Compassionate Care

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Why Islamic Medical Ethics Has a Unique Capacity and Responsibility to Contribute to the Recovery of Compassionate Care in Today's Health Care

Stephen G. Post, PhD

What does Islam have to offer health-care ethics that cannot be found elsewhere? I do not mean to suggest that there is only one answer to this question, because there are many. However, I will focus on the elevated status of the patient as the recipient of compassionate care. Today, the primary medical ethical issue is no longer a quandary such as "Should we withdraw artificial nutrition and hydration from a 90-year-old man with dementia?" Such questions are, of course, important. However, the primary issue is that the medical profession is losing its soul to technology and dehumanized care in which patients feel overbiologized and depersonalized, nothing more than "the kidney in room 5." I ask you here today, in the name of Allah the merciful and compassionate, to be the ones who provide leadership in solving this crisis in medical care.

Historians of medical ethics and bioethics rightly begin with Hippocratic ethics (400-300 BCE). We are familiar with the Hippocratic Oath and its influence. One finds in the ancient Greeks and Romans absolutely no passionate concern for the patient. There is no sense that the Hippocratic physician should go out of his way to help a needy patient. The spirit of Greco-Roman medical ethics is more or less casual with regard to the patient's good. One has no image of the physician who goes out of his way or sacrifices ease in order to respond to the patient in need. In fact, for all its strengths, the Hippocratic ethos excludes from care slaves, poor people, and dying patients. Certainly the oath is clear in prohibiting the use of a deadly drug or abortifacient. It affirms confidentiality and "do no harm" and has many other strengths. But that passion for the patient in need, no matter how inconvenient, is simply not part of the ethos. The Hippocratic tradition is elitist, rather than devoted to patients in the spirit of equal regard. It really operates at the level of medicine as a career (*careo*) rather than anything deeper. There is no real call to serve.

Then comes the great period of the Judeo, Christian, and Islamic traditions (est. 400 to 1750 CE). Here the physician is no longer casual but rather called by God to heal the sick regardless of their circumstances, degree of illness, or ability to pay. The Islamic Code of Medical Ethics of 1981, ratified by the First International Conference on Islamic Medicine and endorsed by many Islamic countries, vividly articulates this depth of calling to serve the needy.

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The physician swears to Allah to protect human life in all stages and in any situation, doing his or her "utmost to rescue it from death, malady, pain and anxiety." The physician protects dignity, and is "an instrument of God's mercy, extending my medical care to near and far, virtuous and sinner, and friend and enemy." This new depth of commitment to the patient's good is completely the product of Islam and the other Abrahamic faiths. One finds a similar depth of commitment in the oath and prayer of Musa ibn Maymun (Maimonides), the great Jewish philosopher and physician of Andalusia. Christianity started Europe's first hospitals and devoted entire communities of monks and nuns to the care of the ill. Maimonides' prayer includes "The eternal providence has appointed me to watch over the life and health of Thy creatures." Furthermore, "May the love for my art actuate me at all times; may neither avarice nor miserliness, nor thirst for glory of a great reputation engage my mind; for the enemies of truth and philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children." This is entirely different in tone and passion for helping the needy patient from anything that could possibly have been produced by the Hippocratic tradition.

So when we think of the Islamic tradition and the other Abrahamic faiths, we have what is clearly the most essential aspect of any medical ethics worthy of the word, namely, the passion for the patient, the willingness to serve selflessly as needed those whose lives are imperiled. Elitism is replaced by servanthood and humility.

In the Enlightenment and beyond, we see a strict rationalism and reliance on moral sentiments such as sympathy. The passion for the patient is not lost, but it is de-sacralized and removed from the context of a sacred oath under one God. The God-centered commitment to the patient's good as the child of the divine begins to erode.

In the modern phase (1960 to current), we see a set of principles, now extended to include respect for autonomy, but absolutely no framework from which to affirm strong compassion for patients and a willingness to set aside self in their interests with deep commitment. I do not wish to claim that the principles of modern "bioethics" – respect for autonomy, justice, beneficence, and nonmaleficence – are useless when it comes to the assessment of cases. But they do not provide the power of passion and compassion, the sense of calling and vocation or the appeal to self-denial that the Islamic tradition clearly does. So what is the responsibility of Islamic medical ethics today? It is the special role of Islamic medical ethics to restore deep compassionate care and patient-centeredness to the profession of medicine. In Islamic medical ethics the patient comes first, regardless of social status, poverty, or terminal illness.

The kind of care we are talking about requires humility, empathic skills, and gratitude for the privilege of caring for the sick. In jeopardy in medicine today is the human connection between doctor and patient. There are doctors in training now who do not want to do the physical examinations; they just want to refer to a lab test or the echocardiogram on a heart patient. If the health-care profession would rediscover the power of human relationship we could bring about the kinds of lifestyle changes that would significantly reduce disease. Joe Martin, a retired dean of Harvard Medical School, gave a talk in which he talked about Joseph Michael Foley, a previous head of neurology and the residency director. Joe Martin said Dr. Foley would take him and the other residents into a patient's room and without fail, would appropriately put his hand on the hand or the shoulder of a patient and would ask is there anything he could do to make their hospital a little more comfortable. Joe Martin said one patient, a woman, took Dr. Foley up on his offer and asked for a good cold iced tea, and Dr. Foley made sure somebody got it for her.

There will be a question about cost effectiveness. When doctors are compassionate, the visits are not more time consuming, with the possible exception of palliative care because it deals with very complex situations that actually can take several hours. That is why the issue of cost in palliative care is an important one. In the ordinary clinical encounter, this is not time consuming. In fact, it takes very little time to simply sit on the edge of a bed and nicely ask a patient how they are handling their illness and perhaps if they need any special help from pastoral care. Patients are more emotionally comfortable when cared for in this way, and they are willing to divulge information about themselves without the health-care professional having to probe for it. Moreover, you can get more efficient treatment planning and

treatment adherence. A significant portion of every American dollar spent on health care is spent because people are not adhering to treatment and not taking their medications — whether it is insulin or immunosuppressants — they are not doing the activities their physicians recommend, and they are not following up. What is the single major factor that contributes to adherence in patient response to physician recommendations? It is compassionate care. When patients feel that their doctor cares about them, they will care about themselves. They will take their medications, they will heal, and we will have a much more cost-efficient system.

Dame Cicely Saunders started the first hospice in the world. The word hospice came from the medieval European culture. A hospice was a place that was usually attached to a monastery or a church where travelers and wayfarers would spend the night. She used her analogical imagination to say dying is a bit of a journey, and what people need is hospitality. The notion of hospice was applied to people who were dying.

If you look at the Islamic tradition, or look at the Hebrew Bible, you will find that hospitality is a key moral notion. People on the road, including the road to death, are vulnerable. They require something exceptional from us. Dame Cicely had to start St. Christopher's in the basement and board the windows. The oncologists thought she was devilish. People at that time in the late 1950s and the early 1960s thought that it was unconscionable to die without a tube in every orifice, whether natural or unnatural, but she fought that. Just like Florence Nightingale, Cicely was a deeply committed Anglican. She felt a divine calling in this work. In a lot of ways, although we sometimes deny this reality, people who do amazing things to help the needy have this sense of God's heart.

In 1999, at a conference I ran at the Massachusetts Institute of Technology (MIT) with The John Templeton Foundation, she gave the dinner speech on empathy and compassionate love. She said, "You know I am 83, and I cannot retire. I still go into St. Christopher's every morning, and I do a menial task. I change bedpans for an hour, and I do it as a spiritual practice. I may be an old woman, but that is what I do." She continued, "I sit on the end of beds, and I just listen attentively in an undistracted way to patients who are dying, because the most fundamental human need for someone who is dying, but more generally, is to know that their lives are significant, that their lives matter, that their lives are worth something, that their lives do not just rest on some cosmic mistake." She added: "The best way you can convey that significance to people is to just be an attentive listener." So she did that. Then she said "Oh. I would go on and later in the day get involved in public relations and fundraising." She combined all those great spiritual emotions that I associate with Islamic and other traditions: inner peace, tranquility, compassion, joy, a joy beyond happiness, a joy that had an inner foundation. There was a sense of depth in her presence that was really quite remarkable.

So what can we do to recover the power of compassionate care in modern medicine? I think it is essential that the Islamic medical societies be involved not just on a theological basis, but also on a scientific basis.

At hospitals across the country, Schwartz rounds are conducted and do not focus on the biological substrate but rather whether a patient was treated with compassion and care and generosity. The Simulation Center training programs are very important. We work with students. We do not want them to simply ask the patients, "What medications have you been on? What is your medical history?" and so forth. We want the students to ask a simple question such as, "This must be pretty tough on you, yes?" "How are you handling this and do you need some help?" or "It is natural to feel pretty overwhelmed at times like this." We have whole sessions with our students in the Simulation Center to encourage them to ask these simple questions. A couple of months ago I was up in the Catskills where the Hindu Medical Association of America was having a retreat on compassionate care. About 700 physicians were there because sometimes they just feel that the core of the healing relationship, the compassionate care, is just being pushed aside at their hospitals. They need to occasionally get together and really firm up their commitment to it because in the end that is really what matters. If we are committed to this kind of relationship, it will happen.

Lynn Halerman, who runs our palliative care program at Stony Brook, has an interesting practice. Before she enters the room of any patient she does something called "Stop, knock, breathe." Instead of

barging into a room where a patient may be in the corner of the bed naked, she stops, pauses, knocks, breathes deeply in a kind of informal meditational way, and then she listens for a response. This is an example of the saying "There are no great works of love; there are small things done with great love."

The field of modern bioethics stressed respect for patient autonomy. But it lost the richness of the Islamic tradition and the other Abrahamic faiths generally, in which caring for the patient regardless of circumstances is the ultimate mark of a virtuous doctor.

My Muslim friends, who insist that all of God's children be treated equally with equal dignity and care, today I call upon you to be the people who bring compassionate care back into medicine, and to bring your fellow physicians back into a domain of generosity of soul and practice that alone can make being a doctor gratifying and enduring.

Let me reiterate. Medicine arose in theological contexts. The ancients swore their healing oaths to the gods and goddesses, thereby adding an aura of sacred depth to the task of preserving life and ameliorating suffering. A revolution in medicine occurred with the Abrahamic faiths, all of which gave rise to a more deeply impassioned concern for the ill than had been seen in classical antiquity. From the Prayer of Maimonides to the Christian founding of the first hospitals, from the advances made by Muslim physicians to the establishment of great medical schools in Europe and the Middle East, from Florence Nightingale's founding of modern nursing to Dame Cicely Saunders's establishment of the hospice movement, from Albert Schweitzer's "reverence of life" to Paul Farmer's "theology of liberation," good medical practice has never been secularly grounded. Rather, medical science has been energized with the noble religious commitment to healing. Good healers have always understood that the art of medicine requires empathic attentiveness to patient spirituality. The patient who is loved feels that his or her life has value and significance in the eyes of the nurturer. Compassionate love responds to the deepest of human needs: the need for significance. It reflects back to the beloved the significance, dignity, and even sacredness that would otherwise be obscured. The need for significance is not the quest for fame or renown. Rather, in navigating through life, all people need to feel that their existence is not an error. The affirmation of significance is profoundly important in times of severe illness.

The great Abrahamic ideal of deep commitment to patients in compassionate care and medical love is the hope of the future. Muslim physicians could organize a new era of commitment to the patient's good that comes from the very heart of Islam and is a light to a profession where more professions have no commitment to anything other than their own comfort. Regrettably, too many physicians today are little more than Hippocratic, and their deep loyalty to the care of patients is diminished. We need a renewed appreciation for the passion and compassion for the patient, and here Islam is well positioned, along with Judaism and Christianity, to show the way.

The recovery of compassionate care is linked to patient hope. Those who feel cared for with compassion tend to be hopeful. The Islamic tradition ultimately places all hope in Allah, so to relinquish hope is to distrust the Creator. Most of us would agree that "hope" is a "bigger" concept than optimism. Clinical pastoral care brings perhaps the deepest perspective on hope, and at its best, the most promise for resetting the goals of hope. For each of us as finite beings, the negotiation with hope ultimately raises questions of ultimate meaning and what can be broadly considered matters of spirituality. There are many patients for whom hope cannot be seriously discussed outside of a spiritual-religious tradition.

The word "hope" has been loosely drawn into the art of healing from early on. Thomas Perceval, the great Enlightenment physician, provided a code of ethics that was reflected in the first American Medical Association (AMA) Code of Ethics, in 1847, as follows: "For the physician should be the minster of hope and comfort to the sick..." This is as true today as it was two centuries ago. Contemporary bioethics and classical medical ethics differ deeply on the matter of the ethics of sustaining hope. Bioethics has no ethical principle of "respect for hope," while classical medical ethics makes this principle central. Bioethics centers on the principle of respect for autonomy, reflecting its roots in the patient's rights era of the late 1960s. It was born in an era before the connection between mind, emotions and body had been explored, such that the importance of nurturing hope was not yet on the horizon of allopathic medicine in the way that is was in other healing arts.

Bioethics has much to learn from the perennial wisdom of medical ethics in regard to the principle of respect for hope. On the other hand, hope ought not to provide an excuse for deception and manipulation, as was often so before patient autonomy came to be taken seriously.

Positive psychologists are now examining positive emotions, including hope, compassion, serenity, and happiness, to better understand how these not only provide a buffer against negative emotions, but also have broader beneficial impacts on health. We have arrived at a point where the study of hope and health outcomes is credible. In this regard, the Islamic tradition of medicine has much to offer.

Discussion

Julie Byrne, PhD: Thank you so much, Dr. Frisina. Thank you so much, Dr. Post. And thank all of you for the privilege of being here.

As I heard Dr. Post's presentation my thoughts are that you have a very difficult job concerning the commitments and concerns of the Islamic Medical Association and its interest in medical ethics. You have a very difficult set of concerns that you try to see through every day. Yet these are, as Dr. Post said, some of the most important, not only medical but also religious and human concerns that one could have. I am someone who studies American religious history, and from that perspective, I say that one of the very difficult things that you face is that the constituencies of the hospitals, the patients, and the colleagues with whom you work are from several ethnic and religious backgrounds. I tell my students in Religion 10, which is Introduction to Religion in America, that in any job it is crucial for them to have some kind of literacy about different religious traditions. We run through all of the ones that have showed up in the United States over time and how they get along, and how they do not get along, and how wondrous it is to have a country where there are so many religious traditions in contact and in conversation with each other. If I tell my students in Religion 10 that they need for their future jobs to have a basic sense of religion in the United States and how it works, how much more do you who are on the frontlines of the entirety of the population and its religious diversity at the most crucial moments of people's lives, where their bodies, spirits, and minds are in a crisis moment trying to relate to each other and to their families as they are going through these experiences? I felt just as we were talking that there is an incredible calling that you are following and an incredible inherent difficulty, namely to address people who are coming from the different religious traditions. How could you know enough? How could you ever get a sense? And one of the great things about talking about compassionate care is that it has a way of cutting through a great number of religious traditions to get to some things that people in crisis situations just need humanly.

The area of my particular expertise is American Catholicism. The ways in which you all encounter Catholicism in America are quite varied. I will say something about them. One thing that has come up in the discussion is just the way in which compassionate care makes it less crucial to know that particular nuance of Hinduism, Buddhism, Catholicism, or Lutheranism and instead get to what are human-to-human contacts, day in and day out, that can definitely come from the wellspring of the Abrahamic traditions and others, but might not need to get into their specifics so much. That has been very informative to me.

In your professional lives, you encounter Catholicism in your work areas in at least three ways, and they are all very much imbued with implications for health-care work, and they all relate to hope, to different takes on hope, and what it means to hope. We will talk more about that as we get in the discussion later, but hope is, I think, very basically the grounds for believing that something good may happen and what that ground is for different Catholics in different places might be very different. When you are talking about Catholicism you are talking about a church that is incredibly centralized in the form of its central organization in Rome but is global and incredibly populist. Worldwide, one in six people are Catholic. The United States, despite all of its religious diversity, is still a country that weighs in at somewhere between 76 and 82% of its residents claiming Christianity. Of those Christians, the largest Christian body is Catholicism, which accounts for one in four Americans.

Catholicism is a good example simply because it is one of the most populous faiths, and because the Christian tenor and perhaps the Catholic tenor of United States approaches to medicine go far beyond the influence of just the official Catholic Church

positions. That is because the Catholic Church is so organized, because it has incredible institutional presence in the form of hospitals and its health-care system, and because of its government contracts and its national lobbying arm and international influential presence. For all of these reasons Catholicism is one good way to illustrate the incredible diversity about the approaches to health care that might be even within one tradition. I think the most visible Catholic viewpoint is the one that comes from its leaders, especially the bishops and backed up by the Vatican. It is a very visible take on health care, which since the 1960s has emphasized more and more what Cardinal Joseph Bernardin, who was dying of cancer, came to call in his book *The Consistent Ethic of Life*.[a] This consistent ethic of life was Bernardin's way of pulling together a number of Catholic social and moral teachings that included life issues and other issues. It also included that the Catholic church is visibly and officially against abortion, euthanasia, the death penalty, war and nuclear armament, artificial birth control, and torture. All of these were an encompassing set of positions that included end-of-life issues about which medical ethics are concerned. To put it more positively, this is an array of issues that the Catholic church has spoken consistently for in terms of many social justice issues, antipoverty programs, human rights, and antideath penalty in so far as they were putting forward officially and programmatically a stance against what Pope John Paul II called the culture of death. That was the Catholic church's modern and perhaps postmodern response to what is sensed as an ongoing devaluation of human life, and that it was important to take a stand against it. This is the most visible Catholic church stance from the bishops, from Rome on controversial topics such as abortion and birth control. This stance can be significantly politicized, for example the prolife lionization of Terri Schaivo's family for keeping her on feeding tube through many years, and it can also have another aspect that is perhaps exemplified in the very moving story of Cardinal Joseph Bernardin's death and the acceptance of life in whatever form it takes as death approaches. This is the official set of positions.

What I think is the second most visible, and perhaps most visible to you as physicians, is what Nicholas Kristof wrote in a *New York Times* editorial recently that there are two Catholic churches. One is the official Catholic church, that is the bishops and the pope with many pronouncements, and then there is the other Catholic church, which runs hospitals and does poverty work, and its many orders of sisters, brothers, worker priests, and people who are in the trenches. These are the people with whom you work all the time in the Catholic hospital system. They have different views than the official Vatican positions. One can see this very explicitly, most recently when there were Catholic talks on the Obama health care plan. The Catholic bishops' conference came out with one stance, and the Catholic nuns' group came out with another. These were opposite stands: for and against. This is where I see the most of what Dr. Post was describing in the flourishing and robust compassionate care tradition, whether it is about end-of-life issues, care of the mentally ill, or care of those who are disabled or on the margins of life. Perhaps the most clear example of this, from the Abrahamic traditions valuing life in a very practical way no matter what the state of that life comes in, is a group that Dr. Post mentioned, the Arche community and the Arche homes, founded by Jean Vanier. I think there are about 16 such homes in the United States and more in Canada. In these homes, people who are disabled and people who take care of them live in home as a community with the intent that this is a model or a microcosm of the overall community. There is much to learn about life in its supposedly diminished forms for those who are supposedly not diminished. This cooperation and synchronicity between those "disabled" and "able bodied" exemplified and learned in the Arche homes is seen in many other forms in a second tier of Catholic approaches on how to care in hospitals.

Then there is a third group of Catholics with whom you come in contact all the time, that is patients and coworkers who are Catholic or come from Catholic backgrounds. As I mentioned before, 25% of Americans call themselves Catholic. There was a study a few years ago that showed if you counted ex-Catholicism as a religious group, it, at 11%, would be the third largest group in the United States, following the Roman Catholics at 25% and the Baptists at 16%. People who are Catholic or are from Catholic backgrounds are quite variable as to whether they buy much, any, or all of the official Vatican pronouncements. For example, only 11% of

American Roman Catholics believe that abortion is wrong in all circumstances, despite the official position. In 2005, 25% of Catholics believed that you could be a good Catholic even if you did not believe Jesus rose from the dead physically. Seventy-six percent believed that you could be a good Catholic even if you did not go to Church every Sunday. What was the other very characteristically American pluralistic statistic? In 2003, 86% of Catholics agreed with the statement, somewhat or strongly, that if you believe in God, it does not really matter what religion you belong to. Therefore, what makes your position so hard is that any Catholic you encounter could be in a range of identification with Catholicism that might be all over the map. Is this a Catholic who believes the Vatican statements 100%, lives his or her life by them, wants the end-of-life sacrament according to the book from a priest, preferably in Latin? Or are you talking to one of the 19% of Roman Catholics who believe in reincarnation, clearly not a Catholic belief, but one that is so much in the air in a country that has Eastern religious ideas available and popular that 19% of Roman Catholics believe they are going to come back in another life someday, as Hindus and Buddhists do. This is a very challenging scene in which to make assumptions about the beliefs of any particular Catholic colleague or patient.

At the same time, there is a sketching of the range of the official position, the social justice tradition and the incredible plurality of actual individual Catholics. However, compassionate care, the kind of compassionate care that is human, should be offered regardless of these beliefs. Your religious background and other person's background, are to some extent minimized and relativized in the face of a situation where compassionate care can do the work. Thank you.

Dr. Warren Frisina's comment: It struck me listening to both Professor Post's and Professor Byrne's presentations that it is clear that we live in an age when the issues are so complicated, and the problems are so severe, while the modes of communication are so limited, even as they are profusely abounding. The tendency when talking about religion is to grasp for some thing, and typically that means identifying a religious tradition with some little facet, some little corner of what it is, and then using that as the defining, essential characteristic. Everything else you say works off of that. One of the things that happens if you hang around a religious scholar is that it becomes clear as you listen, for them, the things we talk about as Islam, Christianity, Catholicism, Buddhism, and Hinduism are the terms that actually dissolve as we look more closely at people's lives and practices. They dissolve because they do not say anything by themselves. You have to know, as professor Byrne was just suggesting, what is the context, what is the activity, what are the subgroups, what are the ways in which this person lives a life influenced by Catholic tradition but also influenced by other kinds of things? You know you just have to turn the radio on for 30 seconds and hear someone announcing or pronouncing something about a tradition and then going to denounce that thing. They have no idea what they are talking about or who they are describing. Everyone knows that from inside their own tradition. Muslims know the ways in which Islam is complicated and sophisticated and spread out over all these historical and geographical places and instantiated in different ways. It is true also for the Catholics that Professor Byrne is talking about. I want to bring that observation together with Professor Post's presentation. Because it is in listening to somebody before you move ahead to draw conclusions about how to respond that you find out what kind of Catholic is in front of you, or what kind of Muslim you face, what is his or her frame of reference is, and, as a result, you are able to respond in the ways that are most helpful and most likely to contribute to healing. The two talks for me brought these things together. On the one hand, the ethics of care, which requires an ability to listen, is what will reveal to us, all of us, not just physicians, who are the people we are working with, interacting with, and dealing with. It also helps us to step away from the abstractions and get to the concrete realities.

The question I wanted to start with, Professor Post, is why is there a focus on the Abrahamic faiths? I took it that you were juxtaposing those with the enlightenment traditions' understanding of ethics. I wanted you to reflect a little bit on the extent to which the things you were pointing to are usually core to many religious traditions, whether or not Abrahamic. The obvious example is Buddhism, which is centered on the value of compassion, its core value. In the Confucian tradition, as I under-

stand it, they understand that what roots humans is "ritual," which you could translate quite easily into "ethics" or "etiquette." Dr. Post, could you talk about the ways in which these values are rooted in religious traditions and use that as a way to think more broadly about what the different religions' roles are in healing and in helping physicians to achieve their tasks?

Dr. Post: Indeed we can learn a lot from picking up a text by, for example the Dalai Lama's *Ethics in the New Millennium*.[b] It is all about compassion. In other words, we need to get more basic about the connective tissue between human beings, which is the basis of ethics. I have always rejected most of Enlightenment ethics because it is so contractarian. It says, "Look, we are so self-interested individuals, and we can agree on certain kinds of minimal restraints." The principle of "Do no harm," while it is important, is also trivial at a certain level. We can agree on restraints with regard to want and harm, deception and the like so that we can live together well in our self-interested ways. Of course, as soon as one is adequately incentivized, greed takes over, convenient restraints are set aside, unless you have something deeper, which is where we get to the Islamic tradition and the Buddhist tradition and so forth. Unless you have some kind of connective glue between human beings as the sort of ontology of moral life, you are really out of luck and out of ethics. At some point you can be one with others because you believe in an all compassionate God, Allah, and you believe we are all the children of that Compassionate, Merciful God. As a panthiest, you can believe that we are all one because somehow God is alive in the molecular bonds in whatever way you want to look at it. Not a silly idea, because the famous Michael Sinmorly actually believed that you could not explain H_2O without the power of a transcendent presence. Now maybe we are talking about mirror neurons in both sides of the brain that allow us to empathize or feel into the experience of others, which is deeper than sympathy. There is a whole neurology of group selection.

In the Journal of American Medical Association not too long ago, Paul Ekman wrote an article on Darwin and compassion based on Darwin's book *The Descent of Man, and Selection in Relation to Sex*, which was published 11 years prior to his death. Darwin thought that in fact individual selection theory, "me versus you" versus some desired object in the environment, is mostly mistaken. However, most evolution actually occurs between groups. Group A will do better than group B to the extent that group A develops within itself certain cohesive qualities such as altruism, compassionate care, helpfulness, and the like. In fact, Darwin even speculated briefly that we ought to have built-in health benefits when we engage in those kinds of activities.[c] That is why I am not surprised to read studies out of the National Institutes of Health (NIH) or proceedings of the National Academy of Sciences showing that when people are even thinking about making a contribution to charity, for example, the mesolimbic pathway lights up.[d] This pathway is associated with feelings of joy and the doling out of feel-good chemicals, including dopamine and serotonin, one of which is used to treat depression. That is a bit of a natural law argument. My point is, whatever the connective glue is, you know we need it. The religions of the world, in one way or another, enforce that. They teach us that we are not as separate as we think we are, even as we live separately. In a clinical environment, where we train medical students to approach a patient only as a biological object and not with any concern for the subjectivity of it all, we are really limiting our opportunity to be healers.

Questions from the audience

Dr. Fred Smith: *I just want to be a little contrarian. I grew up in an evangelical tradition in which certainty was very important, and I think it is a problem in our political life today. My relatives and others in the hinterland believe they have that certainty. I think we have to be careful as religious people not to be triumphalists. I do not want to belittle secular or Kantian ethics because I do ethics consultations and I would be lost without them. I cannot speak in religious language when I do ethics consultation; I have to speak in a language that everybody, including many nonreligious people, which doctors often are, can understand and appreciate. Besides, those four normative principles help me in my thinking. I think we could argue that paternalism and patriarchal society are sort of an Abrahamic tradition in some ways, correct? As a Protestant, one of the few here, I imagine, I do value the Enlightenment. I think autonomy grew out of the idea that the individual has a big role, and the hierarchy is not the sole repository of truth and that we can individually find the truth.*

As far as hope, the subject of today, and how it relates to this uncertainty I think we all die alone in a sense. We die, hopefully, with our family around us, which is the point I made yesterday in trying to argue for dying with hospice so that you can have people holding your hand. But you die alone. I remember a number of years ago, maybe in the last decade or so, something in the "New York Times" struck me. The Archbishop of Paris was talking about Pope John Paul II's declining health, and how he would soon face the void. It really struck me that the Pope was facing the void. The New Testament says that no man has seen God at any time. I guess Moses got a glimpse at his back. Elijah heard the small voice. Jesus certainly claimed to have a direct relation, but we have not. When we die, there is uncertainty. We hope that something good will happen after we die, but we cannot be certain. I just want really to caution, certainly from my tradition, and I think the lessons I learned from it, the necessary rebellion. Let us not be triumphalist about our religious values. I agree with everything you said, Dr. Post, about what we need to do, but I think we need to see it more as "let us not," as I said yesterday. Some of the noblest, most righteous people with the best etiquette I know are atheists. We have to work together in our society today. We cannot separate ourselves from those who do not have religion.

Dr. Post's response: That is a great comment. Thank you, Dr. Smith. It is not that the four principles are irrelevant. I carry them around. I do clinical consults all the time. They are useful, minimize harm, show concern about the patient's good, respect autonomy, and the like. These things matter, and we should have that kind of common framework. But let us recognize, too, that the Enlightenment was highly theoretical. I mean whether you are Utilitarian or Kantian, you are coming up with some theory up here, and you are doing applied ethics. You are applying some theory to reality, but you know reality is too complex for that. I remember back in my Chicago days, being a teacher's assistant to Stephen Toolman when he was doing his course on the abuse of casuistry. But casuistry, which is more the traditional medical approach of medical ethics, is basically comparing cases. We know about this case, and that is how we resolved it. Here's another case. What are the continuities and differences? In fact, cognitive science now is very clear that the moral mind does not work deductively from principles and theories, but analogically. We generally reason ethically in the same way that a child learns about the color yellow. There is a yellow banana on the table, a yellow piece of paper, and a yellow teddy bear, and suddenly the kid realizes "ahhh, yellow." So casuistry is really important. It does not mean that the principles are irrelevant. They are good things to have around, but they do not do that much work. Similarly the ethics of compassionate care focuses much more on the details of the case. You know the other night I was in New York listening to Peter Singer and Dinesh D'Souza having a debate at the Socrates in the City program. Peter Singer, in a conversation with Eva Feder Kittay, who was a great ethicist of care, a feminist. Eva had been for many years taking care of her daughter, Sesha, who has severe cognitive disabilities. After this debate, Eva asked Peter, who would essentially dispatch children with cognitive disabilities into the waste basket, parents willing, if he would go with her to visit Sesha so that he could see their relationship and understand that life is not just about hypercognitive values, but also about emotion, relationship, and love. Peter Singer said that he would have nothing to learn from such an encounter. What I am saying is that the highly theoretical approach does not do much work in the real world. It is nice to have those principles around and, of course, we want to respect autonomy, but on the other hand in the process what have we done? We have actually vilified hope. If you look at the modern medical ethics literature, hope is essentially the villain; it is something that is abused, that is used to manipulate, and of course sometimes it has been abused. To recognize that ethics has to be rooted not in abstraction, but in a healing relationship, I think it is the key. Autonomy is important, and, in the heel of the hunt, every patient has the legal and ethical right to make his or her own decision. Willard Galan and Bruce Jennings wrote the book *The Perversion of Autonomy* 15 years ago.[e] Charles Foster wrote *The Tyranny of Autonomy* in 2009 and said we were abandoning people in the name of autonomy.[f] Edmund D. Pellegrino wrote a book about this. It is so true. How many clinicians do I know who, in order to be so-called ethically right, will give patients a laundry list of things? Well would you like this, this, this, check A, B, C, and, of course, there is no conversation; the physicians do not even make a recommendation. The patient wants a recommendation. They would ask what would you do if I were your brother? They want

some guidance. They say you are the professional, you have the knowledge, at least tell me what you are thinking. The whole thing of autonomy is overblown, and most of medical ethics, even in the standard sort of clinical ethical literature has slid back to a more negotiated dynamic between physician and patient. I think there are a lot of problems with the Georgetown Four, which I will not go into because it is a long conversation. Autonomy, yes, is very important, but let me tell you we are missing a lot of things, and we are certainly not recognizing the core of all good moral living, which is respectful compassion.

Dr. Aasim Padela: *Professor Post this question is for you. Thank you very much for your talk. I think it was very illuminating. Like the last speaker, you spoke about, potentially from what I understood, the idea that our religion in the United States, or the inherited religion or religious tradition, perhaps caused or at least influenced the ethics that we see now. I think that something can be taught in many different ways. Therefore, I want to ask you about what Aristotle even spoke about, that is the idea of virtue ethics encultured by emulation of a teacher. Maybe the issue is not necessarily that society has moved away from religion, because, in America, many people say they are religious in some sort of way. Rather, we have lost the mentor worthy of emulation in medical education. So we do not have the good physician. We have the physician who wants to make his practice better by making more money. We do not have the doctor who spends time. You mentioned a physician, Dr. Foley, who makes spending time with the patient a priority, or those who keep their clinics open until 7 p.m. when patients cannot come earlier. We have an influx of private practice physicians who get their training at the universities, where the emphasis is on mental and intellectual quantification as opposed to caring for the patient. Medicine used to be in many religious traditions. It has moved away from that and is a totally different beast. That is why I wanted you to comment on those two aspects.*

Dr. Post's response: I think modeling and mentoring is everything. I do not think it is adequately rewarded in the health-care system today. Students get out into the clerkship environments, and they can see very wonderful models such as Dr. Foley. On the other hand, they report the most horrendous things imaginable. The doctor who comes in, spends two minutes disrespectfully with the patient, and then says, "Well I hope you get better. I have to go golfing." I mean this happens. Modeling is key, and the Aristotelian tradition is 100% correct about this. All of the great moral traditions, and not just the religious ones you know, but all of them understand. John Dewey understood this, and he was a secularist. It is all about passing the torch; it is about my accepting the fact that I am supposed to be a model, a pay-it-forward as the common culture goes. Do not worry about tit-for-tat, about payback, just take delight in your life because you are a model of a certain kind of behavior for others. You do not know how that will affect people down the road. You have no idea, you will probably never see it, but you take joy in simply knowing that you have contributed that kind of a dynamic. Our physicians need to accept the fact that they are models, and they have forgotten that in many contexts. Certainly I agree with that. I think the way people are focusing on economic goals to the exclusion of the real core of the healing art is a serious problem. That is why I try to present some slides indicating that, in fact, if you really look at it from a cost-efficiency basis, there is an awful lot to be said for a healing relationship as economically solvent.

Dr. Mamdouh Farid: *First, I would like to say that the presentation was excellent. I have two short comments and one question. First, many of the studies Dr. Post mentioned are correlation studies or cause and effect that I did not see because you used the term "related to." We definitely did not know, for example, that a patient's hostility is related to the rate of recovery or the rate of recovery is affected by patient hostility. The second question is about teaching compassion and empathizing with the patient. You talk about role modeling, but you show us a lot of evidence in terms of studies again. What about information on changing behaviors? Is this information given to new doctors in a way that convinces them that they have to change the behavior because it will result in less effort. My question, actually, is how these principles relate to the ranking or the rating of hospitals because they will not change if they do not have something that affects their rating. Thank you.*

Dr. Post's response: It does affect ratings, in fact it affects hospital ratings a lot. Long Island Jewish Hospital has an interesting program. When it hires anybody, it is my understanding, whether it is the valet or the cook or the doctor or the nurse, they actually get together in the same orientation meeting, and the chief executive officer (CEO) talks to them about the importance of a seamless culture of compassionate care and medical etiquette. It is

tremendously beneficial. If you look around the country, Stony Brook has a cancer center, but it is competing against Sloan Kettering now. I am assured that you know the entity that has this dynamic of care will thrive. In today's day and age of patient-centered care, if you lack these assets, you will not thrive. This is true, and it is very Darwinian. I think we are beginning to understand that. CEOs everywhere around the country in hospital systems are emphasizing patient-centered compassionate care. They are doing lots of training in these areas with staff at every possible level. In terms of how you educate students, you know there is exhortation. You can talk about the noble purposes of the profession, and you can bring science to it. Some of it is correlates, and some of it is cause and effect. Just like you could bring science into a talk about depression for example, it is nice to be able to bring science into talks about compassion and altruism. I love the study about cause and effect. For example, David McLowen's study at Harvard called "The Mother Teresa effect."[8] He took Harvard undergraduates and had them watch two movies. One group watched a movie about Mother Teresa helping people in Calcutta; the controls watched an emotionally neutral movie. The students who saw mother Teresa showed elevated levels of gamma globulin A in their saliva, which is a standard test of the strength of the immune system. Then McLelan, who was the greatest psychologist of his generation, divided the subject group in two. He had half of the group meditate, or visualize, or just imagine deeply giving warmly toward others, and they continued with the spike in salivary gamma globulin A. The group that did not go through that internal exercise decreased to baseline. That is cause and effect; it is an intervention study. If you bring up the science, but even then I acknowledge what was said earlier from this gentleman here that you know the science. I like the science, but it is limited.

In the end, it is role modeling. In the end, I mean we all have to look back on our lives and say to ourselves, thank heavens there were these three or four. Maybe if we are really lucky two or three dozen people we have known in our lives really exemplified compassionate care. We can remember the details. It is like Joe Martin remembering the details of what Joe Foley did for that woman: "I'd like some iced tea." He cannot forget that; he will never forget that. So that is what I mean. We do what we see, and I think that is the key issue here. It is the absence of compassionate care and treating patients like they are simply biological slabs that is so destructive for the patients and for the healing professions.

Dr. Seleem Khan: *Thank you very much. I am a child psychiatrist from Delaware. First, a comment. Once, in the early years of his papacy, Pope John Paul II, was attending Special Olympics. I still remember his comments, which goes back to 30 some years. He said, "The greatness of a nation is judged by the way it treats its most disadvantaged." Any medical student over the centuries, if you ever ask, or asked, why are you joining this profession, the answer would be the same: "Because I want to help those disadvantaged people who are in need." All that was discussed earlier, and all the nice advice that we heard, if we all can just remember that and why we joined this profession, then we will do things properly, irrespective of who we are treating and which religion they observe. Having said that comment, my very specific question, which is very different, is for Dr. Byrne. My understanding is that when it comes to reward and punishment, pretty much all religions are similar, at least the Abrahamic faiths, and over the years with 30 years as a child psychiatrist I have been confused about one issue. I ask teenagers who are pregnant and come to me what their options are. I can count on fingers how many of them said that they would opt for abortion. As you know, punishment consequences for premarital sex and abortion, according to many religious traditions, are pretty much close to each other. What happened in our culture in the United States? Premarital sex now seems like no big deal. I have teenagers, even boys, who say, "Oh it is like just eating carrots."On the other hand, you know when it comes to abortion, I honestly thought, coming from a different culture, that almost every girl would be saying "I will just go for abortion." It is much more common attitude in other cultures that I know, so I would like your comments as a researcher.*

Dr. Byrne's response: I am not sure that there has been in the course of American religious history. The way the story is usually told is that there were the Puritans, and nobody had extramarital or premarital sex. Then there was a long decline of morals, culminating in the 1960s when all morals went out the window and extramarital and premarital sex became actually a positive value. Then came the backlash in the 70s, 80s, 90s with the religious right and reining it all in. I am honestly not sure that that is a historically accurate description of the trajectory of sexual morals, and it is likely, according to historians and

scholars, that the more accurate story is that there has always been extramarital sex, premarital sex, that it has always been inveighed against by the religious forces for the building up of a conservative or ideal social space, and that the only thing really that has varied is the permissibility of contrast with those religious voices. I am not sure there has been what scholars call history of decline. It is definitely the case that religious and moral commentators in the United States have always created a narrative of constant decline, usually to try to get people back on the right track. That is my short answer to a very, very complicated question. Thank you so much.

Dr. Frisina: When Professor Varisco asked me to put this panel together I knew fairly quickly that these two folks would give you outstanding presentations. My expectations have been fulfilled, and I would just simply like to end by asking you all to join me in thanking Professor Post and Professor Byrne for their presentations.

Editor's Notes

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