

The Role of Compassion in Medical Ethics and Its Reintegration in Modern Practice

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Abstract

Compassion has been an integral part of medical ethics since its origins, but as medicine progressed, compassion slowly disappeared from practice. The development of any industry results from many complex factors, but the decline of compassion in medicine can be largely attributed to the evolution of technology and role of medical ethics committees. Change is not always negative, but in this case, medicine neglected one of its foundational principles. This is seen by analyzing the history and progression of medical ethics and its four pillars. Plato and Aristotle defined *justice* in Greek philosophy, Hippocrates used the concept of *non-maleficence* in his oaths, the philosophy of John Gregory and Kant brought *autonomy* into a medical context, and the work of Thomas Percival sought to view medicine a *beneficent* undertaking. These critical principles were summarized by Joseph Fletcher. Each of these individuals also acknowledged the great role compassion played in medical practice. However, as the medical field developed, its reliance on compassion was in part replaced by a thirst for progress and acting ethics committees. Medicine needs compassion because it was built on compassion. It is not simply an ideal drawn from philosophers, it is a necessity for the wellness of both patients and practitioners.

The Role of Compassion in Medical Ethics and Its Reintegration in Modern Practice

The term ‘medical ethics’ may be new, but its foundation is thousands of years old. Analyzing the history of medical ethics allows a greater understanding of its purpose. Medicine began with compassion-oriented service. As the early medical field developed so did the ethics behind it. The compassion that once drove the profession is deteriorating, and its absence is a result of many complex changes. This paper focuses on the roles of technology and ethics committees in the removal of compassion from medical practice. Compassion is still a priority for many physicians but some of the medical community has strayed from the origins of medical practice and the compassion it was founded on. History teaches the consequences of its absence and scientific research has shown the benefits of compassionate practice.

Compassion is a positive emotion, typically embodied by action. Based on a piety and a desire to protect life, compassion can be seen as kindness, willingness, or charity. It is deeply rooted in the biblical Old and New Testament, drawing from the imperative to respect and protect humanity, who are made in the “image of God” (Genesis 1:26). The people of the Old Testament were commanded “to love your neighbor as yourself.” This was an instruction repeated in the New Testament, Matthew 7:12, “do unto others as you would have them do unto you.” The moral imperative for compassion is founded in the creation of mankind. Therefore, because medicine lies in direct correlation with human health, it should be deeply rooted in compassionate practice.

The Development of Medical Ethics

Medical ethics is woven throughout cultures everywhere, resulting from a combination of philosophy and medicine. Understanding the role of compassion in the development of modern American medical ethics creates a clearer picture of its necessity in modern practice. This particular historical summary discusses only the major publications on medical ethics leading to the development of British and American medicine.

One of the greatest threats to medical ethics is ignoring its origins. When the true history is acknowledged we can see “compassion is a long-accepted facet of medical practice in all systems of medicine in all countries in all ages – modern, medieval and ancient” (Jonsen, 2000). While suffering cannot be comprehended and sometimes even understood, the ability to serve, alleviate, and empathize is what brings value and life to the field of medicine. This delicate approach with patients, family, and disease is a “reflection of [the] understanding of what it means to be human” (Souba, 2002).

Ethics and Ancient Medicine in Mesopotamia, Egypt, and India

The first code for ethical health care was created 4000 years ago by a Sumerian physician, containing personal values and a compilation of remedies. This physician guidebook was accompanied by the Hammurabi Code, written between 1795-1750 B.C., an inscription inspired by the Sun god and given to the king of Babylon. The code was arranged by topic, one of them being the practice of medicine, referring to physician conduct, fees, and punishments required for negligence. Analysis has revealed that medical care in this culture was strictly authoritarian, with justice

dependent on social classes. The Code is the earliest evidence of conceptual health care and sits at the crux of the development of modern ethics (Halwani, 2006; Jonsen, 2000).

India had its own “Father of medicine,” named Acharya Charak. Born in 300 B.C., Charak greatly influenced the Ayurveda, a type of medicine and lifestyle practiced in ancient India. He wrote the Charaka Samhita and Sushruta Samhita which contain oaths of initiation for medical students. The oath’s promises mirrored the Indian culture and Hindu beliefs of the time. Physicians committed that “day and night, however thou mayest be engaged, thou shalt endeavor for the relief of patients with all thy heart and soul. Thou shalt not desert or injure thy patient for the sake of thy life or thy living” (TEAM, 2016).

Medical Ethics in Greek Philosophy

As concepts of health care grew so did philosophy and they soon become mutual influencers for one another. This can be seen in Plato’s *Protagoras*; the analogies constantly examine the relationship of a “healthy body and a good human (Plato and Jahn, 1857). Plato sees an individual as a doctor of their own souls, empowering each individual to continually care for the state of their mind and soul, just as they would their body. He emphasizes the good of wisdom just as the good of a healthy body. There is no shortage of health when others become healthy, it is simply for the betterment of man as a whole. Nourishment plays a role in the health of the body, but the body is also affected by the soul, for “the body is treated by the soul and it is not possible for a soul that is or has been evil to treat anything well” (Plato & Jowett, 1894).

Plato’s counterpart, Aristotle, was one of the first philosophers to directly address justice (Miller, 2017). The Greek philosopher proclaimed true justice required

“equals to be treated equally and unequal unequally” (Chroust, 1942). This definition has been challenged under the presupposition this idea fueled discrimination. However, health care was not simply responsible for distributional justice. It is also held under the law of universal justice, which seeks the good of all humanity (Jonsen, 2000). The justice found in health care concerns giving everyone the opportunity to seek treatment, rather than limiting medicine to a specific class.

The reference to equal and unequal by Aristotle is more aptly understood when placed in medical context. Not everyone needs the same medical treatment, nor is everyone afflicted with the same disease. Because of this people receive different treatments and that is why personalized care exists. Justice in health care originated as giving individuals the treatment they deserved.

Hippocrates, one of the greatest contributors to Greek medical philosophy, is largely known for his collection of more than one hundred books concerning medical doctrine. Greek historians credit him with the introduction of the logic of observation and method to medicine. Previous beliefs suggested diseases were punishments from the gods. He was the first to use clinical characteristics to diagnose patients and attribute diseases to environmental factors - the introduction to epidemiology. The Greek literature declares the physician is the servant of the art (Lidz, 1995). This art is composed of the disease, the patient, and the physician, once again solidifying that the person is not his disease. There were even essays that encouraged the holy and good behavior of physicians stating, “some patients, though conscious that their condition is perilous, recover health through their contentment with the goodness of the physician” (Hippocrates, Lloyd, Chadwick, Mann, & Hippocrates, 1978). Addressing physician

behavior, patient and family involvement, and treatment methods, he contributed to almost every aspect of medicine.

The Hippocratic Oath, written in 400 B.C., is one of the most well-known medical inductions. However, it is not known whether it was originally penned by Hippocrates himself, due to the varying tones found in his collection of literature. Containing covenants with deity, teachers, students, and patients, the most controversial aspect of the oath is the promise to “do no harm,” giving us the concept of non-maleficence. There is a large difference between doing nothing and doing harm. In the early age of medicine, the “aggressiveness of traditional therapists clashed with the abstentionism of the believers in the healing capacities of natural processes. The reality is that this principle does not seek to restrict treatments, it seeks to protect people.” However, despite controversial sections of the oath, it still contains many essential aspects of current medical care (Gupta, 2015).

Medieval Medical Ethics

The next movement of medical ethics occurred in the third and fourth century. After Italy and North Africa had been swept over by plague, Catholic churches played a large role in the development of hospitals, which played an even larger role in the deontological tone driving the movement. In the following centuries, church councils began addressing many aspects of medical practice. Many monastic manuscripts described the decorum of physicians, practically identical to the Hippocratic literature of ancient Greece. They continued to emphasize that medicine was not to be used for the gain of a physician, and it was their duty to keep the body in balance. These writings as well as other classical works of Greek antiquity were preserved by the center of

scholarship in Jundi-Shapur.

This major scholastic collection led to the major work of Ishaq bin Ali al-Rohawi, *Practical Ethics of the Physician*, written during the ninth century. Twenty-one chapters on pure medical ethics, it was the first writing of its kind, with frequent references to Hippocrates, Aristotle, and Islamic philosophers. It contained long dissertations on anatomy and physiology, as well as the role of God over life. Medicine was to be used justly, “so that the benefits of the medical art be universal and similar for the strong and weak” (Ruhāwī & ‘Asīrī, 1992). The Islamic culture developed a highly organized medical system in accompaniment with their massive collections of scholarly literature. Similar to the Catholic church, the number of charitable hospitals associated with mosques grew during the tenth century (Jonsen, 2000).

Reconceptualizing Medical Ethics

The moral philosophy of David Hume became the next stepping stone for medical ethics as John Gregory asserted “the entire moral life is found on natural and intuitive sympathy with the moral sentiments of others. The central duty of a physician, deriving from sympathy, is to relieve suffering and cure disease” (Jonsen, 2000). Immersed in the philosophical world of Romanticist Ireland, Gregory continually emphasized the importance of philosophical foundations. Only this could draw out the drastic importance of sympathy, that which “produces an anxious attention to a thousand little circumstances that may tend to relieve the patient; and attention which money can never purchase: hence the inexpressible comfort of having a friend for a physician” (Gregory & McCullough, 1998).

Gregory also addressed the role of autonomy in medical practice. Developed by

the German philosopher Immanuel Kant (1724–1804), autonomy was first defined as the moral obligation to treat every person as an end and never merely as a means (Johnson, 2018). Autonomy was freedom, specifically political freedom found within a set of bound rules, rather than being exempt from them. The law is only autonomous if it is determined by the will of the people within a state. It was in this way that citizens were not bound by external forces, but by the will of their own hearts (Johnson, 2018). The combination of Gregory’s theory of morality and Kant’s vision for a body politic created the support for autonomy within medical ethics. This principle required physicians to “respect the decisions of rational agents and thereby provided a rationale for informed consent, truth telling and promise keeping” (Jonsen, 2000).

Church hospitals continued to grow through the 1700s, but wealthy founders often held control of hospital staff and admittance. When dissension became too great at a Manchester infirmary, Thomas Percival, a renowned physician and administrator, was enlisted. His Manchester experience inspired him to pen the essay *Medical Ethics: or, a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons* (T. Percival, 1850). This essay coined the term “medical ethics,” which had not been given a specific name until 1803. Divided into four chapters, it referenced the commitment to hospitals, commitment to professional conduct, integrity of prescriptions, and duty to the law. It was once again emphasized that physicians were to focus as much on conduct as medical treatment, in attempt to “unite tenderness with steadiness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect, and confidence” (T. Percival, and Chauncey Depew Leake, 1927).

Pulling from the Georgian-Era of English gentlemen, Percival emphasized integrity, honor, and compassion in practice. His philosophy on altruism found its basis in Hume's moral theory (Morris, 2017). This took the form of beneficence, an obligation to provide and balance benefits against risks (Beauchamp, 2016). (Jonsen, 2000),” It determines the obligations of physicians, instructing each to pursue Described as continually pursuing the utmost good for others, medicine seemed to find its sole purpose in this “beneficent undertaking healing for patients. While beneficence has been reduced to a moral ideal in some circles, it remained an integral piece in medical ethics and intention.

The combination of John Gregory and Thomas Percival's work earned each of them the title of “inventor” of early modern medical ethics. However, neither of their works were particularly popular in their homeland. Rather than impacting the state of medicine in the 18th century, the writings of Percival and Gregory fed directly into the world of medical ethics growing in America. This led to the Code of Medical Ethics created by the American Medical Association in 1847 (Zaidi, 2017).

America's Role in the Ethics Debate

The regions which produced the most literature on ethical dilemmas were concurrently attempting to create concrete health care regulations. Great Britain had already made large contributions to the field of medical ethics and in combination with its well-organized health care system, no further debate existed in the public realm for nearly another century. There was great agreement in the British hospitals that “ethical dilemmas raised in medicine were best handled...by the integrity of private practitioners following clinical judgment and their own consciousness” (Jonsen,

2000).

The public discussion of medical ethics grew in America and the next great influence was Joseph Fletcher's *Morals and Medicine*, written in 1954. It was the first major work to closely examine the "knotty issues" of medicine, old (e.g., euthanasia) or new (e.g., artificial insemination) (Aulisio, 2016; Majumdar, 2003). Radically transforming the tone of ethical conversation, the essay challenged medical ethics to adapt to the new technology available in the modern era. It was also the first essay to discuss the four pillars of medical ethics, drawing from the ethical foundation beginning in Mesopotamia. Justice, non-maleficence, beneficence, and autonomy were now the guidelines for ethical practice.

The Abandonment of Compassion in Ethics

The complex relationships between ethical principles are one of the reasons ethics committees exist. Modern discussion paints these committees as personal constructions of the 21st century, while history speaks differently. Treatises, essays, and laws on ethical medical practice range back to 1700 BC. It was not until the 18th and 19th century that ethicists and physicians began to understand the great responsibility resting on their shoulders. Sadly, the greatest ethical action taken resulted from some of the greatest atrocities in medicine

The American Eugenics Movement

Medical technology found one of its greatest expansions in the 19th century, coupled with high levels of experimentation. The reality of medical innovation required a deeper understanding of the human body, specifically the brain. It took hundreds of attempts for Edison to create the light bulb and years for the Wright brothers to build

the plane. Medicine assumed it could use the same avenue which expanded industry and technology.

In health care, as in other industries, there are periods of technology expansion and periods of technology refinement. The drivers for rapid expansion typically include enabling technologies and societal needs...factors that contributed to this state of affairs included improved communication facilitated by the industrial printing revolution, pain-free operations made possible by the advent of anesthesia, and improved surgical safety using antiseptic techniques. These led to robust experimentation and innovation in neurosurgery (Menon & Riskin, 2015).

Abandoning its original principles of practice for the attractive nature of research and experimentation, medicine began to treat people as means rather than ends. In fact, the evolution of American medicine and its clouded judgment played a small role in the Nazi ideals that fueled World War II.

California Quest for Perfection

The reality was that Adolf Hitler and Germany were not the originators of the “master race.” Just like with many other German tactics, they were inspired by the writings of others. The particular quest for a master race was inspired in part by the research of California eugenicists in America. It began with forced sterilization and barred marriages with hopes of preventing the contamination of genes. While talk of eugenics in the present medical field is unsettling, it was once supported by countless philanthropic parties and charities, including the California State Board of Charities and

Corrections, Carnegie Institution, the Rockefeller Foundation and the Harriman railroad fortune (Black, 2003). At the time, social Darwinism suggested characteristics such as poverty and unreputable behavior were linked to blood. The goal of scientists from institutions such as Harvard, Stanford, and Princeton was to perfect the current society through genetic and reproductive control (Black, 2003).

The Carnegie Institution in Washington began to stockpile index cards containing the genetic traits of families. Named the Eugenics Records Office when Carnegie officially took over, it was originally called the *Station for Experimental Evolution*. This began in 1904. The genetic information was used to create pedigree charts and special trait studies (Wilson, 2018). The station was founded after the Harriman railroad funded and subsidized the project (Black, 2003).

The railroad contributed to many other charities in the region, with rumors of links to the New York Bureau of Industries and Immigration. Jews and Italians were threatened with deportation or forced sterilization (Black, 2003). Scientists at the time viewed genetic manipulation and forced sterilization as the most effective form of societal control. They convinced the state that sterilizing “degenerate” individuals was more effective than caring for their offspring. The states thought traits such as criminality and sexual deviance could be uprooted, and sterilization became legal in more than 32 states (Black, 2003). California alone contributed to more than 20,000 documented sterilizations.

Propaganda and pseudoscientific newsletters began to permeate the scientific realm as the United States led the way in eugenic treatment control. The connection between Hitler’s quest for a master race and American Eugenicists cannot be ignored.

Hitler even acknowledged the “progress” of America in this area, noting they had a weak beginning of better citizenship (Allen, 2004). He was inspired by the "Preliminary Report of the Committee of the Eugenic Section of the American Breeder's Association to Study and to Report on the Best Practical Means for Cutting Off the Defective Germ-Plasm in the Human Population” compiled by the Carnegie Institute in 1911. It was comprised of eighteen solutions to purify America; however, sterilization and barred marriages were the only two enforced by the law.

A book written in 1918 by Army doctor, Paul Popenoe, presented solutions with greater frankness, suggesting execution was the clearest solution as “value in keeping up the standard of the race should not be underestimated” (Popenoe, 1933). The eugenic movement was growing in the United States and soon the Supreme Court was dominated by eugenic ideals, with Justice Oliver Wendell Holmes stating “It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind.... three generations of imbeciles are enough” (Smith & Nelson, 1989).

Medicine had lost its duty to compassion and was being used as a tool to further racial and social prejudices. The dangers of the frontier of medicine were becoming clear and the extremes of eugenics were made evident during the Hitler regime. Medicine was in its early beginning of experimentation, coupled with racial fears and class bias, and the quest for an elite race soon grew out of control. It became evident that not every goal of perfection and good for society lay within the scope of medicine or science in general.

Virginia Sterilization

Virginia adopted sterilization laws in 1924, allowing the sterilization of any individual who was afflicted with hereditary forms of insanity, idiocy, imbecility, feeble mindedness or epilepsy. Despite the legality, it usually took a public case to initiate the widespread use of the technique across a state. In this instance, it was the case of Carrie Buck, now one of the most infamous instances of rape and forced sterilization.

Carrie Buck, born in Charlottesville, Virginia, lived as a ward and was raped as a young girl. After being sent to a Virginia colony, Buck was used as an experiment to test the legitimacy of the newly established laws. Still unsure how such arguments would hold up in court, Albert Priddy pushed for the sterilization of the young woman under claims of feeble mindedness seen in ill decision making (i.e. her illegitimate child.) This operated under the principle thinking that heredity transmits insanity and promiscuity. Priddy died before the case was brought before Justice Holmes and was replaced by H. Bell. The result in *Buck v. Bell* rested in Bell's favor leading to the sterilization of women with illegitimate children in Virginia (Richards, 2019).

Historians later revealed Carrie Buck had led an active life after her sterilization and her daughter was even placed on the honor roll in her elementary school. Through letters, she gave her own record of the events, proving there was another side to the story and that there was no actual evidence of feeble mindedness (Richards, 2019). The misconception of Carrie's mental stability is not why medicine wronged her, rather, the medical community made a mistake when they decided to permanently damage and punish those with mental disabilities, supposed or real.

Many other medical travesties occurred in the history of American medicine,

such as the forced experimentation on African males with untreated syphilis during the Tuskegee project. The spread of eugenics offers some of the greatest evidence of medicine abandoning the four pillars of medical ethics in pursuit of progress. This period of medical history exemplified the danger of placing *progress* before *people* and demonstrate how medicine had lost its heart.

Formation of Modern Ethics Committees

As injustice in medical practice continued, literature concerning medical ethics grew rapidly, influencing Joseph Fletcher to write *Morals and Medicine* in 1954 (Fletcher, 1954). The brief summary of ethical practice spurred others to continue adding to the powerful influence of ethical literature while also applying them. Paul Ramsey, a theologian and ethicist, coined the term “bioethics” in 1970 when he published his work *The Patient as a Person*. It was a noble attempt to “systematically” approach the dangers and complexities of practice. This platform allowed questions and inspired physicians and clinics alike to start developing their own discussions. This began the great shift from pen to practice. Catholic hospitals had also been making their own progress in applying medical ethics in real-world practice. Deeply rooted in a desire to maintain religious values in health care decision making, they formed some of the earliest “medicomoral committees” in 1949 (Jonsen, 2000).

The Original God Committee

The expansion and development of medical practice had not slowed, and the development of organ replacement played an instrumental role in the evolution of ethics committees. As practices become more complex, resources and the skills to perform modern operations were limited (Aulisio, 2016).

This was first seen with the development of dialysis treatments in Swedish hospitals. Previous treatment only allowed a vein to be used once, practically creating a countdown to death. However, new techniques allowed a vein to be used multiple times. Hospitals were soon overwhelmed by requests and referrals. Belding Hibbard Scribner, a medical doctor at the University of Washington, who had invented the treatment, had concerns about fairness and rationing of the procedure, but “aside from a few obvious medical exclusion criteria, there was no strictly medical or scientific answer” (Aulisio, 2016). He along with a lawyer, pastor, housewife, politician, banker, and union member formed the “God committee” in 1962 (Levine, 2009). Whether the name was simply ironic or acknowledged the gravity of decision making, the committee was one of the first official panels formed under the supervision of a public hospital.

Procedural decisions were soon not the only topic of ethical concern. End-of-life decisions particularly in intensive care units also led to formations of ethical committees. Physicians began to feel unprepared in making decisions when “faced with the reality of a no-win situation” (Teel, 1975). It was evident that responsibility had to go somewhere and similar to the observations of Scribner, many questioned whether doctors should be “charge with the responsibility of making ethical decisions which [they were] sometimes ill-equipped to make.” Acting in good faith was no longer enough and as legal liabilities continued to grow physicians became even more controlled by fear (Aulisio, 2016).

A Legal Need for Committees

Despite the apparent need for ethical committees or even training in ethical decision making, the concept of ethics committees took hold slowly (Aulisio, 2016).

Many attempts to begin conventions and even seminars were unsuccessful, perhaps because physicians had swung to extremes and saw no need to make choices between life and death. The history and foundation of medicine had been to heal. The radical revolution of technology allowed physicians to preserve life even when it seemed impossible, such as dialysis treatment and organ replacement procedures. Dominated by a desire to heal and a fear of legal liability, hospitals and physicians avoided ethical committees at all costs, with only 1% of hospitals in the U.S. adopting committees in 1982 (Aulisio, 2016). Still in the beginning of the movement people feared what it would mean to let someone die if they could be kept alive. Some even noted that “it [became] almost impossible for some classes of patient to die without a court order” (Morison, 1981).

Karen Quinlan’s case in 1976 posed as the perfect example of this phenomena. At the age of 21, Quinlan fell into a vegetative state after consuming high levels of valium and alcohol. With little prospect of regaining consciousness the question of removing life support became a furious battle between her family, physicians, and the law (Kennedy, 1976). It was this specific incident that brought the issue to the modern public. News headlines were read much more than history books. The personal story of a family no one had ever heard of soon became every family’s worst nightmare.

Like the God Committee, the Quinlan case highlights many of the features of the need that ethics committees emerged to address: technological developments creating options that formerly seemed unthinkable, value-laden questions and decisions that go beyond what medicine or science itself can address, the fact that not all involved share

the same values, and the time-pressured need for decisions. Unlike the God Committee, however, the Quinlan case had very broad resonance, as nearly anyone could easily imagine him- or herself in the same position as Joseph, Julia, or Karen Quinlan (Jonsen, 2000).

The actions in response to the cases of Karen Quinlan and many others became purely reactionary. Physicians desperately sought the counsel of renowned ethicists, but the disconnect was too great.

Consultants v. Physicians

There was a great increase in consultations, committees, and even immersion courses but the theoretical construct of ethical conversations found no root in physicians' day to day practice (Tapper, 2013). Despite the lack of involvement in clinical consultations and conventions, there was a rapid increase of non-medical persons in medical ethics, a fact that frustrated many physicians. Mark Seigler, the director of the University of Chicago's ICU in 1972 was one of the first to speak on the intrusion. Acknowledging the intentions of ethicists, he insisted that their current trajectory was misguided. Seigler insisted that clinical decision making could not rest upon the "false courage of a non-combatant" (Tapper, 2013). The technicality of medical procedures and the aspect of medical decisions could not belong to separate entities. Hoping to gain back the rights to physician decision making, Seigler created the term 'clinical ethics.' At face value this was no different than medical ethics or bioethics, but its deeper meaning attempted to make clinicians the biggest contributors to its progress once again. Publishing a pamphlet in 1982, Seigler attempted to create systematic process for clinical ethical decision making, but the committee era of the 20th

century was not finished.

A manual was not enough and whether a result of public demand or hospital need, John Fletcher organized a conference in 1985 at the National Institutes of Health in an attempt to define the requirements, results, and needs for ethical consultants. The conference itself was composed of few practicing physicians and the consultant cases discussed during the meeting only contained 21% who went on actual hospital visits. It was a fight between philosophers and physicians, an obvious battle which had been brewing for centuries and it finally came to a head in 1985. The conference came to no conclusion, essentially leaving each to his own opinion (Tapper, 2013). Some insisted consultants must have certifiable credentials and competence. This could require certification, but others believed pure experience was the most important qualification.

A joint task force in 2000 reaffirmed the ideas of many physicians, recommending that consultants did not need certification or accreditation programs (Aulisio, 2016). This recommendation has not completely eliminated the formation of ethical committees or even the use of ethical consultants. There are certain diagnoses that may require outside assistance, but for the most part physician-physician consultation provides the greatest outcomes. Studies have attempted to observe the efficiency and use of consultants but found it extremely difficult to quantify the amount of information shared by an ethical consultant when compared to the actions taken by the physicians themselves. Ethical committees are still in existence, but rather than serving on a case by case basis they exist to protect hospitals and support physician decisions in legal battles. The purpose of many committees is to extend the responsibility beyond that of the physician, rather than taking over the process in

general. In 2006 ethics consultants were found in 81% of hospitals, but only used in 0.16% of admissions (Aulisio, 2016; Fox, Myers, & Pearlman, 2007). The credibility of modern ethical committees and consultants rests in their ability to “soothe the anxiety and share the responsibility for making difficult medical decisions” (Aulisio, 2016).

Consulting ethicists and ethical committees were one solution to the growing ethical problems. They created a buffer while also providing perspective. Committees removed the moral imperative that once rested on the shoulders of physicians. Compassion, an individualistic endeavor, was overtaken by committees. This would be to the detriment of doctor-patient relationships.

The Effects of Compassion on Practitioner and Patient

The history of medical ethics depicts not just the development of ethics committees, but also the removal of compassion from practice. As committees and psychologists began to play the role of empathizer and compassionate companion, many physicians ceased to practice that essential pillar of care. While hospitals and physicians petitioned to gain back control of their own decision making, they failed to reintegrate compassion, under an assumption that it played no essential role for either practice or patient. Modern ethics considered it an idealistic aspect of rudimentary health care, despite its link to positive health outcomes (Yip, 2018). Compassion has existed for centuries and its presence cannot be ignored in the history of medical practice. While physicians may occasionally acknowledge it, the reality is that compassion is the first aspect of care to be disregarded in the face of serious illness or stress.

Scientific Health Care

As health care and research expanded, a divide was created between scientific

health care and humanistic health care, a division which had not previously existed. The humanistic approach to medicine, derived from knowledge and life experience, was too rudimentary in the scope of the broadening field of medicine. At one point in time medicine rested in this extreme, with no understanding of true science. Practice has swung in the opposite direction, however, becoming largely “empirical, rational, and quantitative” (Halstead, 2001). The difference between the two forms of practice can be clearly seen in *Table 1*. This does not mean one form of practice should be held above

Table 1. *Comparison of Scientific and Humanistic Medicine for Selected Healthcare Elements.*

Health Care Elements	Scientific Medicine	Humanistic Medicine
Structure		
1. Physical setting	Impersonal	Personal
Process		
2. Problem orientation	Disease	Illness
3. Physician’s role	Doer, Knower	Teacher, Learner
4. Patient’s role	Passive	Active
5. Care orientation	Physician (staff)-oriented	Patient-oriented
6. Physician’s relation to patient	Reserved	Empathetic
7. Physician’s relation to health team	Dominant	Facilitative
8. Physician’s relation to colleagues	Competitive	Collaborative
9. Therapeutic approach	Treatment of disease	Management of illness
Outcome	Curing	Healing
10. Objectives	Enhancing physiological function	Enhancing functional performance

Note. Table adapted from Halstead LS. The Power of Compassion and Caring in Rehabilitation Healing. Archives of Physical Medicine and Rehabilitation 82, 2001.

another. The reality is that each on its own possess strengths and weakness which can only be complimented through balanced integration. A purely humanistic approach to medicine will often fail to further scientific horizons, while pure scientific practice fails to view patients as more than a disease. Patient-centered medicine was overtaken by research, which led to the degradation of compassionate practice.

Compassion and Empathy in the Brain

Some individuals notice the relative absence of compassion in practice, mainly in the physician-patient relationship. The lack of compassion has also affected physician

health. In an attempt to reintegrate compassion, society has misinterpreted empathy as a form of compassionate care. Empathy is simply feeling pain or sadness in response to someone else's suffering. Compassion, however, is using the experience of empathy to create action in order to improve a situation or alleviate pain. This stark difference can lead to burnout in physicians who are constantly overwhelmed by the pain and suffering of patients. Empathy and compassion are not only separated by definitions. Studies have also shown that they produce different behaviors by using different pathways in the brain (Klimecki, Leiberg, Ricard, & Singer, 2014). When a control group was shown emotional videos following empathy training in comparison to individuals viewing the same content after compassion training, the empathy control group activated regions in the brain which dealt with pain processing and reported greater levels of negative feelings. The compassion group suggested that acting on empathy through compassion used different pathways (based on fMRI images) and reported positive feelings. The study concluded that a lack of compassion has great implications for burnout, depression, and other stress-related diseases (Klimecki et al., 2014).

This was confirmed by a similar study conducted by the *Planck Institute*, where the principle empathetic response in individuals primarily activated the anterior cingulate cortex and the anterior insula, the regions of the brain activated during the experience of personal pain or in this case the "imagined experience and the empathetic experience of pain" (Hill, 2014). Compassion training in this same group used a significantly different pathway using the medial orbitofrontal cortex, putamen, pallidum, and ventral tegmentum. These are areas strongly related to "positive affect, love, and affiliation" (Hill, 2014). The paper concluded that compassion training

impacted not only the individual practicing it, but the recipient as well (Klimecki, Leiberg, Lamm, & Singer, 2013). The individuals practicing compassion strengthened their own health by improving positive affect and the recipient benefited through “prosocial motivation.”

It is important to note that compassion is a branch of empathy and without true empathy there can be no motivation for action. The production or training of this motivation can only be found when an individual is in a neutral state or the same condition as the patient or counterpart. In another study conducted by the *Planck Institute for Human Cognitive and Brain Sciences*, two groups were assessed through a stimulus test using pleasant and unpleasant stimuli. When individuals were exposed to a negative stimulus, they were found to be more empathetic towards their counterpart’s negative experience. When exposed to a positive stimulus, assessment of counterpart’s negative experience was significantly less empathetic. During each interaction, patients were monitored through functional MRI and it was found that when counterparts were placed in identical situations, the right supramarginal gyrus continually fired. When situations differed in time constraints and the presence of negative stimuli, this signaling was disrupted (Giorgia Silani, 2013). Scientists concluded that the disruption of these neurons was linked to an individual’s ability to strongly empathize.

Physician Self-care

If physicians fail to care for themselves it is impossible to them to care for others. The issue of burnout has played a large role in the compassionate care physicians can provide. The impact of stress is one of the largest contributors to compromising this kind of care. This is supported by a recent study which found that

anxiety and depression rates are higher in the physician population than the general public (Blue, 2013). This may not be a surprise, due to the negative role modeling produced by current physicians and training in medical school. Self-care has been isolated in some institutions, but usually the solutions consist of no more than singular speeches and an occasional conference. But self-care that truly impacts the practice of a physician penetrates their life as a whole. It involves “various strategies that help promote or maintain one’s physical, mental, emotional, and spiritual health... it requires self-restriction and awareness to identify stressor and supports in both personal and professional spheres” (Mills, 2016).

Physicians are placed under immense stress, but increasing compassion is a coping mechanism that may have been overlooked, despite its influence for overcoming empathetic stress while also building resilience. If stressed doctors were just as effective as compassionate physicians, this would not be a problem, but the reality is that compassionless care is practically a lack of care altogether. Thus, it is essential for physicians to reintegrate self-care into their own lives. It is a key to their role as physicians. While many view it as inefficient and rudimentary, the practice of self-care and compassion are just as complex as the practice of scientific medicine itself. This is because compassion is more than kind words.

It involves cognition, affect, intention, and motivation; that in context of suffering, related to the alleviation of that suffering...expressing compassion in clinical practice is, however, a complex endeavor which may either influence or be influenced by a variety of intrinsic, extrinsic, and organizational factors during any give interaction (Mills, 2016).

The compassionate component of medical care takes just as much effort as the scientific aspect and it is just as important. This is why the emphasis on physician self-care is so important. An affect of compassion could change the trajectory of not only the medical care physicians deliver but the lives of physicians themselves, leading to fulfillment which so many long for. Mixing compassion and selfcare allows physicians to “care for their patients in a sustainable way with greater compassion, sensitivity, effectiveness, and empathy... genuine compassion requires compassion for oneself (Mills, 2016)” and the best place to begin is through compassionate behavior, because it actually gives practitioners a positive affect and an enhanced sense of purpose (Haq, 2014).

Compassion and Patients

While it has been acknowledged that compassionate behavior can improve physician health and well-being, this is not the only reason compassionate practice should hold a greater emphasis in medical care. Compassion also affects the patient. Physicians are expected to “ease human suffering.” This can only be done through compassionate behavior, with the word compassion meaning to literally “suffer with.” This sort of care creates trust and allows for true therapeutic relationships, which treatment alone could never have fostered. It is important to recognize that sometimes patients do not need a cure, but rather healing and comfort. This concept was beautifully illustrated in a personal story from a family practice physician in Australia. After losing a patient, their practice of compassionate care gave both the physician and patient exactly what they need. They concluded “while I was not able to cure his diseases, I was able to listen, to acknowledge and ease his suffering, to express sympathy, respect and warmth to celebrate his wishes and to support his family as they grieved his loss”

(Haq, 2014).

This kind of care can only be provided through a balance of scientific and humanistic medicine. Compassion is not only rooted in the philosophy of ancient medicine but finds its basis in neurobiology as well.

The Future of Compassion and Medicine

In reality, the scientific side of medicine should not stop expanding. Even now, neurotechnology is one of the fastest growing areas of research and experimentation. But this does not mean the humanistic aspect of medical practice should be ignored. With the invention of new tools like the functional MRI, the science of compassion is becoming clearer. Finding its origins in ancient philosophy does not mean physicians can find no use or benefit for it in modern practice. It is quite the opposite - there is even greater opportunity to explore the deeper physiological and neurobiological impacts of compassion on both patient and practitioner.

Doctors are to care for their patients and they should be just as compassionate as they are competent. As medicine and its treatments have become more “efficient” many have assumed ethics should also take a more streamlined approach, with compassion being the first to go (Smajdor, 2013). Life is still life, people are not their disease, and doctors are still healers. Many things have changed along the way, but compassion has remained a common thread in the design and purpose of medical ethics and cannot afford to be removed. History has proven what this results in.

It is impossible to ignore the advances in biotechnology, but as technology advances physicians cannot cease to prioritize the healing of the patient, placing more focus on “curing and less on caring” (Souba, 2002). This was the very reason ethics

consultants were brought into medicine. As technology evolved physicians were often faced with decisions they were ill-equipped to make (Aulisio, 2016). However, this new role divided the ethics of medicine and the practice of medicine into two separate fields. The truth is that compassion cannot be removed from medicine and treated as a separate discipline. The very actions which led to instances like nationwide sterilization and the Tuskegee project were the abandonment of these core medical ethics.

Effective health –care depends partly on health professionals taking a human approach, which actively involves patients, rather than making them recipients of what may be seen as a pre-occupation with impersonal, high-tech procedures. But the human approach to treatment of both body and mind of the patient is the central message of medical ethics. It is man that counts, and not the machine or the method (Jonsen, 2000).

Medicine is surely rooted in science, but medicine’s original purpose rested in the healing of the body. This required an understanding of humanity and a respect of the person. Leading with compassionate hearts, physicians served as both supporter and healer, an aspect often ignored in modern medicine. Modern medicine has become much like an assembly line, and while emotive actions can be dangerous if overused, its complete absence is detrimental to medical practice as a whole. Compassion within practice has been twisted into weakness and described as inefficient. Compassion does not have to entail indecisiveness and empathy is not a sign of poor intellect. It is these two characteristics that form the basis of medical ethics and without them physicians “lack the wisdom and will to tackle the problems facing health care today... [and]

sadly, the commercialization of medicine has encouraged an external orientation—one that hinders the personal journey of transformation and contributes to the lack of meaning and direction permeating the workplace today” (Souba, 2002).

There is nothing wrong with ethics committees and consultants. The medical field must be held responsible for the power its new technology has created. However, ethical concerns do not stop with committees. Instead, balance is found in education and perspective. Providers must learn to have open discourse about what it means to be both an academic and sympathetic physician, as these characteristics are not contradictory. It allows for the accountability of committees, but also requires integrity and solidarity in physicians themselves. This change will not occur overnight, it is impossible for organization to change until the people with in them change first (Souba, 2002).

Medical schools have sought change on the forefront of the issue by building such dialogue into curricula and residency training. However, this also means great educational effort for faculty as well. It is more than simple statements of purpose, it is a way of living. It is a change in the status quo. It will take more work and more learning. Understanding people is not an easy job, seeking to empathize with strangers is not a simple task. But this is what makes medicine different from science. This is what transformed medicine into and art and is the missing piece today. The truth is that “medicine is not a vocation – it is a mission.”

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