

Medical Humanities Report

This Issue: Debating the value of Medical Humanities

Fall, 1994

Bioethics, Literature and the Creation of the Priestly Physician

This issue's lead article is written by Dr. Judith Wilson Ross who is an Associate at the Center for Healthcare Ethics at the St. Joseph Health System in Orange California. It was adapted from a presentation at the 25th Anniversary celebration of the creation of the Hastings Center, NYC, June 6, 1994, which presentation is summarized in the June-July 1994 issue of The Hastings Center Report.

In the very beginning, it was theology that brought our attention to the problems of medical practice. Soon, however, religion gave way to philosophy which offered a newly articulated (or engineered) high road by which medicine could get itself on with the task of saving itself from residency in a moral slum. Then, when medicine failed to respond quickly enough to philosophy's offerings, it was law that was looked to. Perhaps the courts would ensure that the principles and consequences espoused by philosophy would alter the face of medicine. And yet, there still was not the change that bioethics hoped for and so it became the task of educators. Medical schools, residency training programs, even CME programs began to open up divisions of bioethics and of medical humanities and to offer time in the curriculum and in the CME schedule to proffer the appropriate principles and consequences to those in and reaching for membership in the

medical fellowship. And now evidence gathers that education too has failed.

Anyone who has taught in a medical school hospital can attest to the lack of empathy and compassion. Suffering collects in hospitals, and treatment givers engender much of it. I found that "detached concern" --an ideal widely subscribed to by medical educators and physicians generally--was realized thus: the students arrive with the concern, and medical school teaches them the detachment. Or, as one of my former medical students recently said to me: in my 2nd year of residency, it now takes me five days even to see an ethical problem that in my first year of medical school I would have understood in a minute. In bioethics circles, this "failure" of ethics to produce compassionate, empathic caregivers now gives way to the belief that courses in literature will teach doctors to attend to the "patient's story." Once again, we confuse subject with behavior. Mastery of ethics does not guarantee ethical behavior; mastery of humanities does not guarantee humane behavior. But we need to ask some questions: Why is it that medicine is so resistant to being saved? And, if it does need to be saved, can literature put on the Superman costume and do the job, once and for all? And would bioethics be happy if it did?

(Bioethics continued on page)

*Center for Ethics and Humanities in the Life Sciences
Michigan State University*

Let us go back for a moment to the beginning and look again.

Bioethics found a voice with the public in its attacks on the doctor for playing God and choosing whether people die or endure long suffering. This anger was directed toward doctors who were like the Old Testament God, the one who was willing to gamble with Job's fate, inflict Job with grievous illness, in order to deal with His own ego needs. Now, we hear calls for a different physician; not one like that all-powerful God who makes decisions that result in terrible outcomes for people, but one like that all-powerful God of the New Testament; the one who is loving and understanding. This one has the wisdom, the time and the inclination to talk with patients about their wide assortment of problems. These wise doctors do not have a tragic view of life--or even a scientific or mechanistic view of life--because they understand that making human contact with patients will heal if not cure, and that healing is what patients most need.

These doctors enter into their patients' experiences. They will do this 25 or 30 times a day as their patient load streams before them. They will do this even though they do not know most of their patients very well. They will do this even though they are but 30 years old and their patients 70 or 80 with lives and memories as foreign to the doctor as those of people of a different race, ethnic background, or social class. They will do this even if patients are of a different race, ethnic background, or social class, because literature has made them "sensitive" to differences.

Who would not want such a physician? Yet, if one is worried about the authority of the physician, about the potential for improper use of power, about the need for empowering patients--as bioethics has relentlessly been with its emphasis on patient autonomy and its origins in civil rights--then such a powerful physician might be of great concern. It is particularly ironic that a field arising from fears of physician authority should now imagine the solution to the ethical

problems of health care to lie in an even more powerful physician. This is the healing physician that is envisaged in the new emphasis on narrative, on literature, on ethnography, and on an ethics of caring.

Does this image correspond to our own experiences? When Anatole Broyard was diagnosed with prostate cancer, he talked about wanting a physician who had "a tragic sense of life. . .[a] furious desire to oppose himself to fate." Later, he thought it better to have one who could read him like a critic would read a novel or a poem, one who was "a bit of a metaphysician" and who would "mingle his daemon with mine; we would wrestle with my fate together." ("Doctor, Talk to Me", NYT Magazine, 8/26/90:33, 34) Kay Toombs, similarly, though less dramatically, wants a doctor who will help her to face the existential difficulties of life with illness. ("The Metamorphosis: the nature of chronic illness and its challenge to medicine." Journal of Medical Humanities 1993; 14 (4): 223-30.)

If bioethics is to be in the business of remaking physicians, it would behoove us to think clearly about our goals. What do we want from physicians? Do we want them to unlock the secret of life? Do we want them to make severe illness bearable? Do we want them to make death understandable? Or do we want, on the contrary, something less grandiose: for example, physicians who will provide us in a thoughtful way with some technical assistance in improving our physical condition as best they can given the limits of their abilities and knowledge and the difficulties of any two strangers joining in

Medical Humanities Report, Vol. 17, number 1, Fall 1994

The Medical Humanities Report is published quarterly by the Center for Ethics and Humanities in the Life Sciences at Michigan State University. The Center is an academic unit whose faculty teach in the medical, nursing and veterinary colleges, as well as in Arts and Letters.

Editor: R.L. Jackson, M.A.

Center Director: H. Brody, M.D., Ph.D.

a common enterprise in which each has reason to be suspicious of the other because each has important things to gain and to lose?

When I ask people about their real experiences with physicians, even in the face of some serious illness or difficult procedures, they tell ordinary, predictable stories, not stories of heroic proportion. For example, a friend is diagnosed with melanoma with lymph node involvement. His physicians tell him he has a terminal illness; that their oncology board recommends no treatment; that he can go to UCLA to have experimental treatment that they don't do at this hospital and that he is free to go there and have it done if that's what he wants to do. After that, they're still his doctors, but they don't have much to say to him. He's still alive, he's still dying; hard to know what to expect from them, my friend says.

Another friend faces surgery. Her doctor says, this is the problem, this is the treatment, these are the risks, these are the benefits, this is what I think you ought to do, and, if you agree, when are you available to have it done? My friend is not a text; she is simply a problem in need of a solution. What should she reasonably want from this surgeon beyond this information, she asks?

Doctors almost always behave to us as if we were customers with a problem that they may be helpful in solving. They are seldom rude; they are often crisp, to the point; they seldom acknowledge any uniqueness about us in the face of this problem, or any uniqueness about this problem in the face of us. They are generally more like technicians than they are like wise men and wise women. If they are the guardians of wisdom and mythological magic, they generally keep it well hidden.

But I doubt if they are any more knowledgeable about those matters than are the rest of us. And we are not very knowledgeable, so to

acknowledge that none of us knows much about how to face the existential difficulties of life with illness is a very alarming event. However, to insist that if only physicians were better metaphysicians or better literary critics or better historians, in general had a better training in the humanities, were more humanistic in their essential being; if all that, or if any of that, then our confrontation with the terrible threat of disability and death would be made less frightening--that seems

...to insist that if only physicians were better metaphysicians or better literary critics...then our confrontation with the terrible threat of disability and death would be made less frightening---seems an essentially naive conclusion...

an essentially naive conclusion. We would as easily argue that patients should be more schooled in the humanities, more sensitive to the meaning of their inner life, more fluent in the mysteries of the soul.

At least they may have more time to achieve this. We look to find a priest, a magician, a god to hold together the dark parts we do not understand and cannot bear. If we want a guide for this journey, better to find a Mother Teresa than a magician who will take away the hard parts. The journey is also about the hard parts; why should we think that physicians would be able to make them less so just because they are familiar with the sight of those hard parts?

I do not question for a moment that there are physicians who are a genuine gift to patients who are dying, who are suffering, or that, if I were dying or suffering that I would give much to have such a physician. It is just that I do not expect that to happen. I have seen physicians do

(Bioethics continued on page 4)

what they do but I have not seen generally any special insights into either sickness, suffering, or dying. I do not think that there is any reason any longer to suppose that this priestly role inheres in being a physician, or that studying literature will nourish this role. What matters is that physicians do not understand their duty as being powerfully humanistic or priestly. It is true that many physicians continue to be willing to accept the priestly power that adheres to the role; but it is also true that many are understandably unwilling to accept spiritual responsibilities of the priesthood because it is not clear that there is a religion that the priesthood any longer serves.

The study of literature is unlikely to change that. Although stories can surely give one the thick description that is considered such a valuable commodity, the dependence on stories may serve to heighten the same uncertainty that encourages physicians to distance themselves from patients. Every event includes many stories, and one may legitimately ask whose story is to be told and whose is to be believed. The way in which point of view changes the nature of perception intensifies the sense that all is relative. Further, if deconstruction is to make its way into bioethics' interest in literature (as it must), then we must acknowledge that, although the patient may be the text, any text can be read as saying something quite different from what it appears to be saying, that it may carry many meanings, and that these meanings are fundamentally at variance with, contradictory to, and subversive of any imposed single, stable meaning. Literature may make things worse, not better. Bioethics seems to want to remake medicine and the emphasis on literature, narrative, and compassion implies that its method is to change physicians' character. To do so is a larger enterprise than bioethics can achieve on its own. At the very least, it needs the support of medicine, which it does not have.

The reports saying that medical education must change are routinely made, read, and responded to; new courses are introduced; curricular changes are made. But when I ask the students whose course of study is intersected by

these changes, they say that it is superficial; that the real text continues to be about "mastering" material, material that all agree is as time-dated as a container of milk. Teaching them literature surely will not harm them, but I doubt that it will make much difference in their character, in their capacities for empathy or for compassion. What is required for that is an act of personal transformation on their part, not piecemeal training on ours. The belief that an elaboration of courses will effect this training only reveals the persistently mechanistic and simplistic approach that underlies our thinking.

Jay Jacobson, who heads the medical ethics program at the University of Utah, recently wrote a brief piece for *Western Bioethics News* about the literature and medicine meetings that he has organized for the past several years for physicians. The group, which has a rotating attendance of 15-25 from a larger group of about 100 physicians, is designed to meet multiple needs: physicians who come can bring their spouses and they can eat dinner as well as talk about a piece of writing. Jay thinks that this is a more acceptable way to teach ethics because, he says, there is "a widely held view that discussions about medical ethics are generally about what doctors don't do or what they do wrong." What has resulted from these meetings is this: "we've raised awareness of ethical issues in medicine, achieved some new insights, forged some connections across specialty lines and the town-gown gap, learned a lot from what would otherwise be unread sources, and generally had a good time." I doubt very seriously whether LDS Hospital or the University of Utah Medical Center is filled with physicians saved by literature, but I would think that the claims for the study of literature as Jay puts them forth, are just about right. If bioethics must reform medicine, it would seem to me that, in the same spirit, we could resist romanticizing the physician role and ask simply for technical competence, politeness, and good will as a reasonable standard, with curiosity about people and their lives as a desirable addition.

Two Responses to Judith Ross's article, "Bioethics, Literature and the Creation of the Priestly Physician"

In order to further debate on this important topic we have invited two writers to respond to Professor Ross's thesis about the merits of the medical humanities. The first respondent, Dr. Harriet Squier, is a physician who teaches literature to medical students in the Michigan State College of Human Medicine. Our second commentator is Professor Tom Tomlinson, Assistant Director of the Center for Ethics and Humanities in the Life Sciences and Director of the Interdisciplinary Program for Health and Humanities.

Commentary One: Harriet A. Squier, M.D., M.A.

Dr. Ross equates medical schools with hospitals, literature with literary criticism, ethics with communication skills, empathy with power. She is sarcastic about "loving and understanding" physicians who deal with patients' psychosocial problems. For Ross, physicians should only be technicians, biomedical experts, and strangers. Patients should simply be "problem(s) in need of a solution." It is not surprising that the biomedically and subspecialty-oriented schools and hospitals which Dr. Ross has had the most exposure to have failed miserably to produce caring and compassionate physicians. What is surprising, is that Dr. Ross relies on a few anecdotes about "competent" physicians who do not possess interpersonal skills to conclude that medical practice does not need a psychosocial orientation. Even in a biomedical arena, this kind of anecdotal evidence would remain unconvincing.

The biopsychosocial mode, with which Ross is apparently unfamiliar, posits (and research increasingly documents) that disease (and certainly the perception of illness) arises from disruption of the body, the psyche, the person, the family, the community; each level influences the functioning of every other level. For instance, the closing of a factory in town may cause

unemployment, leading an individual unemployed person to become psychologically stressed as well as impoverished, which may cause organic disease like ulcers, hypertension, depression, etc. as well as other problems such as homelessness, malnutrition, frostbite, etc. Dealing only with the biomedical problem will not affect the causes of the disease processes, and ignoring these other causes will lead to poor medical outcomes. Part of the treatment process, then, would be to ascertain the patient's psychological and social issues, and to assist with the provision of services which would help deal with these issues as well as the biomedical issues.

In order to be an effective physician (especially a primary care physician), the trainee must learn effective communication skills, must appreciate the influences of psychological and social problems, must understand the issues of culture, gender, and ethnicity on patients' help-seeking behavior, must understand that diagnosis is rarely a clear-cut proceeding -- in other words, to tolerate ambiguity -- and must be patient-centered in a way that empowers patients to deal with their psychosocial as well as medical problems

A number of courses are very effective to help support the principles of the biopsychosocial model. Communications skills training facilitates communication between doctors and patients.

(Squier continued on page 6)

Ethics courses educate students to deal with ethical issues. Literature courses help students understand how to interpret language and the stories that patients tell (which is necessary to formulate a differential diagnosis, the mainstay of competent medical practice). They also help students see how the psychological and social context of patients affect their well-being. History of medicine helps students understand how their own world in medicine is contextual, and how many of the issues today were thought about and dealt with in other contexts. Anthropology can help students understand the values inherent in other cultures which may conflict with ours. Spirituality helps students understand their own values, and how to appreciate and strengthen the spirituality and the values of their patients. Comprehensive care of the patient requires comprehensive education of the physician.

The point of humanities courses is to train physicians in **MEDICAL PRACTICE**, not the humanities per se. A physician who is narrow-

minded, unreflective, arrogant, and judgmental, is a poor physician. Some of the skills necessary to become a good physician can be learned; many must be inherent in the students and supported in the teaching environment. Perhaps the best message to be learned from Ross's article is that the medical schools and hospital environments Ross had been exposed to don't support these humanistic qualities. Schools such as Michigan State University which train students in community (rather than tertiary care) hospitals, which emphasize primary care and the biopsychosocial model, and in which humanities are (and have always been) an integral part of the curriculum, do produce caring, compassionate and humanistic physicians. We would welcome Professor Ross to visit this school and those like it, and witness humanistic medical practice and informed and progressive medical education. As medical schools universally shift to the education of primary care physicians, Ross's emphasis on and belief in specialty, tertiary care practice, is already outdated.

Commentary Number Two: Tom Tomlinson, Ph.D.

Judith Wilson Ross is right to warn us against entertaining grandiose expectations for the teaching of ethics or literature to physicians and medical students. Neither of these is likely to produce, all by itself, very many saintly practitioners. The cultivation of habits of mind, an most importantly, temperament, are products of a life's work, and not the measurable "outcomes" of any course.

That said, however, it would have been useful for her to have offered some insight into whatever less lofty and more achievable goals might be legitimate aims for ethics teaching. After all, even if that teaching doesn't transform character, it hardly follows that it accomplishes

nothing worthwhile. She could have made a parallel observation about the teaching of basic science in medical education. Hardly anyone since Flexner has thought that it actually succeeds in turning the average practitioner into a rigorous scientific thinker, despite overblown and sometimes self-serving rhetoric to the contrary. Nevertheless, bits and pieces of it have more mundane, but worthy, uses.

What could some of those lesser goals be for ethics teaching? One place to find them is in a 1980 article by Daniel Callahan, "Goals in the Teaching of Ethics"¹-- all the more pertinent a choice here, since Ross' talk was delivered at a 25th anniversary celebration of the Hastings Center. Callahan's goals included stimulating the moral imagination, recognizing ethical issues, eliciting a sense of moral obligation, developing analytical skills, and tolerating (and reducing)

disagreement and ambiguity. Every one of these goals could be idealized to the point of absurdity. We shouldn't hope that in stimulating our students' moral imagination we will transform them into Charles Dickens. But equally, every one of these goals admits of degrees, and it is not unrealistic to think that in some measure a course in ethics can help students in their development of these skills and attitudes. In developing students' analytical skills, for example, we can't aim to make them moral philosophers, but we can help them develop (through example and practice) a better understanding of the importance of careful reflection about their reasons.

Admittedly, the realization of these goals will be a weak force in the shaping of any person's moral development and behavior. They will fre-

quently be overwhelmed by the other pressures exerted by the institutions of medical education and practice. Frequently, but not always. When not overwhelmed, they provide the foundation for continuing moral growth. Without these skills and attitudes, there will be a few less sandbags to set against the tides of money, expediency, and indifference. I think we should use as many sandbags as we can get.

I. Callahan, D. "Goals in the teaching of ethics." In Ethics Teaching in Higher Education, ed. Daniel Callahan and Sissela Bok. New York: Plenum Press, 1980, pp. 61-74.

Announcements

Judith Andre presented "Against 'Preventive Medicine' at the Society for Health and Human Values meeting, October 9, in Pittsburgh. Her essay "Respect for Bodies" appears in The Good Body, Winkler and Cole, eds. She is also Vice President of the Central Consortium on Teaching, a unit of the American Philosophical Association.

Leonard Fleck's has had two chapters, "Justice, Age Rationing, and the Problem of Identifiable Lives" and "Just Caring: Lessons from Canada and Oregon", included in the collection, Health Care for an Aging Population ed. Chris Hackler, State University of New York Press, 1994. He has also had a chapter, "Just

Genetics: A Problem Agenda" included in the collection Justice and the Human Genome Project, eds. Timothy F. Murphy and Marc A. Lappe.

Howard Brody has had a chapter, "Age Cut-Offs for Health Care Entitlements: The Missing Moral Level" included in the collection, Health Care for an Aging Population ed. Chris Hackler, State University of New York Press, 1994.

Coming Events

The Center for Ethics and Humanities is an academic unit whose faculty teach, write, and consult about bioethics and the other medical humanities. Staff members frequently conduct public discussions about a variety of such topics and we encourage our readers to attend and participate in these forums.

Thursday November 3, 12:00: Brian Brown M.A. and Judith Andre, Ph.D., will describe the course they taught last summer in London, and discuss current developments in the British National Health Service. Open to the Public; C 214, East Fee Hall.

Tuesday, November 8, 6:30-9:30: Kenneth R. Pelletier Ph.D., will conduct his seminar "Sound Mind, Sound Body" in Dart Auditorium on the campus of Lansing Community College in down town Lansing. Prepaid registration is required to reserve your space and will be limited to the first 300. For further information call (517) 483-2135.

Thursday-Friday, November 17-18: Richard Selzer, M.D., former professor of surgery at Yale University, and a nationally acclaimed writer of short stories, will be coming to campus under the sponsorship of MSU Press,

Sparrow Hospital, Office of the Provost, the College of Arts and Letters and the Center for Ethics and Humanities. On Friday at 8:00 a.m. he will be speaking at Sparrow Hospital and attending a reception in his honor from 4:00-6:00 p.m. at the Kellogg Center. Saturday, from 11:30-1:30 p.m. he will be discussing his short story, "Brute" in Rm. 102, Conrad Hall, MSU (RSVP required 355-7550, by Nov. 10). From 7:00-9:00 p.m. he and Peter Josyph will be at Grand River Books, 515 E. Grand River, signing copies of their books, Taking the World in for Repairs and What One Man Said to Another: Talks with Richard Selzer. All events are open to the public. For further details please contact Lori Lancour at 355-9543.

CENTER FOR ETHICS AND HUMANITIES STAFF

H. Brody, M.D., Ph.D.....Director
T. Tomlinson, Ph.D.....Assistant Director and
Director, Interdisciplinary Programs in Health and Humanities
J. Andre, Ph.D.....Faculty
L. Fleck, Ph.D.....Faculty
A. Hogan, Ph.D.....Faculty
R. Jackson, M.A.....Editor, Medical Humanities Report
K. Hankins.....Editor, Ethics-In-Formation
J. Holmes.....Office Supervisor

Reprint permission granted with MSU and CEH citation.

Published by:

Center for Ethics and Humanities
in the Life Sciences
C-201 East Fee Hall
Michigan State University
East Lansing, MI 48824-1316

Non-Profit Org.
U.S. POSTAGE
PAID
E. Lansing, MI
Permit No. 21

MSU is an affirmative-action, equal opportunity institution.