence on autonomy: "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."[6]

The right of the patient to informed consent, and the corresponding duty of the physician to disclosure, are founded on autonomy. The purpose of informed consent is "to promote patients' decisional authority over their medical fate," presupposing that "patients can or should be allowed to make their own decision, based on the fullest disclosure possible."[7] It challenges the long held notion that the doctor, like daddy, knows best. Hippocrates sanctioned such medical paternalism:

> Perform [these duties] calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and sincerity, turning his attention away from what is being done to him; sometimes reprove sharply and emphatically, and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present condition.

The justification for concealing information from the patient, as articulated in a precedent case, was that "a complete disclosure ... could so alarm the patient that it would, in fact, constitute bad medical practice."[8] Therefore the physician was given a therapeutic privilege -- to disclose or to conceal -- so long as "the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in similar situation." The "reasonable medical practitioner" was deemed to know best. Judge Robinson challenged the paternalistic attitude underlying therapeutic privilege, which he found to "assum[e] instability or perversity for even the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself."[9]

The Supreme Court of the United States also decided that the criminal abortion statutes of Texas violated Jane Roe's right to privacy. This right to privacy, Justice Blackmun remarked, "whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action,... or ... in the ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."[10] He observed that the "detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent"[11]:

> Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved.

"State intervention to restrict maternal autonomy during pregnancy or to compel medical procedures," one constitutional scholar points out, "suggests a vision of women as being little more than reproductive vessels." For men, that is. In Planned Parenthood of Missouri v. Danforth, the Supreme Court invalidated Missouri state requirement for a woman to obtain the written consent of her husband prior to procuring an abortion. Because the woman "is the more directly and immediately affected by the pregnancy as between the two," Justice Blackmun argued that "the balance weighs in her favor," irrespective of the husband's "deep and abiding concern and interest [in] his wife's pregnancy." The requirement, in his view, "rested on the false premise that the husband's interest is always superior."[12]

Autonomy:

Another Word For Compassion?

Autonomy has become the touchstone of medical ethics. What is "good" is what the patient wants. What is "right" is for the patient to decide.

In a sense, that is compassionate. Giving patients who are suffering and want to die their right to die is compassionate. Karen Anne Quinlin's sufferings, as we might imagine by her "fetal-like and grotesque" posture, her emaciation and deformity, were finally terminated with respect to her right to privacy. Giving patients who are anxious and want to know what is going to be done to them their right to informed consent is compassionate. Canterbury's urinary incontinence, bowel paralysis, and penile clamp were iatrogenic sufferings made more iatrogenic by the deprivation of his self-determination over his own body and fate. Preserving for Jane Roe control over her own body and her choice to terminate an unwanted pregnancy is compassionate. The harm to her mental and physical health, the distress and the stigma of an illegal abortion or unwanted parenthood -- the sufferings of having no choice -- were avoided because her right to privacy was respected.

Our respect for individual autonomy has generated a certain kind of compassion for our patients. We show compassion by giving autonomy. It is as if autonomy is our rational-legal way of feeling compassion, if by compassion

we mean to respect patients as autonomous persons, or at least to leave them alone.

Autonomy means self-rule, derived from the Greek autos (self) and nomos (rule, governance, or law). That is, "a person is autonomuous if and only if he or she is self-governing"[13]. It draws inspiration from John Stuart Mill and Immanuel Kant. For Mill, autonomy meant non-interference with self-determination -- "[a]utonoumous actions and choices should not be constrained by others." For Kant, autonomy meant moral self-legislation -- "giving oneself the moral law ... in accordance with universalizable moral principles." Mill was interested in maximizing the utility of the individual; Kant was concerned with treating persons as ends in themselves.[14]

Autonomy received increasing medical attention following the Nuremberg trials, as a corrective to the abuse of human rights by the Nazi doctors in their conduct of research on prisoners in concentration camps.[15] The principle of autonomy was fully articulated in the Belmont Report on human subjects research, but it has found its way into just about every ethical debate in medicine today.

It is often codified in the language of rights, and in our liberal individualist tradition, most often in terms of negative rights. A negative right guarantees "non-interference with liberty,"; "for every negative right I have, someone else has a duty to **refrain** from doing

something."[16] For example, the right of privacy in Roe vs Wade is construed as a negative right, as freedom **from** intervention by the physician and the state (and the husband in the Danforth decision) in a woman's choice to abort the fetus. But it is less clear about her positive right, her freedom **to** (distributive) justice in the form of public aid and assistance that would make it possible for her to have an abortion.[17] A negative right is grounded in the principle of autonomy; a positive right is grounded in the principle of justice.[18] As a society, we do better with the former.

So leave them alone; let them be, let them choose, let them know, let them die. Sometimes that may be the most compassionate thing we can do for our patients.

The Limits of Autonomy

But more often we can do more. While autonomy has generated a certain kind of compassion, it has its limits.

We are autonomous only in limited ways, and more limited than we think. As Robert Bellah points out:[19]

> What the relentless effort of Americans to think of human beings as autonomous self-interest maximizers, who also occasionally want to feel good, ignores is a truth that most human societies, including our own not so long ago, were quite aware of: namely, that human beings exist in and through relationships and institutions or they do not exist at all.

We depend on our relationships and institutions all our lives. But in thinking that we are autonomous, we forget

our dependency.

Forgetting Our Dependency. We depend on each other more than we think. No matter how hard we try to be independent and self-sufficient, we cannot escape from our dependency. At this moment, we depend on our relationships and institutions for food, shelter, clothing, knowledge, memories, examples, love, hope, justice, peace, and freedom, among other necessities and realities of life. Dependency is a fact of life, whether we like it or not.

As infants and babies, we depend completely on nurturing from our caregivers. We acquire greater independence and autonomy in childhood and adolescence, but we continue to depend on our family, friends, teachers and others for caring. As we grow older, we experience a growing tension between our need for dependency and our want for independence. We are told that the latter is healthy and the former is pathological. Dependency is seen as immature, weak, or exploitative. Independence means being out on my own, standing on my own two feet, taking care of myself. It means being left alone, needing nobody, free to do as I please. Dependency and independence are defined and understood best in economic terms. I am a dependent if I still need to go to someone for money; I am independent when I no longer need anybody's help.

But from time to time, we are reminded of our dependency. Illness, old age, and death (and dying) are

such times, but also anytime we care or need care, anytime we help or need help, anytime we suffer or suffer with. Our dependency is, of course, not limited to such times, but times like these expose our dependency. They remind us of how we depended on our caregivers once upon a time, and how much we would like to be able to go back to that state of complete dependency and trust.[20]

But we cannot let go of ourselves. Our ambivalence toward dependency is evident in the "sick role" as described by sociologist Talcott Parsons.[21] The "sick role" gives the patient rights to care and to exemption from his or her normal social role responsibilities, but it also imposes on the patient duties to acknowledge the sick role as undesirable and to get well by seeking and cooperating with technically competent help. It recognizes our dependency when we are sick, but it also reminds us that dependency is socially undesirable. The goal of medical care is to return the individual to functional independence as quickly as possible, and not to prolong dependency.

And so our ambivalence is intensified in conditions characterized by prolonged dependency (often in functional terms), such as chronic illness, mental illness, or old age.[22] I mentioned earlier that the self-conflict generated by the chronic state of dependency and the social desirability independence is a source of suffering in chronic illness. The patient's self-conflict is exacerbated

by the physician's ambivalence toward the sick role[23]:

> They may compassionately treat patients with myocardial infarction but still resent the fact that "these people didn't take proper care of themselves in the first place." Physicians may urge their patients to "take it easy" and recover gradually and at the same time worry that patients may be exaggerating residual symptoms or trying to prolong the special privileges of convalescence. Physicians may openly resent persistence of the sick role in people they seem unable to help or "cure." Worst of all, doctors readily become exasperated with persons who "enjoy bad health" (hypochondriacs) or who are always vaguely, annoyingly, but never seriously sick ("crocks").

Robert Bellah observes this ambivalence in psychotherapy[24]:

> I think of therapy as responding to a continuum of psycho-physical problems, as a one-shot solution, a quick fix, a good dose of self-esteem, that will then "empower" the person in need to go out and be autonomous again. Crisis intervention will have no lasting effect if people do not return to relationships, institutions, communities that continue to nurture them and to call forth their own capacities for nurturing others. To ask individuals to be healthy in a sick society is a heroic and impossible demand, yet that, in effect, is what our instrumentalist, self-interest-maximizing culture expects. No wonder it is so often disappointed.

Our ambivalence toward dependency and our preoccupation with autonomy are also spoken in our language about illness. We "fall ill" the way we fall from grace; we "caught a cold" the way we catch tuberculosis or venereal diseases; we "broke a leg" or "sprained an ankle" instead of our "leg is broken" or ankle sprained.[25] By implication we are responsible for our illness; how much we are responsible depends on the disease and the patient. The growing emphasis on self-help, self-care, self-efficacy, among other

"self" theories of illness behavior, makes it clear who is responsible in chronic illnesses associated with behavioral risk factors. As autonomous agents, they did it to themselves.

How we argue about abortion and the right to die is also telling about our ambivalence toward dependency and our preoccupation with autonomy. For many, it boils down to when is life viable and when is death dead. We forget that "dependence is not ended by viability."[26] We forget that navels are more than "gestational artifacts"; they signify "connection and dependency."[27] Just because the fetus is viable does not mean that it is autonomous. It will depend on the caring of its mother, who in turn will depend on others caring for her, for years to come. The ethical question is thus not when does life begin, but what kind of life can the fetus, and the mother, depend on from us.

We suppose the woman to be an autonomous agent, responsible for her action and her choice. We blame the unwanted pregnancy on her irresponsibility. We forget that it took at least an irresponsible man, and perhaps other irresponsible relationships and institutions, to cause an unwanted pregnancy, and it will take responsible men and women, relationships and institutions to care for her, to help her through her pregnancy and parenthood. And if she chooses to have an abortion, we expect her choice to be autonomous, rational, and universalizable. Any doubt,

guilt, or regret that she might suffer from her abortion is taken as a sign of her weakness rather than a call for our compassion.

We also forget that death is not only the cessation of self-consciousness, not even the cessation of vegetative functions, of the individual.[28] A demented patient with Alzheimer's disease might not experience self-consciousness, but we do not consider him dead and stop caring for him. That is because a person is not a person in and of himself, but a person in relation with other persons -- a social person. Death of the person is not an individual death, but a social death. Death tells us about life -- whether it is to be lived in self-consciousness or not at all, or it is to be lived in relation with others, in a nexus of interdependence, in a community of memory. Dependence does not end with death; the dead depends on the living for memory and continuity, and the living depend on the dead for meaning (and protection in many cultures). We forget that both the living and the dead suffer from the death and that we should suffer with both. Autonomy or futility cannot tell us to treat or not to treat; only compassion can.

We forget that many patients come to us in their most dependent moments, in illness, old age, and death, and for some, we may be the only one they could depend on for caring. We might all do better if we let others depend on us, and ourselves depend on others, for caring. We might do

better as patients if we insist less on autonomy and more on caring. We might do better as doctors if we attend less to patient responsibility and more to our own. We might all do better if we can accept dependency as a fact of life, and reject functional (or financial) independence as the way of life.

Compassion is generated by remembering our dependency on each other, our interdependency. It allows us to depend and let depend on.

Misusing Our Power. Why are we so hung up on autonomy? Why is dependency not okay?

It may have to do with how power, derived from being depended upon, is exercised by us and over us.

In his recent study on the history of freedom in the making of Western culture, sociologist Orlando Patterson argues that freedom was generated from the experience of slavery. "People came to value freedom, to construct it as a powerful shared vision of life," Patterson observes, "as a result of their experience of, and response to, slavery ... in their roles as masters, slaves, and nonslaves."[29]

A child depends on her mother; a slave depends on his master. The child values compassion from her mother; the slave, freedom from his master. Why is compassion generated from one form of dependency, and freedom from the other?

It depends on how power is exercised by the mother and the master. The mother wields power over her child, but she

uses her power to care for her child; the master wields power over his slave, but he uses his power to oppress and exploit his slave. Freedom is a fight or flight response of the powerless to being dominated, subjugated, oppressed, and exploited by the powerful. Compassion is an empathic response by the powerful to the suffering of the powerless -- empathic because of our common capacity to suffer and our shared memory of suffering.

When autonomy, not compassion, is generated from the doctor-patient relationship, something may be very wrong with how doctors exercise power over their patients. I mentioned that autonomy received medical attention following the Nuremberg trials, in response to the abuse of human rights by the Nazi doctors. Autonomy was also a response, codified in patients' right to informed consent, to the misuse of therapeutic privileges by physicians. It challenged medical paternalism not only in the sense that the doctor, like daddy, knows best, but also that the doctor, like daddy, does his best for me. I have described earlier how doctors are driven by success and self-interest, and not always by compassion, to do more for (to) the patient. The right to die is the suffering, dying patient's (or the family's) response: enough is enough; just leave me (us) alone! The right to privacy is also women's response to how men have exercised power over women, how men continue to dominate and violate women -- physically,

economically, culturally, politically, and otherwise. We are not asking you to care, women say to men, just leave our bodies and our selves alone!

But giving patients their right to informed consent or their right to die does not make doctors more caring. It might even make doctors less responsive now that patients are more responsible, legally speaking. And giving women their right to privacy does not make men more caring. Arguing about the right of woman to privacy versus the right of the fetus to life diverts attention from the obligation of men to care for both. The right to informed consent, the right to die, and the right to privacy are all negative rights; they require non-interference with self-determination but they do not entail an obligation to care. They may protect your freedom from oppression and exploitation, but they do not promise you freedom to justice and compassion. They may restrain men and doctors from misusing their power, like a master over his slave, but they cannot teach them how to use their power to care like a mother for her child.

Ignoring the Space Around and In Between. I mentioned earlier that compassion depends on what is around and in between us as much as what is in us. By thinking ourselves autonomous, we ignore the space in-between and all-around.

It is said that Western art draws our attention to persons or objects in the picture, whereas Eastern art draws

our attention to the space between persons or between objects.[30] In the West, the space in between separates the persons or the objects; in so doing, it gives them shapes and boundaries, with separate identities and realities. In the East, the space in between provides the context within which persons or objects relate to and connect with each other. Whether I need more space from you or I am connected to you in space depends on how we see and use the space between and around us.

If the space in between us is seen and used to keep us at safe distance from each other, as under a Hobbesian social contract, we relate to each other as potential threat to our survival and freedom. Without that free space, we live in a state of constant fear and terror of one another, our lives "solitary, poor, nasty, brutish and short."[31] If the space in between us is seen as free for all, to be acquired and exploited, than we relate to each other as competitors for survival of the fittest. In this context, freedom to do as I please, to acquire and to exploit, becomes important to me (unless I am less fit; but if so, I will not get to make the rule anyway). But if that interpersonal space, as Gahdhi suggested, is used for "territories or zones of peace in our personal relations where violence and deceit won't be used," then we may begin to trust each other, to depend on each other, to care for each other.[32]

I mentioned earlier Orlando Patterson's argument that freedom was generated from the experience of slavery in Western culture. But he also observes that freedom failed to attain similar status in many slave-holding, non-Western societies, a failure which he attributes to the social bonds they value. "People sought to be bonded," he argues, "it was just such bonds that the person released from slavery in such societies sought immediately to establish."[33] "No slave," he asserts, "wanted personal freedom where no nonslave found it worthwhile." The "nexus of elaborate system of cross-cutting bonds and allegiances" both devalued personal freedom and constrained sovereignal freedom.[34] The context of interdependency made freedom less worthwhile to get.

So autonomy is a response to a certain kind of space in between, perhaps one that is territorial, competitive, or disconnected. Under other contexts, other responses may be more adaptive. The important point for our discussion is to pay attention to the space within which we relate to each other.

When our patients want autonomy, and our exercise of power is compassionate, we need to ask: Why does the patient want to be left alone? Why did Sam want to be left alone? Why did he fear institutionalization? Why did he live alone? Why was he institutionalized? What was in the space all around him that makes him choose autonomy in his

moment of great suffering? How could we make the space in between us more hospitable to trust and compassion? We need to pay attention to the ecology of autonomy, and the ecology of compassion.

Recommendations

Toward an Ethic of Compassion

Autonomy has given our compassion its rational-legal vocabulary, but it has also limited our moral discourse because human beings are not autonomous. We need a language that can speak to the lived experience of human sufferings -- the interdependencies, the causalities, and the contexts of suffering. We need an ethic of compassion.

1. Make Compassion a Goal of Medicine. To be a good doctor is to be a doctor, just as to be a good man or woman is to be a man or woman. What is good depends on the true end, the **telos**, of being a man, a woman, or a doctor. To know what is good medicine is to know what medicine is for, to know the goals of medicine.

But what is the true end of being a doctor? What are the goals of medicine? I believe that the true end of being a doctor is the same as the true end of being a man or a woman, and that the goals of good medicine are also those of a good life. Compassion must be a true end both of a doctor and of a man or a woman, and a goal of medicine as

well as a goal of life, because life is suffering, and medicine is all about suffering.

Compassion has been a goal of Chinese medicine for a long time. "Medicine is practiced humaneness," observed a Confucian scholar over a millennium ago, and therefore "[p]hysicians are advised to practice humaneness and compassion"[35]:

> When someone suffers from a disease and seeks a cure, this is no less important than if someone facing death by fire or by drowning calls for help. Physicians are advised to practice humaneness and compassion.... This is the proper thing to do. Otherwise accidents such as burning or drowning take place. How could a man who is guided by humaneness calmly tolerate such a happening.

Another physician elaborated on the notion of medicine as practiced humaneness[36]:

> The teaching of medicine is the teaching of Buddha. Since in this world man is struck by grave diseases, does not rise any more and advances toward death, compassion and pity arise, as it were, of their own accord in his neighbor. The latter takes pains to serve as a ferryman [in the sea of troubles]; [his help] does not resemble that of brokers looking for profit. And besides, which man who has received his life between heaven and earth would not possess a compassionate disposition by his very nature? For instance, if someone has to witness a child running into the danger of falling into a deep ravine, the [very threat] of an injury to the latter will move the person to pity, even in the case of an enmity between them. How much more does this apply to someone who devotes his entier life only to the purpose [of helping others in need]!

In the Confucian comprehensive paradigm of health, personal health and social health are interconnected. Good medicine and good life are also connected because humaneness and

compassion are the true end of both.

It is our inattention to this teleology that our medical ethics is turned into a "simulacra of morality." When morality is detached from teleology, Alasdair MacIntyre argues, we no longer have morality. "We continue to use many of the key expressions," MacIntyre observes. "But we have -- very largely, if not entirely -- lost our comprehension, both theoretical and practical, of morality." Without a teleology of compassion, what is a minute or two of hand-holding or a second or two of eye-contact? When practice is detached from meaning, "morals is reduced to manners, and ethics to aesthetics." Simply saying "I know you are hurting," "I know you are frightened," "I know what you are going through," are just good manners, not good medicine.

What does autonomy have to do with the true end of a man or a woman, or the goals of a good life? How is liberating the patient, perhaps an isolated patient, from the doctor good medicine?

We must dedicate ourselves to compassion as an end in and of itself. The central goal of medicine is not simply to prolong life, for that does not make life good. It is not simply to cure disease, for that may not be what the patient suffers from. It is not even, and not so simply, to end suffering, for that is not always possible. It is to suffer with our patients.

2. Pay Attention to Suffering. We need a medical ethic that pays attention to suffering.

In chapter two, we saw how pluralistic and individualistic our sufferings are. An ethic of compassion requires us to pay attention to the person who is suffering: "the lived past, the family's lived past, culture and body, the unconscious mind, the political being, the secret life, the perceived future, and the transcendent-being dimension." It requires us to pay attention to and validate the pain that is causing the suffering, especially "when [the pain is] out of control, when the pain is overwhelming, when the source of the pain is unknown, when the meaning of the pain is dire, or when the pain is apparently without end." It also requires us to pay attention to the sufferings generated from isolation and loneliness.

Paying attention to suffering requires us to be present at this moment, to be mindful from moment to moment, and not just at the endpoints. An ethic of compassion is an everyday ethic. It is a primary care ethic. From moment to moment, we need to be vigilant of our compassion: "Are we paying attention to the patient? What is the patient suffering from now?" An ethic of compassion is not about making rational-legal decisions as to when is a life alive or when is a death dead that is disengaged from the sufferings of life and death. It is not "intellectual pyrotechnics on some exotic cases" that engage our

admiration to the rationality of the ethicist and distract our attention from the suffering of the patient.[37] An ethic of compassion is thus not a prerogative of ethicists; it is an imperative for clinicians. It moralizes the day-to-day practice of medicine, rather than marginalizes ethics to something you worry about only to cover your ass.

An ethic of compassion pays attention to suffering of the person not only as an individual, but also in and through his or her relationships and institutions. In so doing, it does more for the patient than the principle of autonomy. Karen Anne Quinlan's suffering is not only her loss of autonomy. Nor is it the suffering we imagine her to experience in her weight loss, grotesque posture or joint deformity. Hers is the suffering of her parents. An ethic of compassion requires us to pay attention to her suffering as we would if she were our daughter. There was nothing more real and compelling to me, not her right to privacy, not the state's interest to preserve life, than her parents' suffering.

Similarly, an ethic of compassion is concerned with more than simply "when does life begin." It is concerned with more than simply the fetus' right to life versus the woman's right to privacy. It pays attention to the woman-fetus relationship prior to conception, to the woman-man relationship, the woman-state relationship, and other relationships that cause an unwanted woman-fetus

relationship. It pays attention to the woman prior to choice. It pays attention to the fetus prior to life. It pays attention to the woman and her relationships after choice. It pays attention to the fetus and its relationships after life. It is concerned as much with their freedom to as with their freedom from. It pays attention to the institutions within and through which these relationships take place.

Sufferings are generated by an unwanted woman-fetus relationship. They may have been generated within an irresponsible woman-man relationship and an irresponsible woman-state relationship. They may have been generated in and through uncaring institutions. The fetus' right to life, the state's interest to preserve life, and the woman's right to privacy, must be weighed against the sufferings that one causes another in their interconnections and interdependencies. The woman, the fetus, and the state all have claims to our compassion, in proportion to their sufferings. In most cases, I believe, the woman's suffering from an unwanted relationship with the fetus and from uncaring relationship with an irresponsible man and an irresponsible state, the fetus' suffering if born into an unwanted relationship with the woman and uncaring relationships with an irresponsible man and an irresponsible state, if they are around at all, and the role of an irresponsible state in causing the sufferings prior to

choice and after life far outweigh the sufferings caused to the woman, the fetus, and the state by the abortion. This is because we suffer in and through relationships and institutions, and we depend on our relationships and institutions for compassion.

3. **Pay Attention to the Context.** We can start by paying attention to the social contexts of our patients' illness, as Alasidair MacIntyre instructs us:

> Autonomy is not, as Kant thought, a property of every rational agent. It is an achievement and a social achievement, as is rationality itself. It is in and through our network of relationships that we achieve or fail to achieve rational control of our lives.... Hence, if we are to look for autonomy and rationality, we should seek them not in individuals abstracted and isolated from their social roles and relationships, but in individuals at home in those roles and relationships. The moral for medical practice is clear ...: to treat the patient as a person in any substantial sense we must refuse to direct our medicine toward individuals abstracted from their social roles and relationships. The home and the work place have to become the locus of medical practice; the family and the working group - and not the individual apart from his or her ties - must become the objects of medical attention.[38]

We also need to pay more attention to the social ecology of power which generates a moral ecology of autonomy. We need to examine how power is exercised by the doctor over the patient, by men over women, by the strong over the weak. We need to examine how such power is institutionalized through our health care system, our family life, our marketplace, our political institutions.... We are led to see what the legendary Pan Ku saw milleniums ago.[39] "The scientist

concerned with the formulas of prescriptions discuss the diseases until they advance to the origins of the government. They treat [the diseases] with a knowledge which equals that of public administration." Personal health and social health are deeply connected; so are compassion and justice in a good society.

VII.

HEALTH CARE AS A VISION OF THE GOOD SOCIETY

> A black man was going down the road in his car, an old beat up car, and maybe it broke down, and he's sitting there trying to figure out what to do. Some other cars come by. The pastor of the established church in town comes by and he's on his way to an important meeting, so he doesn't have time to stop. Then a white government person was also coming by, somebody who's going to a committee to talk about the needs of the black community, and that person was too busy and kept going. Then a woman who was Puerto Rican with a whole bunch of kids in the car came along and she saw his need and stopped to help him.

The hero in this rendition of the story of the Good Samaritan by one of Wuthnow's respondents is the Puerto Rican woman;[1] with a whole bunch of kids in the car, she seems more likely an AFDC recipient than the Lone Ranger. Yet it is she who saved the day -- for a black man in an old beat-up car. Robert Wuthnow pointed out that[2]

> People who know the story understand that the Samaritan is a social outcast and yet he is the one who shows compassion. It is not about us, the privileged, showing kindness to the downtrodden. It is about them showing kindness to us. It is not a story about handouts for the poor, not even a story about welfare for the disadvantaged. It is a story about reconciliation, about the healing of social wounds, about wholeness in the organism of society.

Compassion does more than fulfill us individually; it "enriches and ennobles" us collectively. It tells who we are as a people; it "holds forth a vision of what a good society can be."[3] It "fuzzes the boundaries,"[4] breaks down

barriers, and makes peace. It connects us by our common capacity to suffer and our interdependency on caring. It gives us hope for a better day.

I was struck by what the Good Samaritan can do for us during the recent riot in Los Angeles following the Rodney King verdict. Reginald Denny, a white trucker driving through South Central Los Angeles, was pulled from his truck and beaten unconscious by a dozen young black men. "Rodney King was the white man's verdict," boasted one of the assailants, "that guy in the semi was our verdict." Appalled by what they had just witnessed on television, two black men rushed to the scene and, with the help of two other black men, took Denny to the hospital. "We said to each other, 'Somebody's got to get that guy out of there,'" said T.J. Murphy, one of the black men who came to Denny's aid. "It was just like Rodney King. They beat him and they beat him."[5]

These black men reminded many of us of the Good Samaritan. "They did not see color, they simply saw compassion for humanity," praised Denny's former brother-in-law.[6] "Among the many stories I've seen and heard about these past few days, one sticks in my mind," President Bush said during a nationally-televised address, alluding to the parable of the Good Samaritan. "The story of one savagely beaten white truck driver, alive tonight because four

strangers, four black strangers, came to his aid."[7] Their compassion reminded us of our common humanity. It reassured us that we can work things out. It gave us hope for reconciliation, for peace, for a better day.

But I was also struck by what the Good Samaritan, by himself, cannot do for us. He cannot reconcile the injustices of class structure. He cannot heal the wounds of institutional racism. He cannot not make peace in a house divided. He cannot give a black child born today hope for a better day.

A black child born today is twice as likely to die within the first year of life and has a life expectancy some five to seven years shorter than his or her white brothers and sisters.[8] He has one in three chance of living in a poor household and living in a household headed by a single parent. He has one in five chance of dying from homicide and one in eight chance of graduating from college. He can look forward to an income one-half, and a net wealth one-tenth, of those of his white neighbors, everything else being equal. Of course, everything else is not equal.

What can our Good Samaritan do for him or her?

What have we done for him or her?

What our society needs today is more compassion, and a different kind of compassion. We need compassionate individuals, but we also need compassionate institutions.

And we need them both to pay more attention to the sufferings around them, and less attention to themselves.

We as individual citizens need to be more compassionate. I do not mean simply doing good to make me feel good, to give me self-esteem, to set me apart from the rest. It is not about me feeling good about myself. It is not about me making myself stronger, not like muscle-building. It is not about me doing my own things, not like a cowboy. It is not about me at all. It is about the other. But it is also about us, myself and the other. As Robert Bellah envisions[9]:

> Genuine caring occurs in a community and culture of caring where people expect to care and be cared for because that is the kind of people they are, that is the kind of community they live in. In such situation the eternal monitoring of "how I feel" and how low or high my self-esteem is, can for considerable periods of time, be bracketed because one is simply too involved in activities that have instrinsic meaning to worry about how one feels.

It is about us, suffering together as one because we are.

And as doctors, we need to be more compassionate. That means suffer with your patients; participate with compassion in their suffering. You can start by paying more attention. Pay attention to them even when there is nothing else you can do. Pay attention to them even when it does not pay. Pay attention to them even when they want to be left alone. Pay attention to them even if you have to suffer with them.

When we pay attention, we will see more suffering. We

can turn away. We can pass by on the other side. We can see it as "their" problem. But compassion moves us to see it from the other point of view. Sociologist Troy Duster points out the need for more "perspective-taking" in our race-relations. "Whites tend to ... treat it as an individual, perhaps unique, idiosyncratic moment, an experience about brutality that got on television and will go away," Duster points out the difference in perspectives on the Rodney King beating and verdict. "Blacks tend to see it as systemic, institutional, deeply mired in the whole structure of American society."[10] When we see it from "their" point of view, we see better their suffering, and our own. And we will see how the two may be connected by our separation.

When we see more suffering, we are called to greater responsibility. Compassion takes responding to suffering, as we would respond to our parent's or our own. And it takes responding to not only its symptoms, but also its causes, and the causes of its causes, and the causes of the causes of its causes, and the interconnected causality of suffering. It takes us "upstream," "upstream," and further "upstream" to see who is drowning the babies, the black child, we are trying to resuscitate "downstream." Thereby the "responsible self is driven as it were," theologian H. Richard Niebuhr concludes, "by the movement of the social process to respond and be accountable in nothing less than a

universal community."[11]

Some doctors tell me that they are "not very political," that they are "more introverted," that "social action is not for [them]." But the compassionate self cannot help but to respond to suffering and more suffering, beyond where the personal and the social divides, where "us" and "them" separates, where the self ends and the other begins, for there is no division, no separation, no ending and no beginning to our suffering and our selves. All life is suffering, and the compassionate self is the responsible self.

We can start by responding to the sufferings we cause. That might take giving up some of the rewards that come with our success. It might take doing things that are not always in our best self-interest. And it might take commiting ourselves to less "freedom from" so others can have more "freedom to." It will take losing a little of ourselves to find ourself.

But individual response will often be not enough. Not enough for Sam. Sam's doctor finished his story like this, after Sam had been brought to the emergency room:

> And so we pulled him out. And he was in the ICU for the next ten days, his blood sugar anywhere between 20 and 400. And sure enough, he survived. And sure enough, he lost the other leg. And sure enough, he ended up in a home.
>
> I saw him about three months later. I was no longer his doctor because he kind of got turned over to the institution, which, of course, was his fear. So I went over just for a visit. I really

wanted to know what he thought three months later. He said "I'm still as pissed as hell at you. I wish you hadn't done it. I really do. Look it, this is not what I want."

"But I guess I have to understand you have to do what you have to do," he added. "I wish you hadn't done it. I should've sent you a letter."

Sam died about two months later.

It is not enough to ask simply: "Did Sam's doctor act with compassion?" or "did he suffer with Sam?" Even if he did, it was not enough compassion. We are moved to ask:

"Why did Sam want to be left alone?"

"Why was he living alone, in the Tenderloin?"

"Why did he fear being 'institutionalized'?"

"Why was he institutionalized?"

"Why was his diabetes out of control?"

"Why did he die?"

"Why did he live?"

It is hard to be a healthy person in a sick society; personal health and social health are deeply connected.[12] And it is hard to be a compassionate person in an uncompassionate society; compassion and justice go hand-in-hand. We will not have compassionate individuals without their cultivation by compassionate institutions. And we will not have healthy individuals without the caring of a good society.

It is hard for students to come out of eleven to fifteen years of institutionalized moral adolescence, self-absorbed in an unremitting quest for personal success and

its rewards, and all of a sudden become compassionate doctors. It is hard for doctors to spend more time with patients when "time is money," to be more compassionate when compassion does not pay, or when it does, for themselves or for somebody else. It is hard for them to leave alone, and even harder to suffer with, their patients, when they have to worry about covering their own ass. Some doctors still do; these are the true cowboys in white. But for most of us, compassion has limits. We get burnt out if we give too much of ourselves. We experience "compassion fatigue." But these limits are not natural, at least not primarily natural; they are institutional and ecological.

Our compassion in health care is limited by how we do business in general. Success, self-interest, and freedom are not only values of American individualism; they are also values of the marketplace. Robert Heilbroner deplores the "implosion of capitalism"; Robert Bellah and his co-authors describe the "commodification" of life;[13] Jurgen Habermas decry the invasion and colonization of the "life-world" by the economic and political "systems."

We now witness the implosion, commodification, invasion, and colonization of health care by the marketplace, by the "tide of commercialism," by the "coming of the corporation," by the "businessfication of medicine." I am not pointing my finger only at for-profit medicine, though that has made clear what much of medicine is now all

about. As Bradford Gray argues, "Neither the creation of for-profit health care organizations nor the need for health care organizations to attend to the economic bottom line is a wholly new development. Nonetheless, there has been a change in the explicitness and pervasiveness of profit-seeking behavior."[14] I am most disturbed by the explicit and pervasive "commodification" of compassion, to be bought and sold in the medical marketplace, for-profit or not for-profit, by managed competition or by regulation, free-choice or no free-choice. When we care too much about money, when money "invades and colonizes" our caring relationships, we care less for each other.

What our society needs today is more compassion, and a different kind of compassion. But it has to start somewhere, and nowhere is the calling stronger, and the impulse more natural, than in medicine -- because medicine is all about suffering and suffering with. In many traditional cultures, doctors have been endowed by the gods with the supernatural power to protect the society against evil spirits, as well as to exorcise them from the individuals.[15] With their gift, they were able to see and combat the evil spirits that plague the soul of the individuals and the society.

Compassion is our supernatural power. But it is not given to us by the gods. It is, like true success, self-interest, and freedom, a gift only we can give each other.

We are as great as the least amongst us. What is in it for me is us. I am free only when we are free. I care because we care.

Notes to Chapter 1

1. The word compassion is derived from its Latin roots com- (together with) and pati- (to suffer). It means "[s]uffering together with another, participation in suffering." In German it is **Mitleid**, from **mit-** (with) and **Leid** (sorrow), which means to feel sorrow with another. According to Barnhart Dictionary of Etymology, compassion is "borrowed through Old French **compassion**, sympathy, pity, or directly from Late Latin **compassionem** ... loan translation of Gr. **sympatheia** and formed from **compass-** stem of **compati**, suffer together with, feel pity (**com-** with + **pati** suffer)." Barnhart RK. H.W. Wilson Company, 1980:764. The word patient, or pacyent, is also derived from **pati**.

2. Reported in Seligmann J; Murr A; Rosenberg D; Barrett T. "Making TLC a Requirement," Newsweek. August, 12, 1991: p. 56-7.

Notes to Chapter II

1. Campbell, Joseph. The Mask of God: Oriental Mythology. Penguin Books, New York. 1962:259-63.

2. Zimmer, Heinrich. Philosophies of India. Meridian Books, Bollingen Foundation Inc., New York. 1951:466-7.

3. Campbell, Joseph. The Masks of God: Oriental Mythology. Penguin Books, New York, 1976:274.

4. Cassell, EJ. "The Nature of Suffering and the Goals of Medicine," New England Journal of Medicine. 1982: 306:639-45.

5. Cassell, E. The Nature of Suffering. Oxford University Press, New York. 1991:33.

6. Cassell, E. The Nature of Suffering. Ibid, p.43.

7. Cassell, E. The Nature of Suffering. Ibid. p.37.

8. Cassell, E. The Nature of Suffering. Ibid. p.35.

9. Cassell, E. The Nature of Suffering. Ibid, p.48-65.

10. Cassell, E. The Nature of Suffering. Ibid, p.54.

11. Barker L. "The Recovery Process," Dallas Morning News. Reprinted in San Jose Mercury, Health and Fitness Section, page 1.

12. Wang, YC. The Diary of an Intern. Wild Geese Publishers, Taipei. 1991: 186-7. Translation mine.

13. Wang, YC. The Diary of an Intern. Ibid, p.106-9. Translation mine.

14. For comparison, see Konner, M.. Becoming a Doctor. Penguin Books, New York. 1987.

15. Observation of Dr. Harrison Sadler, M.D., personal communications.

16. We shall take up the question of death and suffering - is the brain-dead dead and does the brain-dead suffer -- in Chapter VI.

17. Wang, YC. The Diary of an Intern. Ibid, p. 84. Translation mine.

18. Bellah RN; Madsen R; Sullivan WM; Swidler A; Tipton SM. Habits of the Heart. Harper and Row, New York. 1985:334.

19. Bellah RN; Madsen R; Sullivan WM; Swidler A; Tipton SM. Habits of the Heart. Harper and Row, New York. 1985:334.

20. Wuthnow R. Acts of Compassion. Princeton University Press, Princeton. 1991:20.

21. Bellah RN; Madsen R; Sullivan WM; Swidler A; Tipton SM. Habits of the Heart. Harper and Row, New York. 1985:198.

22. Bellah, RN. "Personal and Social Health: A Necessary Connection?" Radix. 1991(20):30.

23. The contemporaneity of Protestantism and bourgeois Capitalism was not coincidental. Max Weber pointed out that "work as a calling" for workers had a counterpart for entrepreneurs -- "aquisition as a calling ... which made it lawful to exploit this specific willingness to work." Both were "means of becoming sure of one's state of grace." And because Calvinism "never ceased to stress the notion that a man proved himself exclusively in his vocational work, ... begging was explicitly stigmatized as a violation of the injunction to love one's neighbor, in this case the person from whom the beggar solicits." "What is more," Weber observed, "all Puritan preachers proceeded from the assumption that the idleness of a person capable of work was inevitably his own fault .... Care for the poor was oriented to the goal of discouraging the slothful." "The unequal distribution of worldly goods was the special work of God's providence," Weber restated Calvin, "only when the 'people', in other words, the mass of workers and artisans, was kept poor did it remain obedient to God." See Weber, Max. Sociology of Religion. Beacon Press, Boston:1922 (1963 edition), and Runciman WG. Weber: Sections in Translation. Cambridge University Press, Cambridge. 1982, see also footnotes.

24. Success "is within my grasp as long as I apply myself diligently," Wuthnow states our assumptions about success and failure, while failure "comes about through some fault of the individual." See Wuthnow R. Acts of Compassion. 1991:14.

25. Wuthnow, R. Acts of Compassion. ibid, 13.

26. Bellah RN; Madsen R; Sullivan WM; Swidler A; Tipton SM. Habits of the Heart. Harper and Row, New York. 1985.

27. See Wolfe, Alan. Whose Keeper? Social Science and Moral Obligation. University of California Press, Berkeley. 1989.

28. Bellah RN; Madsen R; Sullivan WM; Swidler A; Tipton SM. Habits of the Heart. Harper and Row, New York. 1985.

29. Wuthnow, R. Acts of Compassion. ibid, 13.

30. Reported in a Newsweek cover story with the title "The Curse of Self-Esteem: What's Wrong with the Feel-Good Movement" on the cover and "Hey, I'm Terrific!" as the article title. Adler J; Wingert P; Wright L; Houston P; Manly H; Cohen AD. February 17, 1992:46-51.

31. There are three types of freedom, according to historian Orlando Patterson. Personal freedom is the "capacity to do as one pleases, insofar as one can," sovereignal freedom is the "power to act as one pleases, regardless of the wishes of others," and civic freedom is the "capacity of adult members of a community to participate in its life and governance." Patterson, O. Freedom in the Making of Western Culture. Basic Books, New York, 1991:3-4. Our most cherished freedom turns out to be personal freedom, to be left alone by others.

32. We owe our political freedom to John Locke, who argued for a limited government "to provide a minimum of order for individuals to accumulate property," and our economic freedom to Adam Smith, who argued that the market does best when left alone to the doing of the "Invisible Hand." See Bellah, RN. Madsen R; Sullivan WM; Swidler A; Tipton SM. The Good Society. Alfred A Knopf, New York. 1991:67.

33. Wuthnow, R. Acts of Compassion. ibid, 12.

34. Seven person in ten (71%) in Wuthnow's survey say it is either absolutely essential or very important to them to "be able to do what you want." Wuthnow, R. Acts of Compassion. ibid, 14.

35. Wuthnow, R. Acts of Compassion. ibid, 11.

36. See Rathbone-McCuan, E; Hashimi J. Isolated Elders: Health and Social Intervention. Aspen Publication, Rockville, MD. 1982.

37. Most heart patients experienced emotional isolation, according to one researcher, "feeling apart from the world rather than a part of it." Ornish D. The Effects of Lifestyle Changes on Coronary Heart Disease, unpublished manuscript, reported in Batson, CD. The Altruism Question. Lawrence Erlbaum Associates, Hillsdale, NJ. 1991:221. See also Turner D. "Tragic Isolation of the Disabled," San Francisco Chronicle. May 11, 1992:A1.

38. See Kubler-Ross, Elisabeth. On Death and Dying. MacMillan Publishing Co, New York. 1969.

Notes to Chapter III

1. Luke 10:30-36 (Authorized Version).

2. Robert Wuthnow reports that in his survey, "two-thirds of those who were currently involved in charity or social-service activities knew the story, compared with only four in ten among those who were not currently involved. Viewed differently, among those who knew the story, 40 percent were involved in charitable activities, but among those who did not know the story only 21 percent were involved.... Among those who were involved, for instance, 72 percent said they had experienced something that reminded them of the Good Samaritan, compared with 53 percent of those who were not involved in charitable work." See Wuthnow, R. Acts of Compassion. Princeton University Press, Princeton. 1991:161-2.

3. Wuthnow, R. Acts of Compassion. Princeton University Press, Princeton. 1991:168-9.

4. Wuthnow, R. Acts of Compassion. Ibid, 170-1.

5. Wuthnow, R. Acts of Compassion. Ibid, 172.

6. Wuthnow, R. Acts of Compassion. Ibid, 171.

7. Wuthnow, R. Acts of Compassion. Ibid, 287.

8. Wuthnow, R. Acts of Compassion. Ibid, 287. Wuthnow found that "people who were the most individualistic ... were also the most likely to value doing things to help others." Using "being able to do what you want" as one measure of "self-oriented values" amongst his respondents in a national survey of volunteers in community service, Wuthnow found a "slight positive relationship between ... self-oriented values and placing importance on charitable activities" (Wuthnow, 1991:22).

9. Wuthnow, R. Acts of Compassion. Ibid, 87.

10. Wuthnow, R. Acts of Compassion. Ibid, 88.

11. Wuthnow, R. Acts of Compassion. Ibid.

12. Wuthnow, R. Acts of Compassion. Ibid, 109.

13. Wuthnow, R. Acts of Compassion. Ibid, 112.

14. Wuthnow, R. Acts of Compassion. Ibid, 117. Alvin Gouldner calls this "the norms of reciprocity."

15. Wuthnow, R. Acts of Compassion. Ibid, 303.

16. Wuthnow, R. Acts of Compassion. Ibid, 288.

17. Wuthnow, R. Acts of Compassion. Ibid, 100.

18. Wuthnow, R. Acts of Compassion. Ibid, 194.

19. Wuthnow, R. Acts of Compassion. Ibid, 281.

20. Wuthnow, R. Acts of Compassion. Ibid, 237

21. Wuthnow, R. Acts of Compassion. Ibid, 231.

22. Wuthnow, R. Acts of Compassion. Ibid, 230.

23. Wuthnow, R. Acts of Compassion. Ibid, 235.

24. This subtitle is inspired by the Buddhist symbol for compassion. "In the Buddhist teachings the symbol for compassion," as Chogyam Trungpa discusses in Cutting through Spiritual Materialism, "is one moon shining in the sky while its image is reflected in one hundred bowls of water. The moon does not demand, 'If you open to me, I will do you a favor and shine on you.' The moon just shines.... It is a matter of an open gift, complete generosity without the relative notions of giving and receiving."

25. "The Legend of Avalokitesvara," in Martin, Rafe. The Hungry Tigress. Parallax Press, Berkeley. 1990:154.

26. Linda Hess, personal communication.

27. In Martin, Rafe. Hungry Tigress. Ibid, 130.

28. c.f. Rosch, "Glossary," in Psychology 107 -- Buddhist Psychology reader; U.C. Berkeley, Fall, 1989. Compassion, or karuna, is said "to arise from experiencing the suffering of sentient beings, including ourselves; insight into the four noble truths; seeing suffering inherent in our bewilderment about cause and effect and in clinging to solid and permanent existence; and spontaneously, from sunyata, or buddha-nature."

29. Batson, CD. The Altruism Question. Lawrence Erlbaum Associates, Hillsdale, NJ. 1991. c.f. chapter 2: "Egoism and Altruism in Western Philosophy" for an excellent summary of

Western thoughts on compassion. Most of the references below are cited in Batson.

30. Machiavelli N. The Prince. E.P. Dutton, New York. 1908:134. original work in 1513.

31. Hobbes T. Leviathan: or the Matter, Form, and Power of a Commonwealth, Ecclesiastical and Civil. A. Crooke, London. 1651:ch. 15.

32. La Rochefoucauld F. Moral Maxims and Reflections, in Four Parts. Gillyflower, Sare, & Everingham, London. 1691:82, 264.

33. Aquinas T. The Summa Theologica. Benzinger Bros., New York. 1917(Vol 2.Part II):30,2. Original work in 1270.

34. Mandeville B. The Fable of the Bees: Or, Private Vices, Public Benefits. J. Tonson, London. 1732:41. Original work in 1714.

35. Bentham J. An Introduction to the Principles of Morals and Legislation. The Clarendon Press, Oxford. 1876. original work in 1789.

36. Comment by Plamenatz J. The English Utilitarian. Basil Blackwell, Oxford. 1949:9, 12.

37. Mill JS. Utilitarianism. Parker, Son, & Bourn, London. 1861:ch.2 paragraph 17.

38. Nietzsche F. Ecce Homo. In The Philosophy of Nietzsche. Random House, New York. 1927:824-5. original work in 1888.

39. Luke 6:35. Authorized Version.

40. See Batson CD. The Altruism Question. ibid, 20.

41. See Campbell, Joseph. The Power of Myth. Doubleday, New York. 1988:112.

42. Rousseau JJ. Du Contrat Social. (R. Grimsley, ed.) Oxford University Press, Oxford. 1972. Cited in Loewy, E. Freedom and Community: The Ethics of Interdependence. Manuscript.

43. In Wuthnow R., Acts of Compassion. ibid, 52.

44. In Lowey, E. Ibid.

45. Hume D. An Enquiry Concerning the Principles of Morals. Oxford University Press, Oxford, 1902:appendix, p.2. orignial work in 1751.

46. Smith, A. The Theory of Moral Sentiments. Alex Murray, London. 1872 (Original work published 1759):I.i.1.1). Cited in Batson, CD. The Altruism Question. Lawrence Erlbaum Associates, Publishers, Hillsdale, NJ. 1991:31.

47. Ibid.

48. As rephrased in Campbell, Joseph. Power of Myth. ibid, 110.

49. Schopenhauer A. Preisschrift uber die Grundlage der Moral. Cited in Loewy, E. manuscript.

50. The question is posed as such by Daniel Batson, who goes on to review the psychological literature on The Altruism Question. ibid.

51. For a more comprehensive review of research on the biology of empathy, see Brothers, L. "A Biological Perspective on Empathy." American Journal of Psychiatry, 1989(146):10-19.

52. Ibid. The amygdala has been described as the "veritable Picasso of our emotional color" (Diamond, 1985:5-26), "a determinant of the organism's attitude toward its environment" (Nauta, et. al, 1986:125). Situated in the dorsomedial portion of the temporal lobe, it is "strategically located for responding to social signals" via reciprocal interconnections with the hypothalamus and sensory association cortex (Brothers, 1989:16). One anatomical study implies that the amygdala processes visual information received from the sensory association cortex and sends signals back to that area during relatively early stages of the processing sequence, "perhaps imparting an emotional tone to analysis of sensory data" (Iwai, et. al., 1987:362-387), see discussion in Brothers, ibid). The most common response in unanesthetized animals to electrical stimulation of the amygdala is an "arrest" reaction "in which all spontaneous activities ease as the animal assumes an attitude of aroused attention" (Carpenter, et. al. 1983:637). The "arrest" reaction initiates agonistic behavior, leading to flight (fear) or defensive (rage and aggression) reactions. Tachypnea, tachycardia, vasoconstriction, pupillary dilation, piloerection, and an elevation of serum levels of ACTH most commonly accompany the "arrest" reaction (ibid). Electrical stimulation of the amygdala in man has elicited rage on a few occasions. Bilateral lesions of the amygdala, in contrast, have caused a decrease of aggressive and assaultive behavior (termed Kluver-Bucy syndrome) in cats, monkeys, and man. In addition, bilateral lesions of the amygdala produce "psychic blindness" rendering the animals unable to distinguish between food and potentially dangerous objects (ibid). Free-ranging

monkeys subjected to bilateral lesions of the amygdala by their capturers had severe difficulties responding appropriately to other animals upon returning to their social group. "They ran away from every approach, including friendly ones, and eventually isolated themselves completely from their troop" (Kling, 1972, discussed in Brothers, ibid).

Research using fine-tipped electrodes to record the activity of a single neuron in the primate brain has demonstrated selectivity in responding to visual stimuli by neurons in the amygdala and the superior temporal sulcus. These neurons showed "preferences" for the identity of the face, responding weakly to some and strongly to others. The neurons in the amygdala fire later than those in the superior temporal sulcus. Moreover, some of these neurons "may be coding for a higher-level feature than the face, namely, facial expression" (ibid). Neurons were found to respond selectively to the orientation of the head and direction of gaze of the eyes in a stimulus picture. A neuron was found to fire robustly to pictures of yawns, which has agonistic significance; another specifically responsive to crouching body posture, also a socially meaningful feature. If empathy requires "attention ... to cues ... in motility, verbalization, affective expression and tempo," then these evidences help locate the neural substrate of empathy to the interplay between the amygdala, sensory (e.g., visual) association cortex, and the hypothalamus and brainstem effecting autonomic and endocrine changes.

53. Psychoanalytic theories view psychic structure as deriving from the vicissitudes of either drives or relationships (Greenberg and Mitchell, 1983, also see Kriegman, 1990:342). Compassion is thus viewed, on the one hand, as reaction formations against libidinal and aggressive drives or, on the other hand, as adaptive extension of parental love (Kriegman, 1990).

Sigmund Freud argued that "feelings of compassion ... necessitate the notion of a reaction-formation" (Freud, 1915a:129). Reaction formation, as developed by his daughter Anna Freud, allows the ego to defend against an unwelcome impulse by asserting the opposite attitude or feeling in consciousness (Goldman, 1988:24). "Reaction-formations against certain instincts take the deceptive form of a change in their content," as Sigmund Freud observed, "as though egoism had changed into altruism, or cruelty into compassion" (Freud, 1915b:281). Altruism and aim-inhibited love (Freud, 1921) was seen not as derivative of, but rather in opposition to, human nature (Kriegman, 1990:344).

Even parental love was seen as "nothing but the parents' narcissism born again":

> The child shall fulfil those wishful dreams of the parents which they never carried out - the boy shall become a great man and a hero in his father's place, and the girl shall marry a prince as a tardy compensation for her mother (Freud, 1914:91).

The child is a "selfobject" to the parents - "an external object that is part of their genetic 'flesh and blood' and whose well being and success enhances the parent's self (incluseive fitness" (Kriegman, 1990:352).

Against Freud's vision of the "Guilty Man, told to be civilized, and unwilling to comply," Heinz Kohut posits his self psychological view of "Tragic Man":

> striving, resourceful man, attempting to unfold his innermost self ... and warmly committed to the next generation, to the son in whose unfolding and growth he joyfully participates - thus experiencing man's deepest and most central joy, that of being a link in the chain of generations (Kohut, 1982:403).

In contrast to Freud's vision of "intergenerational strife and mutual wishes to kill and to destroy," Kohut's vision of parental love is "normal and human ... experiencing man's deepest and most central joy" (ibid).

> It is only when the self of the parent is not a normal, healthy self, cohesive, vigorous, and harmonious, that it will react with competitiveness and seductiveness rather than with pride and affection .... And it is in response to such a flawed parental self which cannot resonate with the child's experience in empathic identification that the newly constituted assertive-affectionate self of the child disintegrates and that the breakup products of hostility and lust of the Oedipus complex make their appearance.... Is it not the most significant dynamic-genetic feature of the Oedipus story that Oedipus was a rejected child? (ibid).

54. For example, D. W. Winnicott included both drives and relations as determinants of the capacity for concern (Winnicott, 1963). To do so he posits the need of two mothers for the pre-Oedipal baby: an object-mother as the object of the baby's libidinal and aggressive drives, and an environmental-mother as the subject of the baby's love. "It is my thesis that concern turns up in the baby's life as a

highly sophisticated experience in the coming-together in the infant's mind of the object-mother and the environmental mother":

> In favourable circumstances, the mother by continuing to be alive and availabe is both the mother who receives all the fullness of the baby's id-drives, and also the mother who can be loved as a person and to whom reparation can be made. In this way, the anxiety about the id-drives and the fantasy of these drives becomes tolerable to the baby, who can then experience guilt, or can hold it in full expectation of an opportunity to make reparation for it. To this guilt that is held but not felt as such, we give the name 'concern'. In the initial stages of development, if there is no reliable mother-figure to receive the reparation-gesture, the guilt becomes intolerable, and concern cannot be felt. Failure of reparation leads to a losing of the capacity for concern, and to its replacement by primitive forms of guilt and anxiety.

Here concern develops out of reparable guilt, guilt because of the vicissituds of drives, reparable because of the stability of relations.

55. Miller PA; Eisenberg N. "The Relation of Empathy to Aggressive and Externalizing/Antisocial Behavior," Psychological Bulletin. 1988(103):324-44.

56. see Goldman HH. Review of General Psychiatry. Appleton & Lange, Norwalk, Connecticut. 1988:410. A review of the theories and presuppositions about its etiology is beyond the scope of my thesis, but the absence of empathic support from caretakers to help the child deal with the frustrations and disappointments caused by the inroads of the environment may be attributable. See also Fromm, Erich. The Anatomy of Human Destructiveness. Fawcett, Greenwich Conn. 1973:414-17. A very popular song by Whitney Houston may also be telling about our narcissism. She started off the "Greatest Love of All" with "... Everybody's searching for a hero/People need someone to look up to/I never found anyone who fulfilled my need/A lonely place to be/And so I've learned to depend on me" and concluded that the "greatest love of all/is easy to achieve/Learning to love yourself/is the greatest love of all."

57. Sagi A; Hoffman ML. "Empathic Distress in the Newborn," Developmental Psychology. 1976(12);175-6.

58. Weber, Max. Sociology of Religion. Beacon Press, Boston. 1922(1963ed):212.

59. Lapierre, Dominique. City of Joy. Werner, New York. 1985.

60. see Kriegman, D. "Compassion and Altruism in Psychoanalytic Theory: An Evolutionary Analysis of Self-Psychology." Journal of the American Academy of Psychoanalysis, 18(2), 1990:342-367.

61. Lorenz K. On Aggression, Harcourt Brace Jovanovich, New York. 1966. reviewed in Fromm, Erich. The Anatomy of Human Destructiveness. Fawcett Crest, Greenwich, Connecticut. 1973:48.

62. Dawkins R. The Selfish Gene. Oxford University Press, New York. 1976:202.

63. Aronson, Elliot. The Social Animal. W. H. Freeman and Company, New York. 1984:52.

64. Aaronson ...The Social Animal. ibid.

65. Darley J; Batson CD. "'From Jerusalem to Jericho': A Study of Situational and Dispositional Variables in Helping Behavior," Journal of Personality and Social Psychology. 1973(27):100-8.

66. Batson, CD. The Altruism Question: Toward a Social-Psychological Answer. Lawrence Erlbaum Associates, Hillsdale, NJ. 1991. A full presentation of all the experiments conducted to test the empathy-altruism hypothesis, against the three "egoistic" alternative hypotheses of aversive-arousal reduction, empathy-specific punishment, and empathy-specific reward, is beyond the scope of my thesis. The reader is referred to chapters 8, 9, and 10 in Batson CD (1991) for details.

67. See Aronfreed (1968), cited in Goldstein AP; Michaels GY. Empathy: Development, Training, and Consequences. Lawrence Erlbaum Associates, Hillsdale, NJ. 1985. Aronfreed hypothesized that

> As children learn that other people's distress often is followed by their own distress ..., they develop an emotional distress reaction to the distress cues emitted by others. In time they come to experience this vicarious emotional arousal even in situations where there is no reason to anticipate that the other's distress will lead to direct negative consequences for themselves.

This describes clasical conditioning. Aronfreed extended his theory of empathy to explain altruism:

> Because the empathic distress response is aversive, activity to help the other is undertaken to reduce the empathic distress that the child experiences. The altruistic act, if it is successful in reducint the other's distress, is reinforced by the cessation of the child's own empathic distress response.

See also Batson's discussion of aversive arousal and empathetic distress, Batson, CD. The Altruism Question. Ibid, 45-58.

68. Batson, CD. The Altruism Question. Ibid, 125-6.

69. Particularly the work of psychologist C. Daniel Batson, who has identified four key steps to empathy-induced altruism:

1. perception of the other's need,
2. adoption of the other's perspective,
3. experiencing empathic emotion, and
4. enacting behaviors to reach altruistic goals.

Step one corresponds to paying attention, and step four to taking responsibility, two teachings emphasized by the coauthors of the Good Society. Steps two and three correspond to cognitive and empathic identification, respectively. See Batson, CD. The Altruism Question. Ibid, 225, and Figure 6-1, p.76.

70. See Bellah RN; Madsen R; Sullivan WM; Swidler A; Tipton SM. The Good Society. Alfred A Knopf, New York. 1991:254.

71. Campbell, Joseph. The Masks of God: Oriental Mythology. Penguin Books, New York, 1976:490.

72. Quoted in Batson CD. The Altruism Question. ibid, 204, from Donald Campbell's Presidential Address to the American Psychological Association in 1975.

73. Batson CD. The Altruism Question. ibid, 204.

74. Reviewed in Goldstein AP; Michaels GY. Empathy: Development, Training, and Consequences. Lawrence Erlbaum Associates, Hillsdale, NJ. 1985:20. The ability for perspective taking, Piaget observes, is developed around six or seven years of age made possible by the development of "concrete operations." Piaget described egocentrism "as a state of fusion or undifferentiation between the self and other people," as in infancy. "Perspective-taking" marks the achivement of a non-egocentric cognitive structure.

75. Suedfeld P; Bochner S; Wnek D. "Helper-Sufferer Similarity and a Specific Request for Help: By-stander

Intervention During a Peace Demonstration," Journal of Applied Social Psychology. 1972(2):17-23.

76. Donne, John. sermon April 19, 1625.

77. Mother Teresa of Calcutta. My Life for the Poor. Harper and Row, San Francisco. 1985:104.

78. Schweitzer, Albert. Reverence for Life. Harper and Row, New York. 1969:124.

79. Wuthnow R. Acts of Compassion. ibid, 105.

Notes to Chapter IV

1. Bellah, RN; Madsen, R; Sullivan, WM; Swidler, A; SM Tipton. Habits of the Heart. Harper and Row, New York. 1985:196.

2. Bellah et al. Habits of the Heart. Ibid, 199.

3. Bellah et. al. Habits of the Heart. Ibid, 197.

4. McCue, JD. "The Effects of Stress on Physicians and their Medical Practice," New England Journal of Medicine. 1982(306):461.

5. Reported in Cohen, RL. House Officer. Plenum Medical Book Co, New York. 1988:226. c.f. references on 232.

6. McCue, JD. Ibid, 460.

7. Sheehan KH; Sheehan DV; White K; Leibowitz A; Baldwin DC. "A Pilot Study of Medical Student 'Abuse'. Student Perceptions of Mistreatment and Misconduct in Medical School," Journal of American Medical Association. 1990(263):536.

8. Cousteau, Voltaire. "How to Swim with Sharks: A Primer," reprinted in Perspectives in Biology and Medicine. 1973:525-528. The footnote pointed out that "[b]ecause it may have broader implications, it was translated from the French by Richard J. Johns ... of the Department of Biomedical Engineering [at the] Johns Hopkins University and Hospital." There are actually six cardinal rules, all of which are applicable to surviving a swim with sharks or third-year clerkship:

1. Assume unidentified fish are sharks
2. Do not bleed
3. Counter any aggression promptly
4. Get out if someone is bleeding
5. Use anticipatory retaliation
6. Disorganize an organized attack

Diana found the second and the fourth most helpful.

9. Richman JA; Flaherty JA; Rospenda KM; Christensen ML. "Mental Health Consequences and Correlates of Reported Medical Student Abuse," Journal of American Medical Association. 1992(267):692-694, and Silver HK; Glicken AD. "Medical Student Abuse: Incidence, Severity, and Significance,"

Journal of American Medical Association. 1990(263):527-532. The incidence of abuse was 72% of 137 students followed over a four-year period in the study by Richman et. al. and 80.6% of seniors surveyed in the study by Silver, et. al.

10. Baldwin DC; Daugherty SR; Eckenfels EJ. "Student Perceptions of Mistreatment and Harassment during Medical School: a Survey of Ten United States Schools," Western Journal of Medicine. 1991(155):140-5.

11. Richman et. al. found that 35.4% of 137 students reported discomfort listening to sexual humor, and 33% reported unfair treatment due to gender. Sheehan et. al. found the most common source of psychological mistreatment to come from residents or interns who "made negative remarks to you about becoming a physician or pursuing a career in medicine," "took credit for your work" (40%), "assigned you tasks as punishment" (44%), and "threatened an unjustifiably bad grade" (40%). Physical abuse were less common (less than 10% in all studies). One student reported being hit on the knuckles repeatedly until they bled for holding the forcep improperly, while another reported being kicked in the testicular region by an attending and required medical attention. See Sheehan KH; Sheehan DV; White K; Leibowitz A; Baldwin DC. "A Pilot Study of Medical Student 'Abuse'. Student Perceptions of Mistreatment and Misconduct in Medical School," Journal of American Medical Association. 1990(263):533-7.

12. Racial harassment was reported in Sheehan, et. al.. Abuse of "gender-atypical" students, as determined by expectations of assertiveness, control over affectivity or emotional feeling, and other items, was reported in Richman et. al.. Richman et. al. suspected that "antihomosexual prejudices" may have motivated the abuse.

13. Psychopathological outcomes reported in Richman, et. al.. Earlier reports had attributed intern and physician impairment to family history or life adjustment prior to medical school. See Vaillant GE; Sobowale NC; McArthur C. "Some Psychologic Vulnerabilities of Physicians," New England Journal of Medicine. and Valko RJ; Clayton PJ. "Depression in the Internship," reference needed.

14. Reported in Sheehan, et. al.. 67% of students reported negative effect of abuse on their emotional health; for 24% the effect was marked or extreme. 43% reported negative effect on family life, and 40% on physical health.

15. Silver, et. al., ibid, 530.

16. Sheehan et. al. ibid, 536.

17. Reported in Sheehan, et. al. ibid, 536.

18. Kleinerman MJ. "Elucidating and Eradicating Medical Student Abuse," Journal of American Medical Association. 1992(267):738.

19. Konner, Melvin. Becoming a Doctor: A Journey of Initiation in Medical School. Penguin Books, New York. 1987:xii.

20. Konner, Melvin. Becoming a Doctor. ibid, 375.

21. Sheehan et al., ibid, 535.

22. Sheehan, et. al., ibid, 535.

23. New York is the first and only state to legislate hours limits for residents, following the 1984 death of Libby Zion which her father attributed to "exhausted and undersupervised house officers." The 405 regulations assure residents an 80-hour work week, a continous 24-hour period off each week, a minimum of eight hour off between shifts, and round-the-clock supervision by a fully trained physician. The advocate is Dr. Janet Freedman of the Committee of Interns and Residents. Reported in Chollar, S. "Resident Relief," New Physician. 1991(40):20.

24. Gabbard GO. "The Role of Compulsiveness in the Normal Physician," JAMA. 1985(254):2924-29.

25. Huebner, LA; Royer, JA; Moore J. "The Assessment and Remdeiation of Dysfunctional Stress in Medical School," Journal of Medical Education. 1981(56):547-58.

26. Gaensbauer, TJ; Jizner, GL. "Developmental Stresses in Medical Education," Psychiatry. 1980(43):60-70.

27. Erikson, EM. Childhood and Scoiety. WW Norton & Company, New York. 1961. in Pfeiffer, ibid, 128.

28. This is an expression of self-interest, which Wuthnow found that sixty-six percent of respondents in his national survey agreed. see Wuthnow, Robert. Acts of Compassion. ibid, 100.

29. Nelson, R. "Can Doctors Learn Warmth?" New York Times, September 13, 1983, Science Section, p. 1.

30. Herzog, DB; Wyshak G; Stern, TA. "Patient Genrated Dysphoria in House Officers," Journal of Medical Education. 1984(69):869-74.

31. See Konner, Melvin. Becoming a Doctor, for more. ibid.

32. Kubler-Ross, Elisabeth. On Death and Dying. MacMillan Publishing Co, New York. 1969:9.

33. Dunphy, JE. "Annual Discourse -- On Caring for the Patient with Cancer," New England Journal of Medicine. 1976(295):313.

34. Becker, HS; Geer, B; Hughes, EC; Strauss, AL. Boys in White. Transaction Books, New Brunswick, NJ. 1961:429.

35. Becker HS; Geer B; Hughes EC; Strauss AL. Boys in White: Student Culture in Medical School. Transaction Books, New Brunswick, NJ. 1961:430.

36. Bellah RN; Madsen R; Sullivan WM; Swidler A; Tipton SM. Habits of the Heart. 1985:149.

37. Bellah, RN. et. al. Habits of the Heart. ibid.

38. Sarason SB. Caring and Compassion in Clinical Practice. Jossey-Bass, San Francisco. 1985:54-5.

39. Bellah RN, et. al. Habits of the Heart. ibid, 287.

40. Bellah RN. et. al. Habits of the Heart. ibid, 335.

41. Bellah, RN. Habits of the Heart. ibid, 154.

42. Bellah RN. Habits of the Heart. ibid, 335.

43. Bellah, RN. "Personal and Social Health: A Necessary Connection?" ibid, 30.

44. See chapter six.

45. Nearly 90 percent of the respondents in Wuthnow's survey indicated that "I'm just a sort of person who tries to be caring" as a reason for them to be a kind and caring person. Wuthnow, R. Acts of Compassion. Princeton University Press, Princeton. 1991:53.

46. Robert Wuthnow found that many of his respondents were willing to stretch the concept of compassion in order to avoid being judgmental. When asked whether "a Wall Street stockbroker might claim to be compassionate just because he tried to help his clients make lots of money," one respondent acknowledged that, though for her personally helping people make money would not be compassion, "I can see that it might make sense, given a Wall Street frame of mind":

because it kind of depends on what your goals are. If your goals involve making a lot of money, and somebody feels a real need for that, then you might be able to show compassion by helping them meet that need.

For example, compassion could be, for the stockbroker, "deliver[ing] the best product possible" and not "goofing off and short-changing your clients." See Wuthnow, R. Acts of Compassion. ibid.

47. Quoted by Derek Bok in "Needed: A New Way to Train Doctors," Harvard Magazine, May-June, 1984:43. Bok points out that "[i]f the faculty is serious about nurturing attitudes, there remains much truth in Plato's observation: 'If you would know virtue, observe the virtuous man.'"

48. In "The Prelude," quoted by Helen Vendler in her 1980 presidential address to the Modern Language Association, cited by Bellah, et. al. in Habits of the Heart. ibid, 293.

49. Haber, Samuel. The Quest for Authority and Honor in the American Professions, 1750-1900. University of Chicago Press, Chicago. 1991:351.

50. Haber, Samuel. The Quest for Authority and Honor in the American Professions, 1750-1900. University of Chicago Press, Chicago. 1991:351.50.

Notes to Chapter V

1. Bellah RN; Madsen R; Sullivan WM; Swidler A; SM Tipton. The Good Society. Alfred A. Knopf, Inc, New York. 1991:91. The quote is from Alan Wolfe in Whose Keeper? cited therein.

2. Bellah, et. al. The Good Society. Ibid.

3. Wuthnow, R. Acts of Compassion. Princeton University Press, Princeton. 1991:13.

4. Schwartz, MD; Linzer M; Babbott D; Divine GW; Broadhead E; SGIM. "Medical student Interest in Internal Medicine," Annals of Internal Medicine. 1991(114):6-15.

5. Babbott D; Levey GS; Weaver SO; Killian CD. "Medical Student Attitudes about Internal Medicine: A Study of U.S. Medical School Seniors in 1988," Annals of Internal Medicine. 1991(114):16-22.

6. Wogensen EO. "Internal Angst," New Physician. 1992(41):21.

7. see also McCarty, DJ. "Why Are Today's Medical Students Choosing High-Technology Specialties over Internal Medicine," New England Journal of Medicine. 1987(317):368.

8. McCue, JD. "The Effects of Stress on Physicians and their Medical Practice," New England Journal of Medicine. 1982(306):458-63.

9. Haber, Samuel. The Quest for Authority and Honor in the American Professions, 1750-1900. University of Chicago Press, Chicago. 1991:205.

10. Haber, Sameul. The Quest for Authority and Honor in the American Professions, 1750-1900. Ibid, 358.

11. Starr, Paul. The Social Transformation of American Medicine. Basic Books, New York. 1982:216.

12. Relman AS. "Practicing Medicine in the New Business Climate," New England Journal of Medicine. 1987(316):1130-1.

13. Relman AS. "Practicing Medicine in the New Business Climate," Ibid, 1130.

14. Council on Ethical and Judicial Affairs, American Medical Association. "Conflicts of Interest: Physician Ownership of

Medical Facilities," Journal of American Medical Association. 1992(267):2366-9.

15. Zollinger. American College of Surgeons Bulletin. 1992(77):7.

16. Haber, Samuel. The Quest for Authority and Honor in the American Professions, 1750-1900. Ibid, 356.

17. Starr, Paul. The Social Transformation of Medicine. Basic Books, New York. 1982:216.

18. Starr, Paul. The Social Transformation of American Medicine. Ibid, 279.

19. Dr. Henrik Blum, personal communication, March 3, 1992.

20. See McCormick, Brian. "Self-Referral Tug of War: Ethical Policy vs. State Politics," which appeared beneath a special report by Janice Perrone, "Physician, Police Thyself: Can Renewed Emphasis on Ethics Blunt Government Regulations?" in the April 27, 1992 issue of American Medical News, the official newspaper of the American Medical Association. AMA Executive Vice President James Todd, MD. pointed out that "The hallmark of professionalism is self-regulation."

21. Reports found that 10 percent of physicians nationwide, and over 40 percent in Florida, are involved in self-referrals and that physicians with a financial interest in diagnostic imaging facilities referred patients at a rate of four to 4.5 times that of noninvesting physicians. See Office of Inspector General. Financial Arrangements Between Physicians and Health CAre Businesses. Washington, DC: Dept of Health and Human Services; 1989. Health Care Cost Containment Board. Joint Ventures Among Health Care Providers in Florida. Tallahassee: State of Florida; 1991: Draft report. Hillman BJ; Joseph CA; Mabry MR; Sunshine JH; Kennedy SD; Noether M. "Frequency and Costs of Diagnostic Imaging in Office Practice -- a Comparison of Self-referring and Radiologist-referring Physicians. New England Journal of Medicine. 1990(323):1604-8.

22. McCormick, Brian. "Self-referral Tug of War," Ibid, 45. The critic quoted was Dr. Michael Isikoff, MD, a Titusville, Fla. radiologist who supported Florida's bill to ban self-referral.

23. See McCormick, Brian. "AMA Seeks Approval for Collective Bargaining by Doctors," in the May 11, 1992 issue, and "AMA Urges OK for Local Fee Review: Medical Society Panel Could Set Pace for Aggressive Self-Regulation" in the April 27, 1992 issue of the American Medical News.

24. One example is the 1938 indictment and 1943 Supreme Court decision to uphold the conviction of the AMA on antiturst violations. It was found that the "AMA and local medical society threatened reprisals against any doctors who worked for [Group Health Association of Washington, a plan of 'cooperative medicine' that paid physicians by salary intead of fee-for-service], prevented them from obtaining consultations and referrals, and succeeded in persuading every hospital in the District of Columbia to deny them admitting privileges, thereby cutting off members of the cooperative from hospital care." See Starr, Paul. Social Transformation of American Medicine, ibid, 305.

25. McCarty, DJ. "Why Are Today's Medical Students Choosing High-Technology Specialties over Internal Medicine," New England Journal of Medicine. 1987(317):368.

26. Starr, Paul. The Social Transformation of American Medicine. Basic Books, New York. 1982:214-5.

27. Anderson, DJ. "The Crisis in Caring: A Physician's Perspective," Radix, 1991(20):15.

28. Recent Medicare reform in physician payment using the resource-based relative value scale (RBRVS) is intended to redress this bias. The "essence of the payment reform ... is to increase payment for evaluation and management services (visits and consultations) relative to that for technical procedures, both surgical and medical." Evaluation and management services include history-taking and physical diagnosis, during which most of the talking and listening and laying on of hands take place. See Hsiao W; Braun P; Becker R; Dunn D. "RBRVS: Objections to Maloney, I" and Radecki SE; Ginsburg PB; Lasker RD. "RBRVS: Objections to Maloney, II," Journal of American Medical Association. 1992(267):1822-5. Also see Hsiao et al for discussion of RBRVS in JAMA. 1988(260).

29. The $35 fee for intermediate office visit, estimated to take 18 minutes in the RBRVS study by Hsiao et al, is reported in Lee PR; Ginsburg PB; LeRoy LB; Hammons GT. "The Physician Payment Review Commission Report to the Congress," JAMA. 1989(261):2383, and Hsiao W; Braun P; Becker ER; Dunn D. "RBRVS: Objections to Maloney, I," JAMA. 1992(267):1823. The figures for gastrocopy and colonoscopy are Medicare allowed charged for a gastroenterologist in Berkeley who accepts assignment as payment in full. Their charges for gastrocopy and colonoscopy are $490 and $603, respectively. The $337 fee under RBRVS is decreased from the $403 fee allowed under the CPR charge system of Medicare in 1991.

30. Radecki SE; Ginsburg PB; Lasker RD. "RBRVS: Objections to Maloney II," JAMA. 1992(267):1824.

31. Berenson R; Holahan J. "Source of the Growth in Medicare Physician Expenditures," JAMA. 1992(267):689. Advanced imaging services (CT and MRI) grew by 32.2 percent in total charges annually. In 1988, Medicare reimbursed physicians a total of $3.1 billion for all office visits, $1.2 billion for all endoscopic procedures, and $3.5 billion for all imaging procedures performed.

32. His favorite expression of doing everything for the patient.

33. The reader is referred to the following: Starr, Paul. The Social Transformation of American Medicine. Basic Books, New York. 1982, for an excellent historical account of the evolution of professional sovereignty, and Brennan Troyan. Just Doctoring: Medical Ethics in the Liberal State. University of California Press, Berkeley. 1991:37-57, for a concise review of the development of fee-for-service system. For a theoretical discussion on monopolistic pricing, see Feldstein, PJ. Health Care Economics. Ibid, 181-4.

34. Health Research Institute. "Health Care Cost Containment Survey," Medical Benefits. 1986(April 15):1.

35. It should be noted that the contribution and the exclusion were regressive: average employer contribution and tax exclusion for employees with household income of less than 10,000 was $636 and $129, respectively, but for over 50,000 it was $2000 and 850.

36. Gibson RM; Waldo DR. "National Health Expenditures, 1980," Health Care Financing Review. 1981(3):32-35, Table 3; 40, Table 5, reported in Feldstein PJ. Health Care Economics. John Wiley & Sons, New York. 1983:175, Table 9-2. Data for 1990 reported in Levit KR; Lazenby HC; Cowan CA; Letsch SW. "National Health Expenditures, 1990," Health Care Financing Review. 1991(13):33.

37. Reported in Feldstein, PJ. Health Care Economics. Ibid, 175, Table 9-2: "Total Expenditures on Physicians' Services by Source of Funds, 1950-1980." "Total" represents total physician expenditure in billions of dollars; "Direct" represents the percentage of direct consumer payment; "Private" and "public" represent third-party payments from respective sources.

38. Goldfarb, David. "Trends in Physicians Incomes, Expenses, and Fees: 1970-1980," Profile of Medical Practice. American Medical Association, Monroe, Wis. 1981:114, Table

1. Bureau of the Census. Statistical Abstract of the United States 1981. U.S. Government Printing Office, Washington D.C.. 1981:467, Table 779. Reported in Feldstein, PJ. Health Care Economics. Ibid, 177, Table 9-4.

39. Source: 1981-84, AMA Socioeconomic Monitoring System Core Surveys; 1974-1979, AMA Periodic Surveys of Physicians.

40. Dyckman, ZY. A Study of Physician Fees. Council on Wage and Price Stability, Washington D.C. 1978:95-103. Reported in Feldstein, PJ. Health Care Economics. Ibid, 176-8.

41. Feldstein, PJ. Health Care Economics. Ibid, 174, Table 9-1. Observations made for 1960-1981. The exceptions occurred between 1971 to 1974 during which price controls were imposed on the U.S. economy, and in the late 1970's, during period of high inflation.

42. Feldstein, PJ. Health Care Economics. Ibid, 176.

43. Cited in Starr, Paul. Social Transformation of American Medicine. ibid, 386.

44. For example, between 1971 and 1974, CPI physician fee increase were limited to about 3 percent, but the number of visits per physician per week increased from 127 in 1969 to 138 in 1973. See Feldstein, PJ. Health Care Economics. Ibid, 176, Table 9-3. Also, when Congress imposed a fee freeze on Medicare Part B from July 1984 through April 1986, the annual growth in fees decreased from 9% to 2%, while the annual growth in volume per enrollee decreased from 7% to 6%.

45. Feldstein, PJ. Health Care Economics. Ibid, 184. For examples of empirical studies lending support to the target-income hypothesis, see citations in reference #16, ibid, 196.

46. Fuchs, VR. "The Supply of Surgeons and the Demand for Operations," Journal of Human Resources (Supplement). 1978(XIII):35-8. Also example of ophthalmologists and cataract operations in San Diego County, lecture, February 6, 1987, Economics 156, Stanford University.

47. Feldstein, PJ. Health Care Economics. Ibid, 184.

48. Schneider DM; Smith RT. Class Differences and Sex Roles in American Kinship and Family Structure. Prentice-Hall, Englewood Cliffs, NJ. 1973:19-20. cited in Bellah, RN, et. al. Habits of the Heart. Ibid, 149.

49. Bellah RN, et. al. Habits of the Heart. Ibid.

50. Sources for the data presented in this paragraph include: Levit KR; Lazenby HC; Cowan CA; Letsch SW. "National Health Expenditures," Health Care Financing Review. 1991(13); Williams SJ; Torrens PR, Eds. Introduction to Healty Services. Wiley and Sons, New York. 1984:342. Pear, Robert. "Health Care Crisis Gives Impetus to Stricter Regulation," New York Times. Reprinted in the San Francisco Chronicle, May 11, 1992.

51. See Richardson WC; "Financing Health Services," in Williams SJ; Torrens PR. Introduction to Health Services. ibid, 344.

52. Paul Starr points out that "the profession's authority puts at its disposal the purchasing power of its patients. From the standpoint of the solvency of a health insurance company, the authority to prescribe is the power to destroy. So, too, the physician's authority to decide whether and where to hospitalize patients gives doctors great leverage over hospital policy. And, similarly, the authority to prescribe drugs and other supplies obliges pharmaceutical companies and other producers to court the profession's good will, to finance its journals, and thereby to subsidize its professional associations and political activities." See Starr, Paul. Social Transformation of American Medicine. ibid, 26-7. Hospital costs, for example, account for 38 percent of national health expenditure in 1990, but physicians act as gatekeepers to the hospitals and, as William C. Richardson points out, the "physician can handle a larger and more complex patient load through increased use of the hospital. Thus, there are both professional and economic incentives to hospitalize." See Richardson WC; "Financing Health Services," in Williams SJ; Torrens PR. Introduction to Health Services. ibid, 346.

53. Reported in Califano, JA Jr. "Billions Blown on Health," in New York Times. April 12, 1989.

54. In 1985, more than one-half of all uninsured workers were employed in two industries: retail trade (24%) and services (28%). Between 1980 and 1985, employment in these industries grew more than four times as fast as employment in industries with traditionally high coverage (e.g., manufacturing and professional and related services). The rate of noncoverage varied between 23% in retail trade and 32% in personal services. 24% of all self-employed workers were uninsured in 1985. Two-thirds of workers reporting no coverage were either self-employed (27%) or employed in firms with fewer than 25 employees. See Chollet, Deborah. "A Profile of the Nonelderly Population Without Health Insurance," in Government Mandating of Employee Benefits. Employee Benefit Research Institute, Washington, DC. 1987:59-89. Also see Blendon RJ;

Donelan K; Lukas CV; Thrope KE; Frankel M; Bass R; Taylor H. "The Uninsured and the Debate Over the Repeal of the Massachusetts Universal Health Care Law," JAMA. 1992(267):1113-17 for statistics on Massachusetts. It is the small firms in hotel services, construction industries, restaurant and recreational services who have been a leading force calling for repeal of the employer mandate in Massachusetts (Chapter 23).

55. Reisner SJ. "Consumer Competence and the Reform of American Health Care," JAMA. 1992(267):1511-15. The replacement of community-rating with experience-rating of risk has widespread consequences; for example, it has virtually confined employees to jobs they dislike due to fears that a new insurer would deny them coverage. A 1991 New York Times-CBS poll found evidence for the phenomenon of "job lock": three out of ten Americcans said that they or others in their household remained in jobs they wish to leave because of health insurance benefits.

56. Light DW. "The Pracitice and Ethics of Risk-Rated Health Insurance," JAMA. 1992(267):18. Light documented many discriminations and exclusion against individuals and industries.

57. Califano JA, Jr. "Billions Blown on Health," ibid.

58. Reported in Califano JA, Jr. "Billions Blown on Health," ibid. 1991 estimate given by Buchanan RJ; Cappelleri JC; Ohlsfeldt RL. "Medicare Expenditures: Factors Influencing the Level of STate Medicaid Spending," Public Administration Review. 1991(51):67-73.

59. See Levit KR; Lazenby HC: Cowan CA; Letsch SW. "National Health Expenditures, 1990" and Gibson R; Levit KR; Lazenby HC; Waldo D. "National Health Expenitures, 1983," in Health Care Financing Reives. ibid.

60. Himmelstein DU; Woolhandler S. "Administrative Waste in U.S. Health Care," The New England Journal of Medicine. 1986.

61. Special Committee on Aging, U.S. Senate. Medicare: Paying the Physician -- History, Issues, and Options. U.S. Government Printing Office, Washington, D.C.. 1984:25, Table 28.

62. Unbundling and upcoding referred to hospitals' attempt to increase revenue from Medicare's Prospective Payment System by "unbundling" one procedure into several diagnostic-related groups (DRGs) or "upcoding" it to a DRG with higher reimbursement rate. "Pingponging" refers to sending Medicaid patients back and forth for unnecessary visits; "family

ganging" refers to examining all members of the family in one visit; and churning refers to mandating unnecessary visits. See Jesilow P; Geis G; Pontell H. "Fraud by Physicians Against Medicaid," JAMA. 1991(266):3318.

63. See McIlrath, Sharon. "Medicare Fraud Investigations: HCFA officials hope to net more crooks with less hassle for doctors," American Medical News, May 11, 1992. Also see Jesilow PJ; Geis G; Portell H. "Fraud by Physicians Against Medicaid," JAMA. 1991(266):3318-22.

64. Jesilow P et. al. "Fraud by Physicians Against Medicaid," ibid. for quotes presented in this paragraph. Also see editorial by Todd, James. "Professionalism at Its Worst," JAMA. 1991(266):3338, who again called for rededication to the principles of professionalism -- honesty, competence, and self-regulation.

65. See Enthoven A; Kronick R. "A Consumer-Choice Health Plan for the 1990s," New England Journal of Medicine. 1989(320):29-37.

66. As President Bush indicated in his state of union address in 1992:

> Really, there are only two options: We can move toward a nationalized system, which will restrict patient choice in picking a doctor and force the government to ration services arbitrarily. And what we'll get is patients in long lines, indifferent service and a huge new tax burden.
>
> Or we can reform our own private health care system - which still gives us, for all its flaws, the best-quality health care in the world.
>
> My plan provides insurance security for all Americans while preserving and increasing the idea of choice. We make basic health insurance affordable for all low-income people not now covered. We do it by providing a health insurance tax credit of up to $3,750 for each low-income family.
>
> The middle class gets help, too. And by reforming the health insurance market, my plan assures that Americnas will have access to basic health insurance even if they change jobs or develop serious health problems....

67. Congressional Research Service. Cost and Effects of Extending Health Insurance Coverage. Library of Congress, Washington, DC. October 1988:46. Education adn Labor Serial No. 100-EE, Energy and Commerce Serial No. 100-CC, Special Committee on Aging Serial No. 100-P.

68. US Government Accounting Office. Canadian Health Insurance: Lessons for the United States. US General Accounting Office, Washington, DC. Publication GAO/HRD-91-90.

69. Quoted by Professor Robert Blendon, Harvard School of Public Health, personal communication. Uwe Reinhardt is at the Woodrow Wilson School of Government, Princeton University.

70. See Starr, Paul. Social Transformation of American Medicine. ibid, 420-449.

71. Gray BH. The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals. Harvard University Press, Cambridge, MA. 1991:14.

72. Chollet, Deborah. "A Profile of the Nonelderly Population Without Health Insurance," Government Mandating of Employee Benefits. EBRI, Washington, DC. 1987:59-89. Data on the uninsured cited hereafter come largely from this source.

73. Inglehart, "Medicaid in Transition," New England Journal of Medicine. 1983(308):978.

74. Lurie N; Ward N; Shapiro M; Brook R. "Termination from Medi-Cal--Does it Affect Health?" New England Journal of Medicine. 1984(311):480-3.

75. Starr, Paul. Social Transformation of American Medicine. Ibid, 300. The reader is referred to Starr's insightful analysis of the ten principles codified by the AMA in 1934, which, in short, "insisted that all health insurance plans accept the private physicians' monopoly control of the medical market and complete authority over all aspects of medical institutions."

76. Starr, P. Social Transformation of American Medicine. ibid, 285.

77. An article in a recent (May 11, 1992) issue of American Medical News, the official newsletter of the American Medical Association, was entitled "Physicians have always [italic] offered free health care to needy." It took as evidence of "Wisconsin doctors' compassion" the $20,900, or 8 percent of total billings, that a Wisconsin physician foregoes in

uncompensated and discounted care on the average in one year (1988).

78. Translation mine. Source unknown.

79. Daniels, Norman. "Why Saying No to Patients in the United States Is So Hard," New England Journal of Medicine. 1986(314):1380-83.

80. Daniels, Norman. "Why Saying No to Patients in the United States Is So Hard," New England Journal of Medicine. 1986(314):1380-83.

81. Mechanic, David. "Cost Containment and the Quality of Medical Care: Rationing Strategies in an Era of Constrained Resources," Milbank Memorial Fund Quarterly. 1985(63):467.

82. Bellah, RN. et. al. Good Society. ibid, 95.

83. Rephrasing Jeremy Bentham's "principle of utility," by Plamenatz, J. The English Utilitarians. Basil Blackwell, Oxford. 1949:9-12.

84. As Donald Light restates the application of libertarian ethic to competitive risk-rating: "A major article on insurance theory and risk-rating states, 'An insurance company has the responsibility to treat all its policyholders fairly by establishing premiums (and coverage) at a level consistent with the risk represented by each individual policyholder.' The closer premium and coverage are caliberated to risk, the argument goes, the 'better' the insurance, because it is more 'efficient' and more fair. Thus, ideal insurance would calibrate coverage and premium to risk so precisely that nobody would have to share anyone else's risk." See Light DW. "The Practice and Ethics of Risk-Rated Health Insurance," ibid, 2507.

85. Reinhardt UE. "Health Insurance for the Nation's Poor," Health Affairs. 1987:104.

86. See Sidel VW; Sidel R. A Healthy State. Pantheon Books, New York, 1983:xxix-xxx.

87. See Auster R; Leveson I; Sarachek D. "The Production of Health, an Exploratory Study," Journal of Human Resources. 1969(4):412-36. They found that income and education were twice as important as medical services as a determinant of mortality. A 1 percent increase in national health expenditures per capita led to a reduction in mortality of 0.1 percent; whereas a 1% increase in expenditure on education led to a reduction in mortality of 0.2 percent. The income

elasticity of mortality was positive, an association the authors attributed to lifestyle.

88. Blum, H. Expanding Health Care Horizons. Third Party Publishing Company, Oakland, CA. 1983:34-38. See Figure 2.9 for diagram of the "force-field and well-being paradigms of health."

89. Henrik Blum, personal communication.

Notes to Chapter VI

1. c.f. "In Re Quinlan," Supreme Court of New Jersey, 1976. 70 N.J. 10, 355 A.2d 647, certiorari denied 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed. 2d 289. Reprint in Areen J; King PA; Goldberg S; and AM Capron. Law, Science, and Medicine. Foundation Press, Inc., New York. 1984:1081-1095.

2. "Canterbury v. Spence," United States Court of Appeals for the District of Columbia Circuit, 1972. 464 F.2d 772, certiorari denied, 409 U.S. 1064, 93 S.Ct. 560, 34 L.Ed. 2d 518. Areen J; King PA; Goldberg S; and AM Capron. Law, Science, and Medicine, ibid, 372-385.

3. "Roe v. Wade," Supreme Court of the United States, 1973. 410 u.S. 118, 93 S.Ct. 705, 35 L.Ed.2d 147. Areen J; King PA; Goldberg S; and AM Capron. Law, Science, and Medicine. Ibid, 1236-1242.

4. Areen J; King PA; Goldberg S; and AM Capron. Law, Science, and Medicine. Ibid, 1088.

5. Areen J; King PA; Goldberg S; and AM Capron. Law, Science, and Medicine. Ibid, 1084. Two recent cases regarding the "right to die" further affirmed the primacy of patient autonomy, despite different decision outcomes.

Nancy Cruzan, a twenty-five year-old woman in a persistent vegetative state after an automobile accident, required nutrition and hydration through tube-feeding. Her parents sought court authorization to terminate tube-feeding, in consideration to her expressed wish that "if sick or injured she would not wish to continue her life unless she could live at least halfway normally." The U.S. Supreme Court, "for the purpose of this case ... assume[d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition," based "not on the right of privacy but rather on the liberty interest delineated in the 14th amendment." The majority opinion, however, decided that the Constitution did not forbid a state from requiring "clear and convincing evidence" that Ms. Cruzan herself had rejected such treatment, rather than accepting the substituted judgment of her parents. c.f. "Cruzan v. Director, Missouri Department of Health," Supreme Court of the United States, 1990. 492 U.S., 110 S.Ct. 2841, 111 L.Ed.2d 224. Also Annas, GJ. "Nancy Cruzan and the Right to Die," New England Journal of Medicine. 1990(323):670-2.

In a case "opposite of Cruzan," Helga Wanglie, an eighty-seven year-old woman who suffered a hip fracture and pneumonia was left in a persistent vegetative state, requiring a

ventilator and feeding tube for continued survival. Her doctors sought court authorization to withdraw life-support, not wanting to give medical care that they describe as futile. Her husband "want[s] her where she is," based on her "strong religious convictions": "Only He who gave life has the right to take life." County court judge decided rejected the doctors' advice and instead gave Mr. Wanglie the power of substituted judgment. "He is in the best position to investigate and act upon Helga Wanglie's conscientious, religious and moral beliefs," the judge said. c.f. New York Times. 1/10/1991 and 7/2/1991.

6. Areen J; King PA; Goldberg S; and AM Capron. Law, Science, and Medicine. Ibid, 374.

7. Areen J; King PA; Goldberg S; and AM Capron. Law, Science, and Medicine. Ibid, 398.

8. c.f. "Natanson v. Kline," Supreme Court of Kansas, 1960. 186 Kan. 393, 350 P.2d 1093. Areen J; King PA; Goldberg S; and AM Capron. Law, Science, and Medicine. Ibid, 370.

9. Areen J; King PA; Goldberg S; and AM Capron. Law, Science, and Medicine. Ibid, 380. And on the ground of autonomy has the Canterbury decision been criticized. Some have argued that disclosure and causation ought to be decided by the need of the particular patient, and not the reasonably prudent person (text, 385). And the focus on disclosure, as Jay Katz points out, "tends to perpetuate physicians' disengaged monologues and to discourage a meaningful dialogue between doctors and patients." "Can patients' right to self-decision-making be safeguarded," he asks, "by merely modifying requirements for disclosure without at the same time expanding the requirement for valid consent" (text, 400). Clearly, the battle of the patient's right to self-determination against the privilege of medical paternalism is being fought over, and decided upon, autonomy.

10. Areen J; King PA; Goldberg S; and AM Capron. Law, Science, and Medicine. Ibid, 1238.

11. Areen J; King PA; Goldberg S; and AM Capron. Law, Science, and Medicine. Ibid, 1238.

12. Areen J; King PA; Goldberg S; and AM Capron. Law, Science, and Medicine. Ibid, 1260.

13. Beauchamp TL; Childress JF. Principes of Biomedical Ethics. Oxford University Press, New York. 1983:63.

14. Beauchamp TL; Childress JF. Principes of Biomedical Ethics. Oxford University Press, New York. 1983:63.

15. Much of the discussion in this chapter are inspired by bioethicists Thomasine Kushner, Ken Meese and Erich Loewy through personal communications. While the ideas that follow are shared property of many bioethicists and thus are not attributed to them individually, it is they who helped me understand and articulate the following ideas.

16. Joel Feinberg, quoted in Beauchamp TL; Childress JF. Principles of Biomedical Ethics. ibid, 52.

17. c.f. "Beal v Doe," 432 U.S. 438, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977), in which the Supreme Court "found that Title XIX of the Social Security Act, which established Medicaid, did not require Pennsylvania to fund 'nontherapeutic' abortions as a precondition to receiving funds in a joint federal-state medical assistance program." Areen J; King PA; Goldberg S; and AM Capron. Law, Science, and Medicine. Ibid, 1260.

18. Beauchamp TL; Childress JF. Principles of Biomedical Ethics. Ibid, 53.

19. Bellah, RN. "Personal and Social Health: A Necessary Connection?" Radix. 1991(20):29.

20. This is referred to as transference in psychodynamic literature, where emotions directed toward caregivers in early childhood are transferred to the physician or the therapist. c.f. Goldman HH. Review of General Psychiatry. Appleton & Lange, Norwalk, Connecticut. 1988.

21. Parsons, Talcott. The Social System. Free Press, Glencoe, Ill. 1951.

22. See Foster GM; Anderson BG. Medical Anthropology. John Wiley & Sons, New York. 1978:154-162 for criticisms of the Parsonian model of the "sick role."

23. Goldman HH. Review of General Psychiatry. ibid, 175.

24. Bellah, RN. "Personal and Social Health: A Necessary Connection?" ibid, 30. This ambivalence is also evident in public policy, as Medicare reimburses only ten sessions of therapy.

25. See Foster GM; Anderson BG. Medical Anthropology. ibid, 155.

26. Noonan, JT. Jr. "An Almost Absolute Value in History," reprinted in Areen, J. et. al., ibid, 1248.

27. Smith, HL. "Medical Ethics in the Primary Care Setting," Scientific Medicine. 1987(25):707.

28. See Engelhardt HT. "Medicine and the Concept of Person," and Dworkin RB. "Death in Context," reprinted in Areen J; King PA; Goldberg S; and AM Capron. Law, Science, and Medicine. Ibid, 1065-69.

29. Patterson, Orlando. Freedom in the Making of Western Culture. Basic Books, New York. 1991:xiii.

30. Thomasine Kusher, personal communications.

31. Erich Loewy argues that the "way we suffer and the way we view suffering is, at least to a large part, determined by our understanding of and by our solidarity with community." He went on to examine different types of social contract from which different conceptions of communities emerge. My argument of how we relate to each other depending on how we relate to our interpersonal space owes greatly to his discussion in chapter two of his manuscript, to be published.

32. see Bok, Sissela. "The Survival Value of Trust," American Health. 1989(september):120-1.

33. Patterson, Orlando. Freedom in the Making of Western Culture. Basic Books, New York. 1991:43.

34. Ibid. Patterson defined personal freedom as the "capacity to do as one pleases, insofar as one can," and sovereignal freedom as the "power to act as one pleases, regardless of the wishes of others." Ibid, 3-4.

35. Lu Chih. Lu Hsuan kung lun, in Hsu Ch'un-fu. Ku-chin i-t'ung ta-ch'uan. 1570:ch. 3b, pp. 13a-13b. See Unschuld, PU. Medical Ethics in Imperial China. University of California Press, Berkeley. 1979:35.

36. The physician is Chu Hui-ming. He left the career of a Confucian scholar to study medicine, with the insight "that the men of letters from the past were of no benefit in this world and that Confucianism was in this respect by far inferior to other teachings." Thus in his writings we see allusions to both Buddhist and Confucian [Mencius] ideas. See Unschuld, PU. Medical Ethics in Imperial China. ibid, 62.

37. Thomasine Kushner, personal communications.

38. MacIntyre, A., in Cassell and Siegler, ibid, 1979:95.

39. Huang-fu Mi, in Chia-i ching., edited by Kao Pao-heng, Sun Ch'i and Lin I in 1092. See Unschuld PU. Medical Ethics in Imperial China. ibid, 37.

Notes to Chapter VII

1. Wuthnow, R. Acts of Compassion. ibid, 184.

2. Wuthnow, R. Acts of Compassion. ibid.

3. Wuthnow, R. Acts of Compassion. ibid, 308.

4. Miller, Jonathan, M.D., personal communication.

5. "Trucker's beating: Hate on Video," San Francisco Examiner. May 3, 1992:A-9.

6. "Rescued Truck Driver is Recovering," San Francisco Chronicle. May 4, 1992:A6.

7. "Beaten Truckers' Parents Thank 4 Who Aided Him," San Francisco Chronicle. May 2, 1992:A12.

8. Data from Department of Health and Human Services. Report of the Secretary's Task Force on Black & Minority Health. Washington DC, 1985. The black child is not the only child in our society who has to hope against hope for a better day.

9. Bellah RN. "Personal and Social Health: A Necessary Connection?" Radix. 1991(20):30.

10. Freedberg, Louis. "Long-Term Effects of King Case: Whites must work to improve race ralations, panelists tell Chronicle," San Francisco Chronicle. May 11, 1992. Although 85 percent of whites and almost all blacks surveyed felt that the verdict was unjust, Duster points out, 80 percent of blacks felt that the whole judicial system was rigged, while less than 40 percent of whites thought so.

11. Niebuhr HR. The Responsible Self. Harper and Row, New York. 1978:65. in Bellah RN et. al., Habits of the Heart. ibid, 283.

12. Bellah, RN. "Personal and Social Health: A Necessary Connection?" Radix. 1991(20):30.

13. B

14. Gray BH. The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals. Harvard University Press, Cambridge, MA. 1991:14.

15. Dr. Sheldon Margen, personal communications.