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Challenging Medicine's Humiliations:
The Need to Re-educate Practitioners

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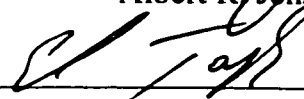Chair of Supervisory Committee:

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Abstract

Challenging Medicine's Humiliations:
The Need to Re-educate Practitioners

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Current efforts to make medical practice more humane by introducing humanistic techniques such as caring, empathy, and mutuality are based on a superficial diagnosis of the problem and hence are misdirected and inadequate. These efforts are misdirected because they implicitly encourage practitioners to take for granted certain problematic structures and customs in daily medical practice. Based on this misguided diagnosis. the treatment plan for addressing difficulties in medical practice has focused on compensating for such problems by encouraging the application of humanistic techniques. While these techniques are perhaps partially useful, they are inadequate to address the enormity and complexity of the task at hand and therefore merely serve as temporary bandages. This approach treats the problem symptomatically and does not attempt to discover the underlying source or cause. Therefore. there is a need for a new diagnosis of the nature and cause of difficulties in modern medical practice. In providing such a diagnosis. I focus on medical practice as the site of various forms of domination. These forms of domination give rise to varieties of humiliation that may, in practice, injure the self-respect of patients. Using case studies, I show that forms of domination and humiliation exist on at least three general levels in our medical culture: institutional, technological, and psychosocial. I argue that these conceptual areas must be given proper attention in the course of seeking a better diagnosis of problems in medical practice. Once a more accurate diagnosis is made, a correspondingly more realistic and useful treatment plan can be developed and integrated into medical practice. Because these powerful influences on the medical relationship are ubiquitous, yet rarely discussed in the medical humanities literature. there is a need to re-educate practitioners to question commonly suggested approaches to making medicine more humane. By recognizing and critically examining these pervasive forms of medical domination as well as thoughtfully considering their ramifications in daily practice, concerned practitioners can perhaps strive individually to reformulate a missed diagnosis. Consequently, they may be inspired to recognize and challenge medicine's humiliations.

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ACKNOWLEDGEMENTS

DEDICATION

This dissertation is dedicated to my beloved wife, Amy Catherine Paige, who has always believed in me and helped me to keep things in perspective. Over the years, we shared innumerable conversations regarding the direction and focus of this work, and she cheerfully provided stellar editorial advice on each draft as it progressed. I am truly fortunate to have such a wonderful partner in life.

Introduction

There has been much attention in the medical literature to a variety of problems in the doctor-patient relationship. For thirty years or more, the wide-ranging discipline of the medical humanities, including the study of history, ethics and models of practice, has been engaged in the effort to answer the common underlying question of how to make medicine more humane. This effort has become necessary for a variety of complex reasons. Daily medical practice is often seen by patients as impersonal, uncaring, harried, and profit-driven with no time for physicians to listen to concerns. Medical technology has become ubiquitous, influencing medical diagnosis and treatments in novel ways. Prices for medical care have increased dramatically with each passing decade. Millions of Americans are without any form of catastrophic health insurance. Patients have difficulty establishing and maintaining a long term relationship with a physician in this era of managed care. We are commonly said to be in a "health-care crisis." Driven by these and other factors, many Americans are seeking alternatives to modern medicine.[1]

As a historically altruistic profession guided by the beacon of service to humanity, the contemporary practice of medicine nonetheless presents certain formidable problems

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[1] According to a widely noted study in a prestigious medical journal, nearly half the population of the United States made visits in a recent year to practitioners unsanctioned by the dominant medical establishment, such as acupuncturists, herbalists, naturopaths, massage therapists, and nutritional counselors. See Eisenberg, D. et al. (1993) Unconventional medicine in the United States: prevalence, costs, and patterns of use. *New England Journal of Medicine, 328*: 246-52.

for practitioners and patients alike because of its increasing complexity. Foremost among

these problems is, in my view, the increasing distance and alienation in the doctor-patient

relationship. This is not a new concern. Various scholars engaged in the medical

humanities have noted some of the effects of problems in the doctor-patient relationship

and presented analyses and strategies for possible improvements.[2] While there has been

much focus on this important relationship, relatively little attention, however, has been

paid to factors deeply rooted in the profession of medicine that inhibit a more humane

medical practice- factors that are the focus of this work.

In addition to concerns about the doctor-patient relationship. many suggestions

have been made for reforming medical education.[3] While many have called for

transformational changes, the tinkering with medical education to date has been somewhat

superficial and the results, in my view, have been negligible. The resistance of medical

school administrators to including education in the medical humanities has decreased

somewhat over the last decade; however, objections are still offered that there is a lack of

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[2] See, for example, Shelp, E.E. (1983) (ed.) *The clinical encounter: the moral fabric of the patient-physician relationship.* Dordrecht: Kluwer Academic Publishers; Siegler, M. (1993) Falling off the pedestal: what is happening to the traditional doctor-patient relationship? *Mayo Clinic Proceedings, 68:* 461-7; and Brody, H. (1987) The physician-patient relationship: models and criticisms. *Theoretical Medicine, 8*(2), 205-20.

[3] See, for example, Culver, C.M., et al. (1985) Basic curricular goals in medical ethics. *New England Journal of Medicine, 312*(4): 253-6; Spike, J. (1991) The need for teaching philosophy in medical education. *Theoretical Medicine, 12*(4): 359-65; McElhinney, T.K. (1993) Medical ethics in medical education: finding and keeping a place at the table. *Journal of Clinical Ethics, 4*(3): 273-5; Miles, S.H., et al. (1989) Medical ethics education: coming of age. *Academic Medicine, 64*(12): 705-14; Pellegrino. E.D., Siegler, M., & Singer, P.A. (1990) Teaching clinical ethics. *Journal of Clinical Ethics, 1*(3): 175-80; Tealdi, J.C. (1993) Teaching bioethics as a new paradigm for health professionals. *Bioethics, 7*(2/3): 188-99; and White, B.D., & Zaner, R.M. (1993) Clinical ethics training for staff physicians: designing and evaluating a model program. *Journal of Clinical Ethics, 4*(3): 229-35.

time for "soft" courses, as humanities courses are often called. This is purportedly due to the pressures of delivering an intense science-based, technologically-driven curriculum that is designed to turn first-year medical students into physicians in a mere four years. At any rate, one would be hard pressed to argue that the few ethics courses offered have changed the culture of medicine. Nonetheless, my goal here is not specifically to reform medical education, but instead to look deeply at daily medical practice and attempt to ascertain why certain problems continue to persist in spite of the best efforts of leading scholars and teachers in the medical humanities.

In what follows, I argue that, despite decades of intensive effort to change the culture of medicine, those who teach and write about the medical humanities have not yet accomplished the stipulated goal of making medical practice substantially more humane. Hundreds of scholars are devoting themselves to this task, yet the work seems more daunting as the years pass. Journals, books and conferences multiply at a furious pace. From all corners of the humanities, calls have been made for the development and expression of more empathy, more caring, and more mutuality with patients as ways to make medical practice more humane. While these are certainly noble and worthwhile goals, they do not generally take into account certain basic factors in daily medical practice that tend to constrain possibilities for a more humane medicine. Because the doctor-patient relationship is inherently asymmetrical, medical practice is often the site of

various forms of domination that are detrimental and perhaps even harmful to the self-respect and healing processes of patients. These aspects of domination that impact medical practice on a daily basis have not been adequately theorized in the medical literature. Their omission at least partially obscures and complicates the efforts of many working in the field.

As a student and educator in the medical humanities, I am concerned about the (mis)direction that efforts to humanize medicine have taken. Much energy has been expended designing and teaching ethics courses for medical students. Professional medical organizations offer workshops for practicing physicians with the theme of promoting humanism in medicine. However, these approaches do not appear to address fundamental difficulties in the daily practice of medicine. I argue in this work that attempts to encourage a more humane medicine have heretofore had a minimal impact despite good intentions. The impact has been minimal because these attempts have failed to account for and address certain forms of domination in medical practice that I will describe as essential to consider in any undertaking in the medical humanities. Using a medical metaphor, an incomplete diagnosis of the problem has prompted the widespread acceptance of a misguided treatment plan.

One of my primary areas of concern is that many difficulties between doctors and patients in the daily practice of medicine appear to stem from a fundamental lack of

respect that has many sources. Rather than merely asserting that clinicians need to show more respect to their patients, and thus adding my comments to a growing list of humanistic strategies that I seek to critique, I will argue that there are certain institutional. technological and psychosocial factors in the daily practice of medicine that inhibit respect between the institutions of medicine, including its practitioners, and those entrusted to its care. I will also argue that these factors which constrain respect are experienced as humiliating by patients, thereby making them feel disregarded as human beings. The relationship between humiliation and respect is a central theme of this work. It is important to note that humiliation does not have to be intentional in order to create a feeling of a lack of respect. In fact, I will argue that many aspects of medical care have the potential to humiliate patients even without the conscious intentions of individual practitioners.

My approach will be as follows: In Chapter 1, I begin to construct my argument against the backdrop of three basic models of medical practice; the technocratic. the humanistic and the holistic, as described by medical anthropologist Robbie Davis-Floyd.[4] These models represent three stages in the evolving history of medicine, as seen by Davis-Floyd. They also represent her description of the path to be taken as the physician of the future ideally progresses from doctor to healer. The first step on this

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[4] Davis-Floyd, R., & St. John, G. (1998) *From doctor to healer: the transformative journey.* New Brunswick, NJ: Rutgers University Press.

path is taken as a physician begins to move from a technocratic to a humanistic approach to medicine. As physicians recognize societal dissatisfaction with modern medicine. perhaps in addition to their own, they may attempt to cultivate humanistic qualities in an effort to counter the effects of technocratic medicine. I indicate how this initial step has been taken by some practitioners in a variety of ways, and note that this movement toward humanism has become institutionalized and received increasing attention in the last thirty years with the rise of the medical humanities as a separate and distinct field. I then place the current discussion of the development of humanistic qualities by physicians in historical context by examining the role of the medical humanities. especially the field of bioethics, in the quest to make medical practice more humane.

Despite increasing attention to the development of humanistic qualities in the delivery of medical care, many difficulties remain. In Chapter 2. I show how many purported solutions for the inadequacies of technocratic medicine are merely additional "techniques" the conscientious physician adopts in order to be more "humanistic." I argue that these techniques, such as exhibiting caring, empathy. and mutuality. are inadequate to resolve the problems they are designed to address. They are inadequate because they do not account for the institutional, technological and psychosocial barriers to their potential effectiveness in daily practice. I then demonstrate in some detail how these efforts (toward "caring," "empathy," and "mutuality") have shown some theoretical

promise and how they are likely to fall short of their aims in practice. The limitations of these efforts toward a more humane practice are important to note because they urge us to consider a deeper analysis of fundamental problems in the institution of medicine that, I argue, should be addressed first in a process of re-educating medical practitioners. Rather than uncritically accepting the use of these humanistic techniques as the answer to resolving problems created by a highly technological medicine, I argue that they must be analyzed within the context of various forms of domination embedded in contemporary medical practice. These forms of domination are at least partially responsible, in my view, for the existence and perpetuation of various humiliating practices that can negatively impact the healing process of patients. It is to this neglected area of study that I turn.

In Chapter 3, I begin to provide an urgently needed new diagnosis in the effort to make medicine more humane. This new diagnosis is important to consider as it may serve to re-direct attention from the current focus on the application of humanistic techniques, while still accepting the status quo of technocratic medicine, to instead challenging medicine's humiliations. In order to begin such an undertaking, I first consider the sources and implications of forms of humiliation that I argue impact patients profoundly in the daily practice of medicine. I then illustrate varieties of medical humiliation through case studies in the following three chapters, which portray the effects of various practices that

are inimical to the respectful practice of medicine in our culture. The effects can be substantial for patients even if the humiliation is unintentional on the part of individual practitioners, as is most often the case. I divide these areas of concern into three main topics for the purposes of my discussion: institutional, technological. and psychosocial forms of domination and their corresponding effects of humiliation as experienced by patients. I argue that each general form of humiliation experienced in medicine finds its roots in a particular form or mode of domination.

Domination

The topics of domination and humiliation are rarely discussed in the medical literature, or any literature for that matter. In common usage, domination is usually invoked in the sense that one entity has some sort of power over another in a political sense and can thereby bend and shape the behavior or conduct of that other individual to its will. Although the medical relationship is inherently asymmetrical and patients are generally expected in our culture to comply with "doctor's orders," even a reluctantly compliant patient may not have the opinion that he is being dominated by his physician in the normal sense of supremacy or mastery. It is not my intention to pursue that line of inquiry here. Nor do I intend to invoke the specter of a dominating physician who pushes his medical, social and personal values on a patient against her wishes. This

stance is commonly known as medical paternalism, the defense and critique of which has occupied many writers in the medical ethics literature over the years.[5]

Rather. it is my intention to use the word domination in a very specific sense. I shall adapt and extend the concept of medical dominance as delineated by Eliot Freidson in his classic sociological study of the early 1970's.[6] Freidson described the medical profession as an exemplar of what he calls professional dominance for a variety of reasons, namely: (1) because of the nature of the specialized knowledge about health and disease which is obtained and purveyed in daily practice. medical professionals have organized themselves in such a way as to be nearly immune from control by legislative bodies: (2) the medical profession has acquired a legal monopoly on the dispensation of drugs and use of medical techniques, medicalized normal life events such as birth and death. and made itself the arbiter of what is health and what is sickness: and (3) the medical profession has reserved for itself the pre-eminent position in the medical hierarchy. In addition, as Paul Starr notes, medical practitioners have used this dominance to progressively claim more authority over the body and its processes as the technological focus of medicine has increased. This claimed authority has by now transcended areas based strictly on medical knowledge, and has begun to claim "social privilege, economic

[5] Beauchamp. T.L.. and Childress, J.F. (1994) *Principles of biomedical ethics*. (4th ed.) New York and Oxford: Oxford University Press; Schneider, C.E. (1998) *The practice of autonomy: patients. doctors, and medical decisions*. New York: Oxford University Press; and Komrad, M.S. (1983) A defense of medical paternalism: maximising patients' autonomy. *Journal of Medical Ethics, 9*(1): 38-44.
[6] Freidson. E. (1970) *Professional dominance: The social structure of medical care*. New York: Atherton Press. Inc.

power. and political influence."[7] Together, these factors comprise a sense of medical

dominance that has become institutionalized over time and whose attributes are enacted

on the level of individual physicians and patients.

Freidson claims that it is important to study these structural characteristics of

medicine as a profession because taken together, they "have far more influence on the

nature of medical care in the United States that either the good intentions and skills of

individual members of the profession or the economic and administrative arrangements

that are usually the focus of attempts at reform."[8] It is this pervasive influence on the

nature of medical care that I wish to explore in this work. Domination in medicine is. in

my view, most often a result of factors intrinsic to the structural organization of medicine.

rather than the intentional motivations of practitioners. Even in the case of psychosocial

domination in the form of prejudice, there are roots in the accepted structure of medical

training and practice. Certain practices are uncritically accepted because they are

embedded in the fabric of training and daily routine. It is important to note that I am not

offering a critique of individual practitioners as evil people, but rather I am trying to

understand how and why it is that various aspects of commonly accepted everyday

medical practice can appear to be dominating to patients and how they may come to feel

justifiably humiliated by those forms of domination.

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[7] Starr, P. (1982) *The social transformation of American medicine.* New York: Basic Books: pp. 3-29.
[8] Freidson, E. (1970) *Professional dominance: The social structure of medical care.* p. 77.

Humiliation

Likewise, I utilize the concept of humiliation in a similarly narrow sense; that is, the normative rather than the psychological. It is the normative sense of humiliation to which Avishai Margalit refers when he argues that a person who has been provided good reasons to feel humiliated may not necessarily feel that way. This is contrasted with the psychological sense of humiliation, whereby a person can claim to feel humiliated but may not actually have a sound reason for feeling that way. By focusing on the normative sense, Margalit's emphasis in on establishing sound reasons to explain a feeling of humiliation due to the action or influence of another human being. In his analysis of the necessary constitutive components of a decent society, he points out that only another human can be the cause of one's sense of humiliation, whether the humiliation is intentionally caused or not.[9] Two points are germane to my analysis here: (1) even if the humiliation experienced by a patient has its roots in an institutional or technological form of domination, the point of contact is still the doctor-patient relationship; thus a human (doctor) is the immediate cause; and (2) humiliation may be caused unintentionally, reflecting my earlier point that this is not a critique of individual physicians with bad intentions, but rather a critique of the structures in which they practice medicine.

In this work, I follow Margalit in focusing on the normative sense of humiliation. I do so because I think it is critically important to question commonly accepted practices

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[9] Margalit, A. (1996) *The decent society*. Cambridge: Harvard University Press. pp. 9-11.

in medicine which constitute sound reasons for patients to feel humiliated, whether or not they actually would consider themselves to be humiliated. My reasoning for this is that because the medical relationship is inherently asymmetrical, patients may feel a loss of power and control as they enter a world of illness, a world that may be unfamiliar and even strange to them. Not only are they suffering from the effects of illness itself, patients often find themselves in a position where they must trust strangers to deliver the comfort and care that they need. In the common institutionalized settings in which patients find themselves, they are subjected to a variety of practices that they may not question because of the effects of illness, fatigue, ignorance, unfamiliarity or timidity. From a variety of perspectives, patients may have sound reasons to feel humiliated because their dignity and self-respect are injured, even if they themselves would not necessarily refer to the feeling they have experienced as humiliation. Part of my argument will stress the importance of considering the relationship between common elements of medical practice that dominate patients in various ways and the humiliation they may have good reason to experience. Using the case studies as examples, I hope to make this line of argument more clear.

Institutional domination

Let us turn now to a brief elaboration of medical domination, with a more detailed

analysis of the relationship to humiliation as experienced by patients appearing in later

chapters. Various forms of institutional domination commonly occur in medical practice

in ways that make patients feel disregarded and humiliated as human beings. For example.

medical care has become increasingly depersonalized and occurs primarily in large

institutions where responsibility dissipates easily.[10] The length of medical visits is often

constrained by economic factors and limits are set for the provision of necessary care by

managed care organizations.[11] There is at times a lack of truthfulness with patients about

their medical condition.[12] The cultural values and practices of patients are often

demeaned or ignored by practitioners. with little or no effort made to understand social

and cultural differences that may be important for a practitioner to take into account in

the effort to support the healing process.[13] These are examples of institutional

domination because even though these activities are carried out by individual

practitioners. they often find their locus of justification within institutional structures.

policies and procedures. The activities described above are commonly accepted by

[10] Gilbert, S. (1995) *Wrongful death: a memoir*. New York; London: W.W. Norton & Co.
[11] Emanuel, E.J. and Dubler, N.N. (1995) Preserving the physician-patient relationship in the era of managed care. *Journal of the American Medical Association, 273*(4): 323-9; Council on Ethical and Judicial Affairs, American Medical Association. (1995) Ethical issues in managed care. *Journal of the American Medical Association, 273*(4): 330-5.
[12] Evans, D. (1995) An ethical dilemma: the dishonest doctor. *Nursing Forum, 30*(3): 5-11.
[13] Fadiman, A. (1997) *The spirit catches you and you fall down: a Hmong child, her American doctors, and the collision of two cultures*. New York: Farrar Straus and Giroux.

physicians as basic realities in daily practice. That they are so freely accepted is troubling because it shows, in my view, that such practices are strongly embedded in everyday practice and are seldom questioned by those who enact them.

Technological domination

As the art of medicine has given way to the science of medicine during the 20th century. reliance on technology for diagnosis and treatment has taken precedence over listening carefully to the stories of patients in an effort to know them as persons and to learn how illness disrupts their lives.[14] In this way, technological domination humiliates patients when they are treated as mere instances of disease processes. distanced from their own healing processes by over-reliance on technology. As Jay Katz has written. "The practice of medicine's art has been given short shrift in this age of science, in the expectation that treatment only requires silent scalpels, wordless monitors, and mute pharmacological agents."[15] Patients may find it difficult to make meaning of their illnesses, and may be given false hope by the implication that the answer lies in just one more test, surgery, or medication. In a technologically-driven medical model, physicians and patients are often distanced from each other and the healing process by reliance on technological interventions. As I will illustrate in a case study, a concentrated investment

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[14] Becker, G. (1997) *Disrupted lives: how people create meaning in a chaotic world.* Berkeley, California: University of California Press.
[15] Katz. J. (1984) *The silent world of doctor and patient.* New York: The Free Press: p. xx.

in a technological approach to healing at the expense of a deep respect for a patient and

his suffering can provide strong reasons for the patient to feel humiliated.

Psychosocial domination

Psychosocial domination humiliates patients when they are the victims of

prejudice on the part of medical practitioners because of racism, sexism or homophobia.

or when they are not treated as credible witnesses regarding their own suffering. Some of

a patient's suffering may be inflicted or exacerbated by a display of prejudice on the part

of a medical practitioner. The quality of the care given may be impacted negatively at

times by practitioners' inability to see each patient as fully human and deserving of

respect. When patients are marginalized due to psychosocial factors and categorized as

different or less worthy in some way due to prejudices expressed by practitioners. they

may have sound reasons to feel that their self-respect has been injured.

The need to consider a new diagnosis

Institutional, technological, and psychosocial forms of domination and the

humiliations they engender have not been explored substantively in the medical

humanities literature. Because difficulties in medical practice have been mis-diagnosed

generally. the currently advocated treatment plan of teaching medical practitioners to

apply humanistic techniques to the practice of technocratic medicine is misguided and hence likely to be ineffective. Thus, there is a need for a new diagnosis of the complicated reasons for dis-ease between practitioners and patients in current medical practice. I attempt to provide such a diagnosis in what follows, illustrating areas of concern by presenting case studies and multi-disciplinary perspectives to argue that until the factors of domination and humiliation are explicitly confronted and actively challenged, efforts of those in the medical humanities will continue to be more cosmetic than substantive.

My hope is that practitioners, on an individual level, will be able to re-envision medical practice from a different perspective as a result of this work. If so, they may begin to challenge themselves to be aware of the forms of domination I describe here in order to prevent humiliation in medical practice. At its most basic level, the practice of medicine consists of a relationship between two persons, a doctor and a patient, who seek to attain the goals of medicine. These goals have been succinctly summarized as "a right and good healing action"[16] for the benefit of the patient. I will conclude that, in order to facilitate this overriding *telos*, or end, of medicine, physicians should become aware of these pervasive forms of domination and humiliation in medical practice and actively seek

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[16] Pellegrino, E.D., & Thomasma, D.C. (1993) *The virtues in medical practice*. New York: Oxford University Press.

to address them from a renewed perspective for the benefit of the patients whom

medicine serves.

Chapter One
The quest of the medical humanities to make medical practice more humane

The physician of the future

In this chapter, I begin to formulate my main argument against the backdrop of some primary questions posed by those engaged in the medical humanities: What do we as a society want the physician of the future to be? What qualities are valued and desired in a medical practitioner? Once accurately identified, how can these qualities be imparted to those who would provide care for ill persons in our society? Implicit in these questions, I believe, is the assumption that it is the responsibility of medical training to mold the physician of the future. As a society, we expect medical school educators and deans to design and implement a curriculum that fosters the development of a certain kind of physician. Also implicit in these questions is the assumption that theory about what should or could happen in the practice of medicine may be able to guide that practice in some way. Others may challenge these assumptions, but I believe they are core assumptions we have as a culture and I will use them as a point of departure.

Medical anthropologist Robbie Davis-Floyd argues that for the past fifty years, our cultural dreams regarding health and healing have been reflected in the development of what she calls the technocratic physician, the consummate scientist who sees every

instance of suffering as a challenge to the current state of medical technology.[17] Because

of the overwhelming focus on science and technology in the technocratic model. the mind

and body of the ill person are seen as separate, which often leads to a widespread

objectification of the patient's body as the singular focus of health and disease. Due to

this pervasive cultural distinction between the realms of mind and body, practitioner and

patient often become alienated from each other. This alienation results in the patient

being seen by the practitioner as merely a body in need of treatment while the practitioner

holds the locus of authority and responsibility for generating health. In addition, the

current medical hierarchy is heavily invested in the technocratic model and supports a

profit-driven system whereby medicine has become a multi-billion dollar business. The

technological focus of current medical care has no doubt achieved many wondrous results.

However, because of the emphasis on using primarily technological interventions to

address flesh and blood problems of suffering, loss of function, grief, and death, medical

practice has somehow along the way become detached from its humanistic moorings.[18]

In response to the inadequacies of the reductionistic technological model, many

physicians and educators in modern medicine have begun to embrace what Davis-Floyd

calls a humanistic model; that is, a technocratic model overlaid with expressions of caring.

[17] Davis-Floyd, R., & St. John, G. (1998) *From doctor to healer: the transformative journey.* New Brunswick, NJ: Rutgers University Press. pp. 15-47.
[18] Hewa, S., & Hetherington, R.W. (1995) Specialists without spirit: limitations of the mechanistic biomedical model. *Theoretical Medicine, 16*(2): 129-39; and Lown, B. (1996) *The lost art of healing: practicing compassion in medicine.* New York: Ballantine Books.

empathy and mutuality by the practitioner.[19] The methods and approaches to medical

curing remain the same as practitioners continue to invest primarily in a technological

paradigm, but these methods are somehow "softened" by a caring or empathic attitude.

Much attention has been paid in the study of the medical humanities to the development

and use of these humanistic techniques which are apparently meant to serve as a kind of

counterweight to the impersonality of the technological focus. Although well intentioned.

these strategies are destined to fall short, in my view, because they do not recognize and

address pervasive forms of domination in medicine, as described in the introduction. The

presence of these forms of domination, I contend, often negatively impacts the medical

relationship by causing patients to have good reasons to feel humiliated.

Going beyond the technocratic and the humanistic models of medical practice and

anticipating the physician of the future, Davis-Floyd speculates that the holistic model

currently employed by many so-called "alternative" practitioners may hold some promise

for the future of mainstream medicine.[20] The holistic model focuses on the essential unity

of the body, mind, and spirit of the patient while recognizing that true healing of illness

must take place in the context of the whole life of the patient. The power dynamic is

rearranged in a holistic model, with the primary authority and responsibility for health

invested in the individual patient rather than the practitioner. While still of vital

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[19] Davis-Floyd, R. & St. John, G. *From doctor to healer.* pp. 81-109.
[20] *Ibid.* pp. 110-146.

importance in the healing process, science and technology are placed at the service of the

individual. Although I believe this model holds promise as an ideal, I will argue below

that for the holistic model to be adopted by and integrated into modern medicine in a

meaningful way, certain fundamental changes must be actively sought in current medical

practice on institutional, technological and psychosocial levels.

The proposed new model of holistic medical practice has been further elaborated

by medical sociologist June Lowenberg, who argues that physicians of the future will

serve as educators, consultants, and facilitators of the healing process.[21] Lowenberg also

describes the physician of the future as ideally practicing within a holistic model, one

which pays attention to the mind, body and spirit of each patient. She reports from her

research with a wide variety of practitioners that the qualities of caring, empathy, and

mutuality are seen as desirable aspects of the doctor-patient relationship by those who

have abandoned the technological model and embraced holism. Rather then viewing these

qualities as humanistic techniques layered onto a technological focus, these practices are

seen by practitioners who embody them as an integral part of the holistic practice of

medicine. Most physicians currently practicing according to a holistic model are by

definition, if not by choice, working outside mainstream medicine and are not trying to

change modern medicine from within. In fact, many of them practice healing modalities

[21] Lowenberg, J.S. (1989) *Caring and responsibility: the crossroads between holistic practice and traditional medicine*. Philadelphia: University of Pennsylvania Press.

not sanctioned by modern medicine and are themselves implicitly or explicitly ostracized

from the modern medical community. It should be noted, however, that some

practitioners who now embrace a holistic medical paradigm previously functioned

somewhat uncomfortably in a highly technological setting and were looking for a different

approach to medicine which was more congruent with their values.

While the number of humanistic and holistic practitioners continues to grow, these

models are likely to have minimal impact in the near future on practitioners of modern

technocratic medicine. This is because the philosophy and methods of technological

medicine are deeply entrenched in our culture and the pace of change is likely to be glacial

at best. The movement to add layers of humanistic practices and techniques to soften the

impact of technological medicine is a relatively recent addition to medical practice. Given

current conditions, truly embracing a holistic model of medical practice in our culture may

take generations. There may not be any significant changes in the practice of medicine, in

my view, unless and until the forms of domination and humiliation described herein are

explicitly recognized and openly confronted by practitioners.

Concern for the development and support of humanism in medicine is, however,

not a new topic in the medical literature. As medicine has become more technologically

oriented, several new issues have emerged as critical to consider and have commanded

much ethical reflection and deliberation. The widely diverse field of bioethics has drawn

some of the leading scholars and teachers in the medical humanities, who have vigorously

set about the task of making modern medical practice more humane.

The promise of bioethics and the realities of daily practice

Beginning in earnest as a field separate from medicine in the early 1960's, the

enterprise of bioethics developed as a platform for a disparate group of theologians,

philosophers, educators, physicians and scholars of jurisprudence to expound upon and

address ethical concerns that had arisen as a result of the "new medicine."[22] The new

medicine has developed as technological progress has altered the ways in which sickness

is viewed and addressed by both patients and practitioners. What once was considered an

extraordinary or even impossible medical intervention is now routine. Medical ethics has,

of course, been an integral part of medicine since the time of Hippocrates, but ethical

standards of practice were mainly called upon throughout history by philosophers of

medicine seeking to address the ideal character and demeanor of the physician and the

requirements of confidentiality.[23] From the Greek philosophers onward, each successive

wave of Western civilization has undergone a process of societal reflection on communal

values regarding science and belief, health and medicine, and life and death.

[22] Jonsen, A.R. (1990) *The new medicine and the old ethics.* Cambridge, MA: Harvard University Press; and Jonsen, A.R. (1998) *The birth of bioethics.* New York; Oxford: Oxford University Press.
[23] Reiser, S.J., Dyck, A.J., & Curran, W.J. (1977) *Ethics in medicine: historical perspectives and contemporary concerns.* Cambridge, MA: MIT Press.

The new medicine of the 20th century, however, created novel ethical dilemmas

based on recently developed technological capacities to transplant organs and tissue, to

alter reproductive abilities, and to keep persons alive who otherwise would have died.

Through the formulation of the doctrine of informed consent (which stresses disclosure of

medical information necessary for informed decision making), and reliance for ethical

guidance on the core principles of medical ethics (respect for autonomy, beneficence, non-

maleficence and justice), medical ethicists have focused on what I call "dilemma ethics." I

use this term because the main focus in medical ethics in the last several decades has been

on the resolution of dilemmas created by the practice of the new medicine. Many

dilemmas are recognized when two or more ethical principles are seen to be in conflict

with each other. These contemporary dilemmas involve questions regarding medical

futility, withholding and withdrawing care, provision of reproductive technologies, and so

on.[24] Medical ethics courses, often electives for medical students, have been organized

around teaching strategies for resolving ethical problems created by the use of rapidly

expanding technologies.[25]

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[24] See, for example, Beauchamp, T.L., and Childress, J.F. (1994) *Principles of Biomedical Ethics*. (4th ed.) New York and Oxford: Oxford University Press.
[25] Jonsen, A.R., Siegler, M., & Winslade, W.J. (1998) *Clinical ethics: a practical approach to ethical decisions in clinical medicine.* (4th ed.) New York: McGraw-Hill; and McCullough, L.B., & Ashton, C.M. (1994) A methodology for teaching ethics in the clinical setting: a clinical handbook for medical ethics. *Theoretical Medicine, 15*(1): 39-52.

Virtue ethics

Because of the pressure and intensity of modern daily medical practice as well as

the presence of ethical conflicts, relatively more attention has been paid in medical school

training to developing the skills needed to generate the resolution of ethical dilemmas than

to the development of the character of the physician. The study of virtue ethics has

traditionally focused on the development of the virtuous character of the practitioner and

has been around in one form or another since the time of Plato and Aristotle. Although

still generally thought to be of some importance in the formation of the physician, the

study of virtue has in the last several decades become secondary, in my view, to an ethic

based on duties and principles. In modern medicine, the character of the physician has

been seen as relatively less important than scientific mastery and technical skill. I believe

that it is at least partially because of the stress placed upon the latter attributes that

ethics in medicine has become dilemma oriented and regularly turns to ethical principles

and problem solving strategies for guidance. Our ethics are constantly challenged by

advancing medical technology precisely for the reason that the rapid pace of innovation

easily exceeds our ability as a society to cope with the implications of those changes.

Although secondary to an ethic based on principles, the role of virtue ethics is still

discussed and debated today. In an important analysis of contemporary virtue ethics.

Pellegrino and Thomasma have argued that the study and practice of virtue ethics is an

important part of a more humane medical practice and should not be neglected.[26] In the

context of practicing the medicine of today, proponents of virtue ethics have emphasized

the possession of a virtuous character along with the performance of humanistic

techniques such as caring, empathy and mutuality. The use of these techniques is meant

at least partially to offset the technological focus of modern medicine in an attempt to

make medicine more humane. Although the virtuous character of each practitioner is

indeed important and perhaps critical to the healing relationship, merely displaying caring,

empathy and mutuality is not sufficient, in my view, to overcome deeply rooted and

pervasive problems in medical practice today. Some of the limitations of these techniques

will be noted and discussed in the next chapter before I move on to an analysis of the

causes and effects of those deeper problems in the final four chapters.

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[26] Pellegrino, E.D., & Thomasma, D.C. (1993) *The virtues in medical practice.* New York: Oxford University Press.

Chapter Two
The limitations of current approaches

Promoting humanism in the doctor-patient relationship

Expanding on the central question of how to make the practice of medicine more humane. in this chapter I review recent literature detailing some of the main strategies or techniques espoused by various writers concerning this effort. While I believe all of these approaches have some utility and are valuable for expanding my thought regarding humanistic practices in medicine. I will argue that, while perhaps necessary and of some value. they are not sufficient to address prevalent forms of domination in daily medical practice.

Within the humanities and bioethics literature. caring. empathy. and mutuality are repeatedly emphasized as key techniques for promoting the development of a humanistic medical practice. These important attributes are echoed in Lowenberg's description of the holistic physician of the future. While individual physicians may indeed embrace and embody these qualities (and I have no doubt that there are many who do), my argument holds that these techniques are usually seen by practitioners as "nice" (read: not necessary) features of medicine, to be employed if and when there is time and inclination to do so.

In order to understand and demonstrate why these approaches are insufficient. in

my view, to address deep-seated problems in medical practice, I will explore the literature

detailing the attributes of caring,[27] empathy,[28] and mutuality.[29] Various authors have

argued that these attributes are essential for the development of a more humane practice

of medicine. While all of these approaches to introducing more humanism into medical

practice are promising, I will argue that by themselves, they stand as mere techniques in

the attempt to practice medicine more humanely. Those who argue for the development

and application of these techniques certainly have good intentions. but merely adding

these features to medical practice in its current milieu is not sufficient to overcome the

inertia of a medical system that is burdened with the sources of humiliation discussed

below. In the next few sections, I will investigate and critique efforts to add caring.

empathy, and mutuality to the doctor-patient relationship as minimalist efforts that

ignore or mask deeply rooted problems in the everyday practice of medicine.

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[27] Noddings, N. (1984) *Caring: a feminine approach to ethics and moral education.* Berkeley: University of California Press; Gilligan, C. (1982) *In a different voice: psychological theory and women's development.* Cambridge, MA: Harvard University Press; and Blustein, J. (1991) *Care and commitment: taking the personal point of view.* New York: Oxford University Press.

[28] Spiro, H.M. (1993) *Empathy and the practice of medicine: beyond pills and the scalpel.* New Haven: Yale University Press; and More, E.S., & Milligan, M.A. (1994) *The empathic practitioner: empathy, gender, and medicine.* New Brunswick, NJ: Rutgers University Press.

[29] Smith, D.G., & Newton, L. (1984) Physician and patient: respect for mutuality. *Theoretical Medicine.* 5(1): 43-60; Briant, S., & Freshwater, D. (1998) Exploring mutuality within the nurse-patient relationship. *British Journal of Nursing,* 7(4): 204-6, 208-11; Murphy, S. (1977) Mutuality and the message: a conceptual model for nurse-client communication. *Oregon Nurse,* 42(1): 10-1; Curley, M.A. (1997) Mutuality-an expression of nursing presence. *Journal of Pediatric Nursing,* 12(4): 208-13; and Henson. R.H. (1997) Analysis of the concept of mutuality. *Image: Journal of Nursing Scholarship.* 29(1): 77-81.

Caring

Conceptions of care and caring are part of our everyday language and seemingly an

integral part of the medical encounter, yet only recently has talk of an ethic of care

surfaced in the literature. This ethic is as yet only partially defined, although a few recent

accounts have yielded much insight. Nel Noddings was one of the first to take a

comprehensive look at the phenomenon of caring. She claims that when we care. we take

seriously the "views and interests" of the other.[30] We are required to try to understand

what is important to the one for whom care is provided. Caring for another in a medical

relationship reaches for a higher purpose than the mere application of medical techniques.

Health care professionals, by the nature of their relationship to patients, are charged with

the responsibility of caring for the patient on various levels in order to bring about a cure

if possible. or at least the palliation of pain and suffering. Noddings claims that the

essential part of caring is "apprehending the other's reality. feeling what he feels as nearly

as possible."[31] The focus is on imagining what the suffering patient is feeling and

attempting to share those same feelings, thus increasing the human connection between

patient and caregiver. This description of caring appears to be strongly allied with

contemporary notions of empathy, which will be examined in the next section. In

practice, those who endorse an ethic of care support the demonstration of caring

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[30] Noddings, N. (1984) *Caring: a feminine approach to ethics and moral education.* Berkeley: University of California Press. p. 9.
[31] *Ibid.* p. 16.

behaviors as a potential antidote to the ways in which the practice of medicine has become less humane.

In his meticulous approach to delineating the philosophical basis of an ethic of care, Jeffrey Blustein claims that such an ethic is generally thought to focus on "personal relations, nurturance and caring, maternal experience, emotional responsiveness, attunement to particular others in actual contexts, and the limited usefulness of principles in the resolution of moral problems."[32] This summary of foci is diverse and provides many points of departure for further exploration. Taken as a whole, however, these components of an ethic of care point toward an obvious emphasis on looking at the caring relationship as one fundamentally rooted in the recognition of the other as an individual with a subjective identity. Although there are several senses of caring for others, Blustein likens the care of the sick to "having care of" someone; being charged with caring deeply for someone's welfare without the required presence of friendship or affection.[33] The development and articulation of an ethic of care stresses the nature of the medical relationship as one of vulnerability and trust and calls on medical practitioners to care deeply for strangers who are suffering and in pain.

An ethic of care is a significant departure from traditional moral theories such as those based on promoting justice, maximizing utility, discerning the duties of the moral

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[32] Blustein, J. (1991) *Care and commitment: taking the personal point of view.* New York: Oxford University Press. p. 3.
[33] *Ibid.* p. 27.

actor, or promoting the development of a virtuous character. An ethic of justice, in

contrast to an ethic of care, focuses not on personal relationships and caring for others,

but on impartiality. In traditional moral theory, impartiality has been seen as desirable

because all persons are, in theory, treated identically and hence fairly by the moral actor.

The actor's position is often ideally stated as that of an impartial observer who has no

commitments or prejudices. Utilitarianism (or consequentialism) morally requires that we

do the action which will bring about the greatest good for the greatest number, without

taking account of who specifically is part of the greater or lesser number. Kantian

deontological ethics instructs us that we can determine the morally correct action based

upon a knowledge of what duty requires us to do, again not taking specific account of the

personal relationships which inevitably form part of the context in which we act. Virtue

ethics, as noted above in the introduction, focuses primarily on the development of the

moral character of the physician. As a recent addition to ethical theory, an ethic of care

specifically and emphatically requires that we take into account the nature of our personal

relationships and is thus in contrast to the traditional demands of impartiality implicit in

most moral theories.[34] Thus, an ethic of care deliberately addresses the needs of the

individual and morally requires practitioners to focus on the humanity of each patient.

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[34] Gilligan, C. (1982) *In a different voice: psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Caring for others requires taking an approach rooted in subjectivity, in the recognition of the one cared for as 'other'. The other may have different values, goals and objectives which must be taken into account. This recognition is crucial in learning to care for others. While the one providing caring must remain true to her values (to the extent possible to avoid conflict), she must also be aware of the divergent values possessed by others in order to connect with that person in a meaningful way. An ethic of care, by explicitly recognizing individuality and the subjectivity of the other, fits well with recent attention to diversity and multicultural issues within medicine as a social and cultural practice.

It is often assumed that, by its very nature, caring is always good. That is to say that when one cares, one is doing something which is desired and welcomed by the other and has only a positive connotation. But certain forms of caring can be perceived as thinly veiled domination. In another example of a moral relationship, a parent may claim that certain behaviors are expected from her children and other behaviors will be punished as inappropriate. Children can be disciplined for caring reasons (which may be explicitly stated), but the specter of domination is never far away. An adult child of an elderly parent may take away the car keys to keep the parent off the road, making it safer for both the parent and other motorists, and elements of care and domination are easily discernible.

In the medical relationship as well, domination can be disguised in the friendly form of caring. The goals and values of the patient may not be respected, and possibly even subverted in the name of efficiency or cost. The narrative of the patient may be inappropriately attended to, and crucial pieces of the personal puzzle that is the patient may not become apparent. Hilde Nelson has noted that "caring can be (and has been) blind and indiscriminate, and there is nothing within the concept of care itself that can regulate its force or direct it toward worthy objects."[35] Caring may lose some of its luster if it merely serves to provide subterfuge for the agenda of the institution in which the patient is served. Caring is not always unequivocably good and may in fact be disguised by subtle forms of domination.

A related and perhaps more pertinent question asks if caring can be morally defective, and under what conditions. Beyond the potential for subtle domination, it may be possible for caring to fall short of its goal by being defective in some way. Blustein claims that caring can be objectionable if it is excessive or misdirected. It is also less than desirable when the person caring "is so preoccupied with a cause or with principles that the concrete interests of fellow human beings are ignored or undervalued."[36] If members of the caring professions are unaware of the psychosocial needs of the other which go beyond the physical, are focused primarily on an institutional agenda, or are reliant on a

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[35] Nelson, H. L. (1992) Against caring. *The Journal of Clinical Ethics, 3*(1): 9.
[36] Blustein, J. *Care and commitment.* p. 40.

vague set of unexamined principles, it can be argued that the care they offer is defective in some way. Nelson also notes that the model of caring offered by Noddings and others is distinctly feminized, unidirectional and reinforces "existing stereotypes of selfless, womanly sacrifice."[37] These stereotypes are constantly reinforced by the institutional structure of medical practice which idealizes the role of caring and places nurses (primarily women) in the position of providing care because they are apparently somehow better equipped to provide it. The ideal of caring somehow becomes gender specific, a similar phenomenon often seen in discussions of the practice of empathy.

Empathy

Empathy is a relatively recent addition to the jargon of medicine. Although the terms compassion and sympathy are related conceptually, neither exactly captures the intent of empathy. From at least the time of Hume, sympathy has been the term used to capture the notion that human understanding requires the ability by those in relationship to pay attention to issues of concern to the other, such as expressions of fear and anxiety. Sympathy was thought to be a valued quality in a physician in an age when scientific medicine had not yet developed. The nature of the interpersonal relationship between doctor and patient was thought to be very important to the course and outcome of the prescribed therapy. Since most, if not all, physicians in the 18th century were men, the

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[37] Nelson, H. Against caring. p. 10.

ability to display genuine sympathy was correspondingly seen as a noble and masculine trait.[38]

In the mid-to-late 19th century, however, corresponding with the rise of scientific medicine, "the language of sympathy was not only feminized, it was devalued and sentimentalized."[39] Sympathy was seen to be more of a feminine quality which did not fit in with the new rationalistic, scientific model of medicine and was hence thought to be suspect. Sympathy was too vague as a concept and not precise enough to hold value for a rational (male) doctor. The concept became re-gendered and was increasingly associated only with female physicians, whose numbers were growing and who somehow (being allegedly inferior beings) supposedly had a greater affinity for the ability to feel sympathy and pity than male physicians. Although this ability was 'greater', it was thought to be a defect in female physicians deriving from their 'natural' inferiority.

At about the same time, perhaps coincidentally, the term empathy was coined in 1872 by Robert Vischer, a German philosopher of aesthetics. His term "einfuhlung" means 'feeling-into' as opposed to the 'feeling-with' of sympathy and translates into English as empathy.[40] Freud soon picked up the term and introduced it into the lexicon of psychoanalysis. In more recent years, the hermeneutical tradition also has made much

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[38] More, E.S. (1994) Empathy enters the profession. In *The Empathic Practitioner: Empathy, gender, and medicine.* ed. More, E.S. and Milligan, M.A., p.22. New Brunswick, NJ: Rutgers University Press.
[39] *Ibid.* p. 23.
[40] *Ibid.* p. 21.

use of empathy in discussions regarding reflexivity and empathic knowledge.[41] Medicine

incorporated the term from psychiatry as medical practitioners and philosophers

espoused the early 20th century ideal of "detached concern," a kind of middle ground

between the necessary subjectivity in relating to another and the need for a scientific and

objective detachment. Ellen More notes that "the model of 'detached concern' thus

acknowledged the need for effective and compassionate communication without

sacrificing the profession's claims to neutrality and objectivity."[42] Those who advocate

the practice of empathy, then, stress the importance of integrating these ideals and

accomplishing the dual goals of 'being objective' and 'feeling-into' in relations with

patients.

In the present age of technological medicine, however, attempts at achieving

neutrality and objectivity often lead to an objectification of the patient, a form of

domination that highlights and extends the power differential already inherent in the

relationship between doctor and patient. Because of this, the relationship of power and

empathy in the therapeutic relationship presents interesting difficulties. As with caring,

an uncritical acceptance of empathy as the proper stance for a medical professional to

take with each patient in an effort to promote humanism may also be problematic. Might

not empathy be just another tool, a learned technique that seems to enhance humanism in

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[41] *Ibid.*
[42] *Ibid.* p. 31.

the medical relationship, but which instead perpetuates the asymmetry of power? By attempting to 'feel-into' another's experience of illness and vulnerability, one makes choices from a certain philosophical perspective regarding what is relevant or important in the effort to display empathy, and the luxury of making those choices obviously rests with the practitioner. How can one individual really understand how another feels about the pain and anguish that surrounds serious illness when one is himself well and brimming with objective 'knowledge' of the medical situation? It may actually be quite difficult for a medical practitioner to be able to really understand what it is like to suffer from a life-threatening illness, unless of course the physician herself had experienced the same or a similar illness. In many cases, a clinician may think she has some sense of what it would be like if she were in the position of the patient but it is extremely difficult in my view, if not impossible, to understand how illness truly impacts another person. Hence, empathy appears to be a partial approach to promoting humanism in medical practice which perhaps has some limited value.

Mutuality

In addition to support for considering an ethic of care and the practice of empathy, striving for mutuality with patients is another approach often suggested in the effort to make medicine more humane. These practices have been promoted as

counterweights to the current practice of technological medicine that is often perceived by patients and practitioners as becoming increasingly less humane. In the medical relationship, striving for mutuality is seen as a way to balance the asymmetry in power that exists between doctor and patient. Mutuality in the medical relationship has been defined as "a connection with or understanding of another that facilitates a dynamic process of joint exchange between people" and lies equidistant on a continuum that ranges from paternalism to autonomy.[43] Mutuality goes beyond caring and empathy in the sense that the practitioner is called upon to do more than display a certain behavior: rather, the focus is instead on the recognition of the other (the patient) as a subjective self who has, because of illness, entered into a relationship with one's own self. A critical feature of the development of mutuality is when one individual self strives to recognize another as a subject in his or her own right.

The process of seeking mutuality with another starts with *recognition* through the establishment of interpersonal dialogue. Recognition from the other is necessary for each individual in the relationship to flourish because selves are continually shaped through the process of dialogue. Charles Taylor, for example, has argued that human life is "fundamentally dialogical" in character.[44] In the process of becoming fully human, we understand ourselves and others through the relationships we create with others, whether

[43] Henson, R.H. (1997) Analysis of the concept of mutuality. *Image: Journal of Nursing Scholarship.* 29(1): 80.
[44] Taylor, C. (1992) *The ethics of authenticity.* Cambridge, MA: Harvard University Press. pp. 32-3.

they are familiar or strangers. This is perhaps especially true in the medical relationship, which often brings strangers together in a healing endeavor. A relationship based on dialogue is critical as power is shared through the creation of meaning and understanding in a process of discovery. Through a focused interchange, new solutions may be developed or the meaning attached to particular choices may change over time. Under this view, medicine is not just about technical choices; it is also about how those choices impact human beings who are suffering. Although domination and humiliation may be experienced by patients as a result of impersonal institutional practices, the impact of medical technology, or the psychosocial prejudices of individual physicians, the results are always observed in the context of the individual therapeutic relationship which is built on interpersonal dialogue.

Expanding on the theoretical work of psychoanalysts such as Mahler and Stern, Jessica Benjamin, a feminist philosopher and psychoanalyst, claims that when individuals begin to mature and form relationships, even at a very young age, they begin to relate to others as individuals, who are exactly that: Other.[45] The other is seen to be in opposition to one's individual self. As one differentiates and distinguishes another as being separate from oneself, a process of recognition begins to take place. This is what Benjamin calls the "intersubjective view" in which one self recognizes another as a subject in his or her

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[45] Benjamin, J. (1988) *The bonds of love: psychoanalysis, feminism, and the problem of domination.* New York: Pantheon Books.

own right.[46] When this recognition occurs for each subject within a relationship, the process of mutuality has begun, a process for which Benjamin claims there is a human need. According to this view, mutual recognition is necessary for the individual to flourish. Striving for mutuality in the medical relationship is seen to be important because, at a fundamental level, the practice of medicine is concerned with the flourishing of lives.

Some recent literature has called for the development of mutuality as a humanistic feature of the medical relationship.[47] In much of the literature on this topic, philosopher and theologian Martin Buber is the key theorist cited in support of the development of mutuality. Most writers suggest that his notion of promoting *I-Thou* relationships as the highest form of dialogical relationship has relevance for the medical relationship and should be adopted by those who practice medicine. These authors suggest that Buber's work is relevant to medical practice because he notes that human beings encounter the world primarily through human relations.[48] In medical practice, the world of illness is confronted, to some degree, through the relationship the patient has established with the physician.

In his work, Buber develops the thesis that some relationships in life partake of what he calls an *I-It* character, where the Other with whom we come into contact is not

[46] *Ibid.* p. 23.
[47] See note 29.
[48] Buber. M. (1970) *I and Thou*. trans. Kaufmann, W.A. New York: Scribner, and Buber. M. (1967) *Between man and man*. trans. Smith, R.G. New York: Macmillan.

treated with the appropriate due respect. The other serves merely to fulfill some need or

desire. The other may thus become objectified to a certain extent through our actions, a

stance which does not support or contribute positively to the development of mutuality

in relationships. On the other hand, some of our relationships, such as those with family

and friends, are of an *I-Thou* nature. A relationship which treats the other as a *Thou*

rather than an *It* more fully approaches the possibility of a true mutuality. In *I-Thou*

relationships, each subject is accorded the full respect due as a human being. Thus, the

promotion of mutuality through the establishment of *I-Thou* relationships in the medical

setting is seen as a way to make the practice of medicine more humane.

Most writers call for an uncritical acceptance of Buber's conception of *I-Thou*

relationships as ideal for medicine because, in so doing, mutuality between the

participants is promoted and objectification of the other is minimized. However, I

contend that this is problematic. In his writings, Buber specifically noted that some

relationships cannot partake of full mutuality because of their inherent asymmetry.[49] He

includes the teacher-student and the doctor-patient relationships among them. Because

the physician is required to exercise medical power and skill on behalf of the patient in the

effort to provide some benefit to the patient, she must have some understanding of what

the patient is going through, while the patient is not expected to understand the physician

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[49] Buber, M. (1967) Healing through meeting. In *A believing humanism*. trans. Friedman, M., pp. 138-43. New York: Simon and Schuster.

and how she feels about the course of events. Buber recognizes that in such cases, full mutuality is most likely not attainable. Hence, while it may be a worthwhile strategy to try to avoid objectification in the medical relationship, achieving true mutuality does not seem to be within the common purview of the doctor-patient relationship because of its inherent asymmetry. Based on my understanding of Buber, I believe that it is implausible to simply say that physicians should embrace mutuality as the proper stance to adopt with patients in order to make medicine more humane. In my view, physicians should instead practice medicine with an awareness of the inherent asymmetry that exists in the medical relationship. With this awareness, they may attempt to address and then confront the forms of domination and humiliation that exist within institutions of medicine.

Thus, it can be seen that the presumed benefits of displaying the attributes of caring, mutuality, and empathy in the effort to make medicine more humane are not guaranteed. In fact, they may present additional problems which should be taken into account. Although the pursuit of these attributes may present a positive point of departure in the effort to make the practice of medicine more humane, they often may stand as mere techniques which, by themselves, are not sufficient to tackle the enormous difficulties in contemporary medical practice. Because the approaches detailed above are inadequate, it is therefore necessary to look more closely at ways in which patients can be

humiliated by the institutions, technology and persons who are called upon to aid in their

healing. These concerns are the focus of the remainder of this work.

Chapter Three
Humiliation in medical practice

The central claim of this work is that for the practice of medicine to become more

humane. its practitioners must address and challenge pervasive forms of domination that

are embedded in current practice. If this is not done, attempts to make medicine more

humane are reduced to cosmetic approaches such as those described above. In this

section. I expand upon and illustrate my claim that certain cultural practices in medicine

should not be accepted uncritically. Rather, they should be explicitly recognized and

addressed in terms of the humiliation they may cause patients to experience. Morally.

much is at stake. Humiliation is an affront to decency and respect. which are owed to all

human beings but perhaps especially to those who are ill, distressed, and vulnerable.

In the context of describing the elements of a decent society. philosopher Avishai

Margalit notes that "a society is decent if its institutions do not act in ways that give the

people under their authority sound reasons to consider themselves humiliated."[50] The

practice of medicine, dedicated to the noble goals of the amelioration of suffering and the

advancement of health, participates in a larger societal context which considers decency to

its members, especially the most vulnerable, to be significant. According to Margalit.

humiliation results from "any sort of behavior or condition that constitutes a sound

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[50] Margalit, A. (1996) *The decent society*. Cambridge: Harvard University Press. p. 11.

reason for a person to consider his or her self-respect injured."[51] Being humiliated by another through injury to one's self-respect is intrinsically undesirable, and perhaps especially so when it is caused, intentionally or not, by a person in a position of trust and authority. The infliction of such injury through humiliation is cruel, and hence morally reprehensible. It is important to reiterate at this point that humiliation need not be intentionally caused to inflict injury to a person's self-respect, and that even in cases of what I will call institutional and technological humiliation, another human (the doctor) is still the point of contact with the individual patient who may experience humiliation.

In the subsequent course of delineating a new diagnosis of the nature of problems in the doctor-patient relationship, I argue and demonstrate through a series of case studies that humiliation in daily medical practice can be traced to various institutional, technological and psychosocial factors. I do not make or support the claim that individual physicians wake up in the morning and wonder how many patients they can humiliate that day. Instead, I think it is more accurate to recognize that the humiliation experienced by patients often results from a combination of factors. These factors have evolved over time in the current culture of medicine. Some are blamed on necessity and expediency, others result from the emphasis on the heavily technological approach predominant in the medicine of today, while still others result from the effects of subconscious or overt

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[51] Margalit, A. *The decent society.* p. 9.

psychological prejudices on the part of practitioners, such as racism, sexism and

homophobia.

Although this work focuses on medical practice and does not provide a detailed

critique of medical education nor a plan for reforming it, I think it is important to note

that medical school is, of course, where the doctors of the future are introduced to the

culture of modern medicine and trained in its values. The process of medical training

certainly impacts the future practice of medicine. There is significant literature

demonstrating (1) the inhibition, if not erosion, of moral growth and development of

students during medical school,[52] and (2) the experiences of medical students in training as

they struggle to retain their humanity in an environment which is fiercely competitive,

demoralizing and dehumanizing.[53] Much of this literature has been generated not by

academics, but by students in training and young physicians in residency programs.

While many in academic medicine have recognized some problems in the practice

of medicine that lead to dehumanization of patients, the focus for reform has often been

on the moral development of medical students.[54] The focus has been primarily on

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[52] See, for example, Self, D.J., et al. (1991) A pilot study of the relationship of medical education and moral development. *Academic Medicine, 66* (10): 629; Self, D.J., et al. (1996) Further exploration of the relationship between medical education and moral development. *Cambridge Quarterly of Health Care Ethics, 5*: 444-9; and Feudtner, C., Christakis, D.A., and Christakis, N.A. (1994) Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development. *Academic Medicine, 69* (8): 670-9.

[53] See, for example, Shem, S. (1978) *The house of God: a novel.* New York: R. Marek Publishers; LeBaron, C. (1981) *Gentle vengeance: an account of the first year at Harvard Medical School.* New York: Penguin Books; Konner, M. (1987) *Becoming a doctor: a journey of initiation in medical school.* New York: Penguin Books; and Greger, M. (1999) *Heart failure: Diary of a third year medical student.* Jamaica Plain, MA: Self-published.

[54] Knight, J.A. (1995) Moral growth in medical students. *Theoretical Medicine, 16*(3): 265-80; Thompson, J.N. (1997) Moral imperatives for academic medicine. *Academic Medicine, 72*(12): 1037-42;

recognizing ethical dilemmas and learning resolution skills as part of "moral

development." However, as Delese Wear notes, professional development specialists

cannot hope to accomplish important goals of medical education such as instilling the

virtues of "compassion, reflectiveness, social responsiveness, autonomy, and diversity"

while the process of medical education itself actually (and counter-productively) rewards

and perpetuates "practices based on competition, hierarchies of authority, fixed spheres

of practice, bottom-line thinking, and economic privilege."[55] Without challenging certain

fundamental difficulties in the practice of medicine, trying to encourage ethical behavior in

future practitioners may in fact be futile, in the original sense of the root word, *futilis*,

meaning "leaky bucket." Frantically trying to patch holes in a leaky bucket lends a sense

of urgency to the task, but it seems to me the bucket of daily practice routinely is subject

to the incessant pressure of a fire hose.

In addition, while one might agree with Stanley Joel Reiser and argue that medical

school educators should focus on treating students in training as they would like students

to treat patients in clinical settings,[56] there has been a proliferation of literature

documenting disturbing physical and psychological abuse and humiliation suffered by

Self, D.J., Olivarez, M., & Baldwin, D.C., Jr. (1998) Clarifying the relationship of medical education and moral development. *Academic Medicine*, 73(5): 517-20; and Self, D.J., Olivarez, M., & Baldwin, D.C., Jr. (1998) The amount of small-group case-study discussion needed to improve moral reasoning skills of medical students. *Academic Medicine*, 73(5): 521-3.
⁵⁵ Wear, D. (1997) Professional development of medical students: Problems and promises. *Academic Medicine*, 72(12): 1056-62.
⁵⁶ Reiser, S.J. (1994) The ethics of learning and teaching medicine. *Academic Medicine*, 69(11): 872-6.

medical students at the hands of their preceptors and role models.[57] While attention to the moral development of medical students is no doubt important, it seems quite likely to me that institutional practices that humiliate students may be at least partially responsible for the ready acceptability and perpetuation of humiliating practices toward patients. Feudtner and colleagues note that, in their study of 665 medical students who had undergone some medical ethics training, 68% of those who had witnessed unethical behavior in clinical settings reported acting unethically themselves, 69% felt they had lost some ethical principles in the course of medical education, and 75% were displeased with their ethical development.[58] Clearly, reform in medical education is necessary, but it must be planned and executed within the context of challenging humiliation in medical practice as a whole.

Some readers may object that humiliation is too strong a word to describe how patients (and students) may be made to feel by certain aspects of medical practice. After all, one could argue that physicians are trying their best to help people under enormous pressures and restraints. I would argue that it is precisely these pressures and restraints that contribute to the humiliations that patients experience. The practice of medicine has become enormously complicated due to the rapid pace of technological change, outside

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[57] Silver, H.K. and Glicken, A.D. (1990) Medical student abuse: incidence, severity, significance. *Journal of the American Medical Association, 263*: 527-32; Luitz, R.M. and Nguyen, D.D. (1996) Medical student abuse during third-year clerkships. *Journal of the American Medical Association, 275*: 414-6; and Kassenbaum, D.G. and Cutler, E.R. (1998) On the culture of student abuse in medical school. *Academic Medicine, 73*: 1149-58.

[58] Feudtner, et al. Do clinical clerks suffer ethical erosion? p. 676.

pressures such as medical insurance, and the restraints placed on practice by managed

care. which appear to require physicians to focus on profits rather than patients.

However, my focus is not on describing extreme or unusual situations. but rather on

commonplace practices that may provide sound reasons for patients to experience

humiliation. Through the case studies that follow, I will attempt to illustrate that many

ordinary, everyday, commonly accepted practices in medicine can be and are often

experienced as humiliating by patients because their self-respect has been injured.

At one end of the spectrum are sensational cases of humiliation (paradigmatic. one

might say) which seem unlikely but are indeed true, such as the man who underwent

surgery for an infection and had his penis and one testicle removed without his consent.[59]

the doctor who carved his initials into a woman's abdomen after performing a Caesarean

section,[60] the man who had the wrong leg amputated,[61] and the woman who died in a

prominent hospital from a four-fold overdose of chemotherapy that went unnoticed by at

least a dozen doctors, nurses and pharmacists.[62] Of course, in a discussion of

humiliations experienced in the course of seeking routine medical care, one could (and

should) also mention the approximately 44,000-98,000 deaths estimated to occur

annually in American hospitals due to medical error and negligence, including prescription

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[59] Seattle Times, 2/11/2000. p. 7.
[60] Seattle Times, 2/4/2000. p.7.
[61] Sharpe, V.A., & Faden, A.I. (1998) *Medical harm: historical, conceptual, and ethical dimensions of iatrogenic illness*. Cambridge; New York: Cambridge University Press. p. 5.
[62] *Ibid.*

drug mistakes and the amorphous category of iatrogenic illnesses.[63] For the purposes of

my argument, however, I will intentionally focus on ordinary, everyday occurrences of

humiliation such as those described below that are so prevalent they commonly go

unnoticed by everyone except the patient and family members.

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[63] Kohn, L.T., Corrigan, J.M., Donaldson, M. (eds.) (2000) *To err is human: building a safer health system.* Committee on Quality Health Care in America, Institute of Medicine: National Academy Press. For one especially moving story of death caused by medical error told by a surviving spouse, see Gilbert. S. (1995) *Wrongful death: a memoir.* New York; London: W.W. Norton & Co.

Chapter Four
Institutional humiliation

Case One

Mr. B., a 58-year-old white male admitted to the hospital by Dr. X. for the

biopsy of a lung lesion, was awaiting test results, which showed he had oat cell

carcinoma. Mr. B. was anxious to learn the biopsy results and expressed his concern to

nurses on each shift. When the nursing supervisor met Mr. B., he indicated that he

wanted to know the biopsy findings to be able to plan for the future. The supervisor had

previously read the medical record that included the biopsy results. While accompanying

Dr. X. on rounds, the supervisor heard Dr. X. tell the client that everything was fine.

Upon further questioning by Mr. B., Dr. X. repeated that the tests showed everything

was okay and that Mr. B. probably could go home shortly.

Mr. B. was very quiet and spoke softly during the visit with Dr. X. At one point,

the supervisor asked Mr. B. if he had any more questions for the doctor, to which he

responded that he did not. After leaving the room, the supervisor confronted Dr. X.

about the discrepancy between the biopsy findings and what the doctor had just told the

client. Dr. X. admitted that Mr. B.'s prognosis was poor and that he had less than six

months to live but added that a client should be given hope for his remaining lifetime

when the diagnosis includes a malignancy. The supervisor told Dr. X. what the client had

said about planning for the future; Dr. X. did not reply and walked off the unit.[64]

I would argue Mr. B. has good reason to feel that his self-respect has been injured.

He has expressed a clear desire to receive information about his clinical condition so that

he may make decisions about the course of his life. Because he has not been provided the

necessary and desired information by the one who has access to that information and is

designated to share it, and has in fact been lied to, Mr. B. may indeed feel humiliated. In

the parlance of ethical principles, his autonomy is not being respected in two critical

ways: his right to self-determination is not honored and he is not shown due respect as a

person by Dr. X. He may indeed have been provided sound reasons for feeling humiliated

if he believes that his self-respect has been injured.

I call this an example of institutional humiliation because Mr. B. is at the mercy of

the institution in which he is temporarily housed. As a physician, Dr. X. has assumed his

place at the top of the medical hierarchy and is using that dominant position to determine

what is appropriate for Mr. B. to know about his own illness. Those around him,

including Dr. X., the nurses, and the nursing supervisor, are all aware of his diagnosis and

yet choose not to tell him for a variety of reasons. The supervisor and the nurses no

doubt feel that it is not their place to give Mr. B. critical information about his condition,

yet they are unable to compel Dr. X. to do so because of an institutionalized hospital

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[64] Evans, D. (1995) An ethical dilemma: the dishonest doctor. *Nursing Forum, 30*(3): 5-11.

protocol. This protocol is unlikely to be written as official hospital policy, yet it commonly allows one individual to determine whether or not a patient will be told the truth. Within medical institutions, doctors are often seen as unapproachable by both patients and fellow medical practitioners who occupy places lower on the institutional hierarchy.

In addition, as Freidson noted, the medical profession reserves the right to determine what is health and what is illness. By claiming that everything is "fine" in the face of an actual diagnosis of carcinoma, Dr. X. is exercising professional dominance. It is eminently disrespectful, in my view, to lie to a patient and tell him everything is fine when there is obviously a serious condition to which Mr. B. and his medical team ought to be attending. Mr. B. has perhaps already suffered various humiliations and indignities in the normal course of hospitalization and now he is humiliated further by being lied to and given false hope. As an ill and vulnerable person who has entrusted himself to the care of others. Mr. B. is being thwarted in his attempt to establish and maintain some control over his situation.

I have indicated that my main focus will be pursuing the argument that patients may have good reasons to feel humiliated in circumstances where their self-respect is injured. In the case study I have described, Mr. B. was not treated with respect by the practitioners to whom he trusts his care. Therefore, to the extent that his self-respect

may be injured, he has good reason to feel humiliated, although the humiliation was

perhaps unintentional on the part of Dr. X. Many indignities and humiliations exist on a

daily basis in medical practice because physicians often do not take time to listen to

patients and to understand that the patient's desired approach to medical care may differ

widely from that of the medical establishment.

Illness Narratives

In what follows, using the concept of illness narratives as developed by medical

anthropologist Arthur Kleinman and medical sociologist Arthur Frank, I will argue that

patients are disregarded and therefore humiliated when their illness narratives are not

taken seriously. In *The Illness Narratives*, Kleinman explores the differences between the

terms 'illness' and 'disease' and how they are used by doctors and patients. [65] To the

patient, illness is the term that captures the "lived experience" of being in a state other

than health. Illness involves a change in life itself, as well as a change in the way life is

viewed by the patient. Illness is an experience that may include the experience of pain

and suffering, the presence of limiting symptoms and disability, changes in ordinary daily

routine, a search for a viable explanation and a subsequent appraisal of options.

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[65] Kleinman, A. (1988) *The illness narratives: suffering, healing, and the human condition.* New York: Basic Books. See also Eisenberg, L. (1977) Disease and illness: distinctions between professional and popular ideas of sickness. *Culture, Medicine, and Psychiatry,* *1*(1): 9-23, and Fabrega, H. (1972) The study of disease in relation to culture. *Behavioral Science,* *17*:183-203.

Through the formation of an illness narrative, a patient attempts to determine the meaning of his illness within the context of his life. The viewpoint of each individual is shaped by a lifetime of culturally mediated experiences surrounding the meaning of illness. The development of an illness narrative may help him to determine answers to questions such as "Who am I now? How have my goals changed?" The illness narrative is the primary medium for the expression of the subjective experience of the patient and is in a constant state of flux as new experiences and information are added. The progress of Mr. B.'s illness narrative has been cut short by the (non)action of his physician; hence, I would argue that he is not treated with respect. In the course of not being treated with respect, his own self-respect may be injured, causing feelings of humiliation. Because Mr. B.'s narrative is an exposition of the meaning that illness represents for him, his self-respect is understandably injured when his narrative is not taken seriously.

In seeking truthful information about his condition, Mr. B. is attempting to fill out his illness narrative. He desires an accurate diagnosis of his condition and a realistic prognosis for his future so that he may attempt to realistically fit these current circumstances into the meaning he attributes to his life. Mr. B.'s illness narrative has been truncated and left suspended by Dr. X.'s refusal to share pertinent medical information. The fact that he is apparently doing so in the patient's best interests would be merely ironic if the consequences were not so grave.

Disease, on the other hand, in Kleinman's framework, is what the illness means to the clinician. The physician interprets the physical complaints and symptomatology of the patient within her learned framework of medical categories. Medical doctors are trained to recognize and categorize disease processes and therefore search for signs that indicate the presence of an 'it'. The organic source of the complaint, if found, may be an isolated germ, abscess, virus or rapidly multiplying cancer cells. The diagnosis is then 'reified' into a disease category. The physician has an ethical responsibility to educate the patient regarding prognosis and plan of treatment, but must first ascertain the etiology of the problem which brought the patient to the encounter.

The clinician takes a medical history, literally asking the patient to explain the nature of his complaint in his own words. These words will be re-interpreted by the clinician, cast into medical language and written down as clinical notes in the patient's chart. The disease entity, upon reification, is 'objectified' into a distinct something that can be treated or at least confronted.[66] Although Dr. X. has indeed ascertained the nature and properties of the disease by isolating the objectified condition, he has failed in his duty to share necessary and desired information with the patient, thereby displaying a lack of respect for Mr. B. and his incomplete illness narrative. In addition, Dr. X. has not treated the patient as an individual; rather, he merely sees Mr. B. within the category of

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[66] Taussig, M. (1980) Reification and the consciousness of the patient. *Social Science and Medicine, 14B*: 3-13.

his disease (carcinoma). To Dr. X., patients with that particular disease need to be given hope, even if that means lying to the patient. This is injurious to Mr. B.'s self-respect because, as an *individual*, he has expressed a specific desire to know the facts about his condition from a medical perspective.

Going beyond Kleinman's dichotomous arrangement of illness and disease, I will now look at three primary kinds of illness narratives, which have been delineated by medical sociologist Arthur Frank.[67] He describes them as the restitution narrative, the chaos narrative and the quest narrative. In a restitution narrative, the patient is searching for the proper diagnosis, treatment and cure. Ill health is seen as a temporary disruption in everyday life that can be alleviated by the right pill, intervention or surgery, whereby the patient seeks to return to health from this disruption in an expeditious manner. The life-world or direct personal experience of the patient is explained to the physician in everyday language and the patient has every expectation that life will soon return to normal with the aid of the physician. The restitution narrative is often short-lived and is generally forgotten as soon as health returns. Restitution narratives can, of course, change abruptly and endure in an altered form when the diagnosis turns out to be more serious than the patient had at first expected.

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[67] Frank, A. W. (1994) Reclaiming an orphan genre: the first-person narrative of illness. *Literature and Medicine, 13*(1): 1-21. See also his more complete treatment of the subject in Frank, A. W. (1995) *The wounded storyteller: body, illness, and ethics.* Chicago: University of Chicago Press.

In the case under discussion, Mr. B. is presently embarked, in my view, on a restitution narrative as he is seeking clear answers to specific questions about his condition. Once in possession of that knowledge, he desires to act in a way so as to bring about closure, either by a return to health or by incorporating the acceptance of serious illness into his ongoing narrative. If Mr. B. is kept in the dark much longer, his narrative may begin to take on characteristics of a chaos narrative.

In a chaos narrative, the patient's story is much more difficult, if not impossible, to tell. The sharing of experience is complicated because "the losses, the pain, the incoherence of suffering become so overpowering that language cannot resocialize what has happened."[68] The voice of chaos is often silence as patients can find no words to express their anguish and fears. Illness is seen as a descent into a world that is unknown and perhaps unknowable. Stories cannot be shared because the world they are meant to represent is incoherent. Sometimes screams are all that emerge from the effort to be heard. At this point, Mr. B. is not being heard. He has attempted to obtain critical information from his health care team which has been denied to him for reasons that, although unspecified, emanate from the effects of institutional domination. It would certainly be easy enough to be truthful with Mr. B. in a compassionate manner. Once he is in possession of an accurate diagnosis, he may be able to shift his narrative to include elements of a quest narrative.

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[68] Frank, A. W. Reclaiming an orphan genre. p. 7.

The quest narrative is, according to Frank, the most common. It has parallels in the world of mythology, as the hero is faced with a summons or 'call' to which he must respond. In the case of illness, the call is the discovery of symptoms which forces one to begin a 'journey' of trials and tribulations. The illness is something which must be overcome. and "accepting the call means accepting the illness as affecting one's life."[69] The trials along the way are seen as educational and necessary, and therefore they are essential in enhancing the meaning that is being constructed around the situation. One's self is affected to the core and a changed, if not renewed. perspective on life often results. This renewed perspective is then shared as the illness narrative continues to be shaped and re-defined as time goes on.

The medical relationship is the canvas upon which meaning is created out of the reality of illness and suffering. Meaning takes on a changing variety of hues and patterns, depending on the patient and the condition. Accordingly, understanding the meaning that symptoms have for particular patients should be a central concern for a clinician who seeks to interpret the experience of the patient as part of comprehensive care which includes attention to the healing of the whole person. Physicians can demonstrate respect for patients by attending to the process of meaning making in which all ill persons are engaged.

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[69] *Ibid.*

When practitioners do not show respect for the narrative of the patient and the process of meaning making in which he or she is engaged, they undermine the self-respect of that patient through medical domination. In doing so, they may provide sound reasons for a patient, such as Mr. B., to feel humiliated. After all, it is his body and his illness that are at stake. It is his personal illness narrative, whether one of restitution, chaos, or quest that must be completed and woven into the fabric of his life. He must attempt to make sense of his illness so that he may cope with its ramifications in his own individual way.

The profession of medicine has developed well-entrenched institutional structures and practices that cause humiliation to be experienced by patients. These practices result at least partially from the prominence accorded to hierarchy, authority and expediency as well as the common cultural fear of confronting the realities of life and death. As a result of institutional domination and humiliation such as the example described here, medical care has strayed from its deep roots which emphasize compassionate service to humanity. What is lacking in this and many other cases, in my view, is respect for the narrative of the patient as he struggles to understand what his illness means to him in the course of his life given the circumstances. Unable to create meaning because his narrative has been truncated by a form of institutional domination which allows and supports withholding the truth compounded by unaccountability, Mr. B. arguably has sound

reasons to be humiliated by this disruption in his narrative. In the next chapter, I will

pursue the themes of narrative development, creation of meaning, and respect for the

patient in the face of medical domination from the perspective of what I call technological

humiliation.

Chapter Five
Technological humiliation

Case Two

In 1973, Donald Cowart ("Dax"), age 25, was severely burned in a propane gas explosion. Rushed to the burn treatment unit of Parkland Hospital in Dallas, he was found to have severe burns over 65 percent of his body; his face and hands suffered third degree burns, and his eyes were severely damaged. Full burn therapy was instituted. After an initial period during which his survival was in doubt, he stabilized and underwent amputation of several fingers and the removal of his right eye. During much of his 232-day hospitalization at Parkland, his few weeks at Texas Institute of Rehabilitation and Research at Houston, and his subsequent 6-month stay at University of Texas Medical Branch in Galveston, he insisted that treatment be discontinued and that he be allowed to die. Despite this demand, wound care was continued, skin grafts performed, and nutritional and fluid support provided. He was discharged totally blind. without use of hands or arms, badly scarred, and dependent on others to assist in personal functions.[70]

Despite enduring incredible physical suffering, compounded by the refusal of any of his physicians to take seriously his refusal of treatment and wish to die, Dax was forcibly treated against his will for years. He himself noted that he was basically a

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[70] Jonsen, A.R., Siegler, M., & Winslade, W.J. (1998) *Clinical ethics: a practical approach to ethical decisions in clinical medicine.* (4th ed.) New York: McGraw-Hill. p. 5. Mr. Cowart's case is also the subject of the documentary film "Dax's Case." *Dax's case: Who should decide?* (1984) Produced by Unicorn Media for Concern for Dying. New York: Filmmakers Library.

hostage to the current state of medical technology. His sanity was questioned due to his request to die in order to escape the unbearable pain he was suffering. Even after he was found competent by not one but two psychiatrists, he was forced to continue to receive painful treatment despite his repeated protests. In what follows, using this case as a representative example, I argue that the dominant role of technology in modern medicine at times prevents patients who are suffering greatly from making meaning given the situation in which they find themselves. This source of domination may lead to what I call technological humiliation, which is often characterized by a lack of respect for the patient as a human being.

I contend that Dax was provided good reason to feel disregarded and humiliated as no one, including his physicians and his mother, would listen to him and take seriously his wish to be freed from suffering and allowed to die. Paying respectful attention to his narrative was not considered to be an important part of the healing process by his physicians. Unable to find meaning in the cruel circumstances life had forced him to confront, Dax wanted to end his suffering, but was prevented from doing so because of his physicians' reliance on the current state of medical technology and their belief that if the technology existed, it should and must be used. They insisted on continuing the painful skin grafts, the excruciating bodily immersions in bleach to cleanse open wounds, and numerous surgeries because, in their minds, that is what they were in medicine to do.

Dax was objectified as nothing more than "a severe burn patient" and he was forced to be subjected to extremely painful treatments that improved his quality of life only marginally, while damaging his self-respect significantly. Objectification is a result of the dominating influence of current medical technology which focuses on the problem and not the person. This objectification can provide sound reasons for patients to experience technological humiliation.

It is important to note that the power of medicine to cause harm is as strong as the power to provide benefit. In what follows, I argue that medical power, when used inappropriately, can be humiliating to patients when it disregards patients as persons by objectifying them. I attempt to show that medical power is in some way channeled through the person of the physician in an institutional as well as a technological sense. The influence of technology on the medical relationship is then explored, specifically noting some of the ways in which the misuse or overuse of technology creates distance between patient and doctor. This distance can prove to be a formidable barrier for the patient as he strives to make meaning from the circumstances of illness he must confront. His ability to make sense of what is happening to him may be confounded by the dominating role of technology.

Medical practice and the problem of power

Medical practice often displays a marked differential in power between physician

and patient, an imbalance that can have moral implications. The power differential is

quite naturally embedded in any such asymmetrical relationship, and in practice, can take

at least two forms. Physicians have the power to provide some benefit to their patients

by accessing medical technologies and exercising due skill and care. Secondly, by virtue of

the cultural authority and social prestige awarded to medicine, the physician always also

has power *over* the patient. This power comes about by virtue of possession of

advanced medical knowledge and training as well as the norms of social interaction that

surround disease and illness in our culture, attributes Freidson noted as falling within the

sphere of professional dominance.[71]

With the rise of highly technological interventions, many areas of medicine have

become routinized and procedure-oriented. In spite of many notable successes, the age of

technical medicine has also, however, created and perpetuated certain problems in

physician-patient interactions such as interpersonal distance, fear, mistrust, derision and

avoidance. These problems have developed from the perhaps unintentional use of

physicians' power over patients while attempting to use medical power on behalf of

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[71] Freidson, E. (1970) *Professional dominance: The social structure of medical care.* New York: Atherton Press, Inc.

patients. In Dax's case, medical dominance was clearly exercised against his wishes, even

under the guise of attempting to use the power of technological medicine for his benefit.

The topic of medical power, although somewhat elusive, has begun to receive

some much needed attention in the literature of the last decade.[72] Nancy Jecker &

Lawrence Schneiderman have provided a succinct summary of power in the medical

relationship which I find conceptually useful for the present discussion. They assert

there are three kinds of power commonly referred to in everyday usage and they apply

these descriptions to modern medical practice. They call the first kind of power "human

power" which refers to the human ability to act intentionally and to accomplish

something. Human action can utilize physical or mental strength to achieve a particular

goal. The authors note that "human power designates the exercise of power by human

beings in relationships with other human beings or inanimate objects."[73] Human power is

thought to be used intentionally and is usually focused on a particular goal. In medicine,

human power is exercised through the scientific knowledge, intelligence, and skill of the

physician as she strives to assist the patient in restoring health. The medical relationship

is the medium through which human power is exercised for the benefit of the patient.

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[72] See, for example, Brody, H. (1992) *The healer's power.* New Haven: Yale University Press; Jecker, N. S., & Schneiderman, L. J. (1995) Judging medical futility: an ethical analysis of medical power and responsibility. *Cambridge Quarterly of Healthcare Ethics,* 4(1): 23-35; and Quill, T.E., & Brody, H. (1996) Physician recommendations and patient autonomy: finding a balance between physician power and patient choice. *Annals of Internal Medicine, 125*(9): 763-9.
[73] Jecker, N. S., & Schneiderman, L. J. Judging medical futility: an ethical analysis of medical power and responsibility. p. 24.

Human power can, however, also be viewed in a negative sense. When practitioners are permitted by society to inflict pain and suffering on patients without their consent, medical knowledge and medical power become dominant in that society. They become dominant in Freidson's sense that the medical profession has reserved certain rights and abilities for itself, while remaining largely immune to legal sanction.[74] In Dax's case, much of his suffering was iatrogenically caused, resulting not only from the medically approved infliction of pain, but also from having his decision making competency challenged and ultimately being ignored as a patient and a person.

The second kind of power discussed by Jecker and Schneiderman is mechanical. Mechanical power refers to a capacity to do mechanical work. It usually implies the use of force in an effort to transfer energy or to move something through the use of machinery. Mechanical power also involves the use of tools and instruments that magnify, shrink, or make visually clearer specific objects in the world, such as the use of a telescope to view a distant planet. Medicine has made increasing use of mechanical power for centuries in an effort to more accurately measure, quantify, and describe the inner workings of the human body. Physicians use mechanical power when they enlist technology in the service of diagnosis and treatment. Sophisticated tests are ordered, high-tech lasers peer into the body, and images of tumors and abscesses appear from deep

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[74] Freidson, E. (1970) *Professional dominance: The social structure of medical care.* New York: Atherton Press, Inc.

within. As mechanical power allows physicians to observe patients in different ways, each innovation "influences power relationships in medicine."[75] In Dax's case, much mechanical power was brought to bear in treating his wounds, which, ironically, caused additional pain and suffering rather than alleviating what already existed. The (mis)use of mechanical power also distanced Dax from those who sought to heal him, as he was objectified by his medical team and hence provided good reason to experience feelings of humiliation.

The final kind of power is divine power, which has a history as old as humanity itself. Divine power is thought to originate from supernatural forces which have varying degrees of control over human affairs, depending on the belief system utilized in a particular culture. The power of divine intervention is invoked at times in medical situations and it is often hoped that this form of intervention will influence events occurring on a bodily realm. This influence is thought to occur through the personage of the physician, as some patients invest their physicians with divine-like powers and expect 'miracles' of a celestial sort through human intervention. Physicians are often seen as agents of "God's will." Dax's mother, who became his surrogate decision maker at the behest of the medical team and against his own stated wishes, said that if she felt it was God's will to let Dax die, she could have gone along with it. But since she felt otherwise,

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[75] Reiser, S. J. (1978) *Medicine and the reign of technology*. Cambridge; New York: Cambridge University Press. p. 228.

she ignored Dax's request and by default, invested his physicians with the (divine) power

to keep him alive. These paradigmatic conceptions of power, illuminated by the example

of Dax and his struggle to refuse treatment, serve as a point of departure to discuss the

impact of medical technology on the medical relationship.

The influence of technology on the medical relationship

Within the framework of human, mechanical and divine power as described by

Jecker and Schneiderman,[76] the role of technology within medicine may now be analyzed.

From the time of Hippocrates until the 17th century, the main diagnostic tools of

physicians were listening to the narrative of the patient, observing symptoms and

following the natural history of the illness.[77] Medicine was historically very low-tech. It

was quite difficult for a physician to have a sense of the inner workings of the present

living body under examination, although some medical knowledge had been developed

over the centuries from dissection of cadavers.

Although human biology has not changed much in 50,000 years, our reliance on

technological measures to explain it increases almost daily. Medical historian Stanley Joel

Reiser notes that within modern man lurks a primitive spirit which harbors feelings of

being "surrounded by unknown powers, which could be mobilized for him by the

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[76] Jecker, N. S., & Schneiderman, L. J. Judging medical futility: an ethical analysis of medical power and responsibility.
[77] Reiser, S. J. *Medicine and the reign of technology.* p 1.

complex medical techniques, and the physician who controlled them."[78] This statement

neatly encapsulates the three paradigmatic kinds of power. Medical technology as

mechanical power has increased in importance in the last several decades, and through its

ubiquity, physicians have gained power by being able to use and control it as an extension

of themselves. By controlling 'unknown powers' physicians are thought to display

unprecedented human power, and at times, divine power. The unwarranted and undesired

misuse of medical power can have detrimental effects on the attempts of patients such as

Dax to create the meaning that they need to make sense of their circumstances.

Reiser has detailed the development of medical technology through the last several

centuries and its impact on the doctor-patient relationship.[79] Through such examples as

the development of the stethoscope, laryngoscope, microscope, widespread laboratory

diagnosis and computer based diagnostics, Reiser illustrates the profound successes as

well as some of the difficulties created in medicine by the common use of such

technologies. For instance, he suggests that there has been perhaps too much reliance on

the use of technology in the cases of x-rays and laboratory tests at the expense of

effective communication with the patient.[80] Technology certainly has a useful role to

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[78] *Ibid.* p. 162.
[79] Reiser, S. J. *Medicine and the reign of technology.* See also Katz, J. (1984) *The silent world of doctor and patient.* New York: The Free Press; and Illich, I. (1976) *Medical nemesis: the expropriation of health.* New York: Pantheon Books.
[80] Reiser, S. J. *Medicine and the reign of technology.* p. 170.

play in the practice of medicine, but, if overused and allowed to become dominant, can inhibit the process of meaning making in which most patients are engaged.

Robert Romanyshyn has also argued that the pervasive cultural reliance on technological interventions for assessment and treatment has led to the development of psychological distance between observer and observed.[81] The observer is required to be psychologically and physically detached from the body of the patient while the observed body is seen as a "specimen" and somewhat less than fully human. According to Romanyshyn, the objectification of patients through the creation and maintenance of technological distance has made the practice of medicine less humane. He claims that we must analyze the cultural values that have led us to value this approach to medicine at the cost of devaluing both ourselves and our patients.

In Dax's case, the maintenance of organic life, although severely compromised, was deemed to be of greater value to all concerned except the patient, whose autonomous decision making capacity was curtailed. He was treated as a specimen, and as such, the forced treatment and subsequent objectification could well provide sound reasons for experiencing feelings of humiliation. Throughout his forced treatment, Dax was perhaps attempting to form a restitution narrative, in Arthur Frank's terms, whereby he could come to terms with what had happened. By being treated as a specimen, he was not

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[81] Romanyshyn, R. D. (1989) *Technology as symptom and dream*. London; New York: Routledge Publishers.

respectfully heard and treated as a human being, and may thus have been forced into a chaos narrative, making the creation of meaning a much more difficult endeavor.

Meaning-making in the context of technological medicine

The role of the patient in technological medicine has been one of a relative absence of power. Yet each patient must struggle to come to terms with his or her suffering and set it within the context of life's plans and goals. As illness pervades the ordinariness of everyday life, patients try to understand what is happening to them and attempt to create meaning out of the chaos of the human condition. Jerome Bruner has written eloquently about the struggle to make meaning in a post-industrial world which invests heavily in the culture of science, at the expense of a cultural psychology which values the creation of meaning.[82] The informational model of medicine, heavily used in a technological framework, relies on mechanistic processing of facts and computation of so-called objective data to provide dispassionate information and an array of options from which the patient may decide. However, in a cultural psychology, or as Bruner calls it, "folk psychology," acts and decisions are motivated and undertaken against the background of a specific context in which meaning is made. Critical factors in the construction of meaning are the motivations or intentions of the actor, as well as the contextual setting in which the action takes place.

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[82] Bruner, J. S. (1990) *Acts of meaning.* Cambridge, MA: Harvard University Press.

Because medicine is often cast as an objective science, individuals with illnesses

are seen as examples of particular disease types which can be categorized and therefore. in

a way, depersonalized. This may contribute to difficulties in communication when the

patient tries to explain the particular way in which the medical condition affects him. By

diagnosing and treating a 'thing' or 'disease entity' a physician may pay less than optimal

attention to the patient's psychological and sociocultural attempts to create meaning

through the formation of his illness narrative. What the illness means to the patient is

quite often far removed from what the disease means to the physician.[83]

The construction of meaning is an ongoing process and involves a subtle interplay

between the participants in the medical encounter. This interplay develops initially from

a reading of the "natural" causes of the complaint and often evolves into a social

interpretation by the physician, which is then reinterpreted and assimilated by the

patient. As the patient and clinician engage in the process of understanding, interpreting

and labeling the symptoms presented by the patient, they are engaged in the cultural

construction of clinical reality, which consists of naming the condition by the clinician and

the attachment of meaning to the named condition by the individual patient. Analyzing

this process, medical anthropologists Noel Chrisman and Arthur Kleinman note that

"joint participation in symptom definition and treatment action is crucial to joint

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[83] Kleinman, A. (1980) *Patients and healers in the context of culture: an exploration of the borderland between anthropology, medicine, and psychiatry.* Berkeley: University of California Press; and Morris. D.B. (1998) *Illness and culture in the postmodern age.* Berkeley: University of California Press.

construction of clinical reality...collaboration in this process...is also the opportunity for

health-promoting patient education."[84] Engaging in such a collaborative effort helps to

fulfill the physician's role as educator as well as a partner in the healing effort.

Michael Taussig argues that the anticipated doctor-patient communication fails to

occur meaningfully on occasion, if not frequently.[85] The reasons are complex. The failure

to communicate meaningfully comes about primarily because of different goals regarding

outcomes, differences of opinion regarding importance of certain social factors. and

significant differences in the world views of the participants. For example. when a cancer

diagnosis is given, not only do doctor and patient have different perspectives as to what

that means (as in the case of Mr. B. in the previous chapter), but patients themselves of

course differ widely in the meaning they might attach to such a diagnosis. Some may

consider it a death sentence. some may fear the family savings will be decimated. while

still another may see it as a challenge to be overcome. This is critical in attempting to

understand the process of meaning making in which the patient is engaged. If the clinician

is involved in a cooperative effort with the patient to create a jointly understood and

agreed-upon reality, he can take the opportunity to use medical knowledge to benefit the

patient. If. however, the patients' attempts to create meaning are thwarted by

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[84] Chrisman. N. J. and Kleinman, A. (1983) Popular health care, social networks, and cultural meanings: The orientation of medical anthropology. In *Handbook of health, health care and the health professions* ed. Mechanic, D.. p. 565. New York: The Free Press.
[85] Taussig, M.T. (1980) Reification and the consciousness of the patient. *Social Science and Medicine*, *14B*(1): 3-13.

technological domination, the process of healing may be hindered. Taussig asserts that

there is an inevitable loss of autonomy on the part of the patient because the nature of the

clinical relationship, at its most fundamental level, is one of domination and control.

Rather than placing the focus of the power-domination discussion on questions of

usurpation of individual autonomy, Taussig claims that we should instead look at the

clinical situation as being one in which "the patient swings like a pendulum between

alienated passivity and alienated self-assertion."[86] Passivity is encouraged as the nature

of the condition is explicated and named, and self-assertion is blunted by the rational,

methodical placing of the patient in a medical context as someone who has a certain

disease. The medical practitioner takes control of the situation by naming and

categorizing the condition, which then becomes a thing to be manipulated. By

manipulating a 'thing', or disease entity, the clinician distances himself from the

psychosocial quest for meaning in which the patient is engaged. Dax was forced to accept

medical treatment passively because he was immobilized, and when he tried to assert his

autonomy, he was further alienated by being told he was irrational.

Since meaning is created jointly in the medical relationship, adopting a perspective

which encourages the sharing of narrative may enable physicians to be of greater benefit

to patients than merely acting as sources of medical information or paternalistic guides.

Patients often are confused or angry, agitated or shocked when they learn of a seriously

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[86] Taussig, M. Reification and the consciousness of the patient. p. 9.

debilitating or potentially chronic diagnosis. The relationship with their physician often takes on a sense of urgency and heightened importance. Cold facts and hard truths are often sought, but due to the inherent uncertainty of medicine, the physician may also be called upon to pursue non-scientific approaches to healing such as active listening and focused dialogue in order to get to know the patient better and reach a satisfactory decision in cooperation with the patient regarding a course of action. Thus the patient's narrative and attempts at creating meaning should be taken seriously by those to whom care is entrusted.

Suffering and the creation of meaning

The struggle to find meaning in illness is a crucial human experience. We are compelled by the human condition to experience pain, suffering, tragedy and loss. Through these experiences we struggle to make meaning for ourselves and to adjust to physical limitations as well as emotional loss. As patients, we try to understand what is happening to us by questioning and seeking answers that will help us to make sense of our situation. It is critically important for patients to be heard and recognized as a "patient," literally, "one who suffers." When patients are not taken as credible witnesses regarding their own suffering, their self-respect may be diminished and they may be provided sound reasons for experiencing humiliation.

One of the primary aims of medicine, going back to the time of Hippocrates, has been and should continue to be to relieve suffering if possible, or at least to prevent its exacerbation. In other words, as a healing endeavor, medical practice should not make suffering worse. Even in the face of this obligation, as Eric Cassell notes, "it is not uncommon for suffering to occur not only during the course of a disease but as a result of its treatment."[87] The tendency to rely primarily on technological means to assess and treat suffering often results in the creation of distance between practitioners and patients. This alienation can not only cause more suffering, but may also lead to diminished self-respect and humiliation, if the practitioner and patient have differing goals regarding the outcome of treatment. When patients are not shown proper respect, as demonstrated in Dax's case, they may be caused to undergo additional suffering. When that suffering is caused by those who are charged with caring and curing, it may compound difficulties a patient may be having in the process of trying to create meaning.

Jamie Mayerfeld has argued that, as humans, we have a moral duty to relieve suffering.[88] He claims that this duty is a prima facie duty that increases as the intensity and duration of the suffering correspondingly increase. The duty to relieve suffering exists (unless superseded by other prima facie duties) because, as Mayerfeld puts it, "suffering is bad and ought not to occur."[89] Because it ought not to occur, we are morally

[87] Cassell, E.J. (1991) *The nature of suffering and the goals of medicine.* Oxford; New York: Oxford University Press. p. 30.
[88] Mayerfeld, J. (1999) *Suffering and moral responsibility.* Oxford; New York: Oxford University Press.
[89] *Ibid.* p. 111.

required not only to relieve suffering but also to refrain from being the cause of its exacerbation. As suffering becomes more intense and of longer duration, it becomes more significant from a moral standpoint, as the responsibility to alleviate it becomes more pronounced. In Dax's case, his significant physical suffering and agony was externally caused (by the explosion) and was compounded by his physicians' refusal to listen to the meaning that developed for him as a result of that suffering. He was powerless within a highly asymmetrical relationship and was forced to submit to the controlling of his body by others as a result of medical dominance.

Medical practitioners in particular, as helpers and healers, have a moral duty not to create more suffering for their patients through unwise overuse and misuse of technology. Because patients can become objectified through their illnesses, they may experience additional suffering beyond that inflicted by their illness alone. Objectification of patients as mere examples of a named disease process can be a source of humiliation to patients which should be recognized and confronted by practitioners in daily medical practice. One way to counter the tendency to objectify a patient through technological means is to pay close and respectful attention to the process of meaning making in which the patient is engaged through the formation of the illness narrative.

The Role of Narrative in the Creation of Meaning

In daily medical practice, when a patient initiates a clinical encounter, the physician sets out to discover the reason for the visit. The narrative that ensues shares crucial information that the physician records in the medical chart. This recording of the patient's subjective experience accompanies physical examination, palpation, and possibly blood work and diagnostic tests. In taking the history, the physician listens for certain information, such as the description of the location, intensity and duration of pain. The patient reports the symptoms, relays his previous history with this complaint or others, shows the clinician physical signs of illness and submits to diagnostic and interpretive tests. These elements are used as needed to enable the practitioner to ground herself in the experience of the patient.

There is, however, more to taking a history than the simple recording of the information presented by the patient. The patient is also actively engaged in interpreting his experience for himself. He does this as he tells a narrative about himself which reflects his lived experience of the illness. A physician may not always find the patient to be an objective and reliable witness, but she listens to the narrative (as nurturer), searching for clues (as detective), that may allow her to make an recommendation for a treatment plan which may be efficacious (as healer and/or teacher) or to perform an intervention (as technician). Jerome Bruner sees the narrative as "a unique sequence of events, mental

states, and happenings involving human beings as characters or actors."[90] A narrative is a

story we tell about our perceptions of ourselves and those around us. For another to

grasp the meaning of one's narrative, attention must be paid to the context in which the

events occur as well as to the impact those events subsequently have on that context.

Understanding a patient's narrative in the context of the medical setting is important

because it enables the physician to place and treat the patient as an individual human

being. Often, the narrative of the patient is key to the physician's determination of a

course of action.[91]

As the patient tells his story, the physician is engaged in analyzing the way the

experience is described. The patient may go into considerable detail to give the clinician

greater insight into his condition. or he may be less than forthcoming with helpful

information. Kathryn Hunter argues that clinicians, in their effort to reconstruct the

patient's story into a medicalized version which they then retell to the patient. approach

the patient as text. Patients' stories themselves are seen as "readings and interpretations

of events" which are "texts" to be examined and comprehended by the clinician.[92]

The putative task of the physician is to take this text and interpret it in terms that

represent part of a sensible and identifiable composite picture of what may be happening

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[90] Bruner, J. *Acts of Meaning.* p. 43.
[91] In particular areas of medical care, such as emergency medicine, physicians of course rely less on narrative for diagnostic purposes if the patient is unconscious or unable to speak.
[92] Hunter, K. M. (1991) *Doctors' stories: the narrative structure of medical knowledge.* Princeton, NJ: Princeton University Press. p. 8.

with regard to the illness. This analyzed story is then retold to the patient as the

medicalized narrative of the physician. With experience, physicians are able to anticipate

the narrative flow of information as it develops in the telling. Eventually they may come

to realize "that the way the story is told is part of its meaning."[93] In the actual process

of telling the story, the patient is engaged in the creation of meaning with regard to his

illness and his life. In this way, telling his story to an observant listener can be a crucial

part of the illness and healing experience for the patient. In Dax's case, he was not

seeking medical care voluntarily, rather, it was forced upon him against his strongly stated

wishes. The construction of his narrative and his attempts to create meaning, perhaps

even more important here because of his dire situation, were virtually ignored.

Certainly Dax was in a position of diminished autonomy because he and his

doctors had markedly different goals regarding outcomes, and differing levels of ability to

carry out their plans. Several physicians blatantly overrode his strongly expressed.

consistent and competent wishes that he did not want to be treated for his severe burns.

Dax appeared to find it extremely difficult to create meaning from his experience because

he was essentially a hostage to the state of medical technology. Many years of suffering

passed before he came to terms with the anguish he was forced to endure. Much of Dax's

suffering was iatrogenically caused and subsequently justified by medical dominance. His

physicians claimed to know what was best for him and based their treatment approach on

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[93] Hunter, K. M. *Doctors' stories.* p. 9.

restoring function through technological interventions rather than listening to him and taking seriously his attempts to make meaning from his circumstances. His clearly stated wishes to be allowed to die were pathologized and ignored. Because his self-respect was injured in this way, he certainly was provided sound reasons for experiencing feelings of humiliation.

I have argued that listening carefully to narrative and participating in the joint construction of meaning is a crucial undertaking for both patient and physician. Each patient is engaged in a search for meaning as he confronts illness and intimations of mortality. He constructs a narrative which attempts to make sense out of his situation and then shares this narrative with the physician as both strive to understand what has occurred and what is likely to be the result of the prescribed medical intervention. This narrative can be subject to domination by the practitioner if she is not aware of the individual circumstances and values of each patient. For a narrative to become meaningful for both parties, it must be approached with respect and a sense of the world of possibilities that exists for that patient. Creation of such a narrative usually includes information obtained through technological means, but that supposedly value-free input should be kept in context and not automatically be given preference by practitioners.

It may be objected that the time of the physician is at a premium and she lacks the time necessary to think about the joint construction of meaning. Modern medicine calls

for increasing specialization, cumulative knowledge and developed skill. Modern managed care has also placed additional restrictions on time spent in the medical office and hospitals and on insurance coverage for certain diagnoses. However, it must be taken into account that medicine is an inherently moral enterprise. Emanuel and Emanuel have argued that we must establish "a health care financing system that properly reimburses rather than penalizes physicians for taking the time to discuss values with their patients."[94] There exists a 'fiduciary' or special kind of relationship with certain roles and responsibilities between practitioner and patient that goes beyond the mere exercise of technical skill.

It is crucially important to take the time to pay attention to individual circumstances in the medical relationship because it is not an ordinary relationship. Active engagement and careful listening to narrative do take more time than guiding the conversation to a quick, if perhaps temporary, resolution. While efficiency is valued in the technical aspects of medicine, I am suggesting that the valuable commodity of time must actually be spent in order to help patients make sense of their illness in the context of their lives. Listening attentively to narrative and participating in the joint construction of meaning are important and beneficial components of the healing process which should not be ignored or trivialized by practitioners. To do so may give patients sound reasons

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[94] Emanuel, E. J., & Emanuel, L. L. (1992) Four models of the physician-patient relationship. *Journal of the American Medical Association, 267*(16): 2221-6.

for feeling humiliated through their interactions with the medical culture as was arguably

so in Dax's case. Practitioners can challenge humiliating practices and show respect for

the patient as a person by paying close attention to the ongoing development of narrative

and the subsequent creation of meaning for the patient in the context of his life. In this

way. they may avoid the appropriation of meaning that often accompanies technological

humiliation.

Chapter Six
Psychosocial humiliation

Case Three

James is a 27-year-old African American male who presents to the emergency

room at Newport Memorial Hospital short of breath, vomiting blood, and delirious.

After stabilizing his condition and admitting him to the hospital, the staff has a chance to

review his previous medical record and confirms that James is HIV positive, has Hepatitis

C, and is diabetic. James has made use of the public hospital on many occasions in the

past because he has no health insurance and is chronically unemployed. Upon initial

assessment, it is determined that he needs a bronchoscopy to determine the status of his

airways. A young intern on duty, Dr. Kreiger, refuses to perform the bronchoscopy and

instead delays action, saying that he does not want to get near "any of those AIDS

patients." This is not primarily because he fears contracting the disease, which is

theoretically possible in the case of an inadvertent needle stick, but because he is

disgusted by having to care for those who, in his mind, are unlike him in so many ways.

Dr. Kreiger apparently has difficulty exhibiting caring or empathic behaviors when he

cannot tolerate the sight of unemployed AIDS patients of a different ethnicity. He makes

several loud comments to the effect that he doesn't have time and there are many other

patients more deserving of his time and talents. James overhears Dr. Kreiger's

conversation with the rest of the medical staff and feels humiliated. He is forced to wait

for over an hour while the staff tries to find another physician to perform the

bronchoscopy.[95]

In this case, we see an example of a health care practitioner exposing his prejudices

in front of his peers with impunity. I want to suggest through the following analysis that

this behavior shows a significant lack of respect for a human being in need. This attitude

on the part of a medical professional could arguably provide sound reasons for a patient

such as James to feel humiliated. When patients are dominated by their practitioners

because of deeply held prejudices, I call this psychosocial humiliation. Practitioners'

prejudices that emerge in clinical settings and are directed toward patients have the

potential to be as dominating as the institutional and technological factors explored

previously, and are just as capable, in my view, of leading to justifiable feelings of

humiliation on the part of patients.

In what follows, I attempt to demonstrate that we can at least partially

understand the sources and effects of prejudices by looking at the roles of self and other

in moral relationships. The existence and expression of prejudices may be attributable in

part to strongly held convictions that those who are "other" are not worthy of the same

respect we may give to those who are similar to us. These attitudes may not be

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[95] This case is a composite case created from personal observations and conversations with various medical professionals.

consciously held, but often become apparent when provoked by the appropriate situation. Medical practitioners are called upon to treat all patients who come to them for aid and comfort without regard to their ethnic identity, religion, sexual orientation, or medical condition; hence, the expression of prejudices toward patients can be seen as detrimental to the healing process and injurious to the self-respect of those who seek medical assistance.

The sources and effects of prejudices in medicine may be examined in a number of ways. To provide support for my general argument that prevalent forms of domination and humiliation in the practice of medicine may provide a patient with sound reasons for feeling humiliated, I will focus in the following sections on the possible psychological and practical ramifications of seeing the world in the broad terms of self and other. I will investigate historical roots of the self/other (or us/them) distinction in Western culture and seek to apply these concepts by exploring the area of psychiatric classification. Through the presentation of examples of research on prejudice in both the sociological and psychoanalytical domains, I will attempt to show how prejudices develop and subsequently affect interactions between practitioners and patients. By addressing these areas of concern, some of the forms of psychosocial domination and humiliation may be better understood and attended to more effectively by medical practitioners.

Self and Other in moral relationships

The individual participants in the daily practice of medicine, as previously noted, are involved in moral relationships. The experience of being ill changes how a patient sees the world and her place in it. As illness takes hold, patients are often forced to trade in the old world of safety and security for a world of pain, loss, uncertainty and grief. The guide along the path of illness and desired recovery is the physician, who, by virtue of advanced medical knowledge and socially designated power, attempts to assist the healing process. These attempts to support healing include caring if not curing, and occur on many levels. The first and most obvious level on which healing takes place is the physical. For many patients and practitioners, attempts to address illness on a purely physical level provide the only point of contact. For many sufferers of chronic pain, long term illness and/or disability, however, there is often significant damage over time to the integrity of the self, which impacts the whole self, not just the physical dimension. As the self experiences pain and suffering in the course of an illness, the world is seen differently. Lives become disrupted and the struggle to make sense of the perhaps chaotic experience of illness becomes an all-consuming activity. When a patient is treated as an "other" by being subjected to expressions of prejudice, he may indeed have good reasons to consider his self-respect injured and, thus, to feel humiliated.

Us-Them Relationships in Historical Perspective

The historical basis for Western conceptions of 'us-them' and 'self-other' can

perhaps be traced back to the architects of Western civilization, the Greeks. How did we

develop such a strong notion of the other as fundamentally different from ourselves? In

The Greeks: A Portrait of Self and Others, Paul Cartledge observes that the concept of

otherness can arguably be traced to the Greeks of the fifth and fourth centuries BC.[96]

Cartledge's central claim is that the idea of alterity, or the conscious placing of the "other"

in opposition to oneself, is a historically identifiable theme in the self-conception of the

Greeks. He points out that the culture known to us as the 'Greeks' was really a

collection of disparate peoples who united for logistical, economic and security reasons

and struggled with a radical form of self-governance they called democracy. Participation

in this democracy, however, was limited to a constrained category of inclusion- the 'us'

being limited to the class of free, male citizenry which excluded by definition women,

slaves, aliens and barbarians.

Cartledge points out that even though the 'Greeks' were not a perfectly

homogeneous society, they divided all people into two categories- us and them, or more

specifically, Greeks and barbarians.[97] The Greeks saw the world as a collection of

dichotomous relationships- everything that was not Greek, male, citizen and free was

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[96] Cartledge, P. (1993) *The Greeks: a portrait of self and others*. Oxford; New York: Oxford University Press.
[97] *Ibid.* p. 11.

seen as an instance of alterity, an otherness that could not be reconciled. It is interesting

to note that this same polarity is seen to exist in the relationship between men and gods.

The gods were thought to have some human qualities such as jealousy, but were generally

'superhuman' and everything that men were not.[98] In fact, Aristotle argues there could

not be any true reciprocity between men and the gods because the differences are

'unbridgeable.'[99] Perhaps this 'natural' and starkly clear delineation is at the root of

conceptions of 'us' and 'them' that encouraged the Greeks to keep themselves separated

from others by means of clearly determined differences.

Cartledge argues that the peculiar tendency of the Western world to dichotomize

by treating everything different from ourselves as an other, an example of 'them'. is a trait

that seems to originate with the Greeks, and flow through the Renaissance and the

Enlightenment to the present day. Descartes is credited (or blamed) for popularizing the

mind/body split in the 17th century that established the reductionistic model as the

paradigm for science and, by extension, scientific medicine. Medicine has created separate

fields of analysis to address illnesses of mind and body, namely psychiatry and general

internal medicine, which perpetuates the reductionistic model that separates the sick from

the well, us from them, self from other, and self from the body as 'other'. One example

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[98] *Ibid.* p. 163.
[99] *Ibid.* p. 165. cf. *Magna Moralia* 1208b: 27-31, and *Nicomachean Ethics* 1122b: 20-2.

of the reductionistic model is the medical categorization of the sickness experience into the realms of illness and disease as noted in Chapter 3.

In the process of separating the sick from the well, professional dominance is exercised. The basis for this form of domination is seen in the separation of those who are similar to us as opposed to those who are not. Many areas of medical classification can be seen to partake of these basic separations that are made due to conceptions of sameness and alterity. The problems of psychiatric classification, for example, become evident when we consider cultural notions of the self as developed from and within our own particular cultural mindset. Atwood Gaines has argued that, indeed, "(psychiatric) classifications are moments of creative cultural historical processes in which certain selves of one Western tradition say something to and about themselves and to and about others."[100] Gaines claims that the 'voice' of U.S. psychiatry is based on a Northern European Germanic Protestant adult male view of the self. This self prides itself on 'constancy' and 'control', both of which are seen as positive attributes. The self is distinct and autonomous and adheres to a cultural imperative to discover the causes of inconstancy and failures to control the self.[101] This self is a 'referential' self that sees others in a similar fashion and seeks to 'discover', name and describe those inconstancies and failures.

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[100] Gaines, A. D. (1992) From DSM-I to III-R; voices of self, mastery and the other: A cultural constructivist reading of U.S. psychiatric classification. *Social Science and Medicine, 35*(1): 19.
[101] *Ibid.* p. 11.

By contrast, Gaines argues that Mediterranean peoples rely on a notion of self that is 'indexical', a more flexible, interactional self that undergoes alteration in contexts that involve others such as family and clan. Relationships with others are emphasized and "the moral or social character of the person as shown in the community is shaped by the actions" of those others.[102] This perspective is more inclusive than the previous example of the referential self which focuses more on exclusion of what is dissimilar. Deriving from the adult male Germanic perspective, U.S. psychiatric classification, through its complicated and yet fluid diagnostic criteria, seeks to exclude the Other who is less in control and less autonomous. Perhaps our approach to psychiatry and the classification of mental illnesses would be different if the great psychiatrists of the 20th century had been Italian.

Notions of 'self' and 'responsibility' play a major role in psychiatric classification and are central to our ethnopsychology.[103] Responsibility is tied to control and a distancing of the self from the other. The uncontrolled 'Other' is seen as uncivilized (hints of Cartledge's Greeks and barbarians) and the victim of emotion which leads to a lack of balance. Balance and control of the self are prized in our culture, qualities Gaines attributes to perceptions of the idealized self. The ideal self is, of course, an adult, male, Germanic self perpetuating a voice that is ethnic, time and gender specific. In this model,

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[102] *Ibid.* p. 12.
[103] *Ibid.* p. 16.

the self requires a negative Other in order to define the positive self. This cultural model can lead to domination by the one who claims responsibility, implicitly or explicitly, for defining the positive self and thereby perpetuating the us-them dichotomy. Medical practitioners in this country have historically been primarily white males, although the demographics have begun to shift in the last decade toward the inclusion of more women and minorities. The doctor-patient relationship can become problematic because of differences in approach to the understanding of the self where the two individuals involved do not share the same cultural framework.

One of the primary ways in which otherness is manifested in medical practice is through the expression of prejudice. In what follows, I will argue that prejudice is a primary form of psychosocial domination in the medical relationship. Emanating as it does from profound distinctions that physicians observe between their own selves and the persons of their patients, as demonstrated above in the example of psychiatric classification, prejudice has the potential to significantly impact the medical relationship in ways that may cause humiliation to patients. An awareness of how physicians might address the sociocultural differences between themselves and those they are called to care for is important, in my view, in the effort to understand, confront, and perhaps minimize psychosocial domination.

Prejudices in Medicine

Being a health care provider does not necessarily make one immune from having

psychological prejudices concerning one's patients. In fact, one might argue convincingly

that working in the high stress world of a tertiary care hospital with large numbers of

patients would cause those prejudices to emerge even more so. Once out in the open (or

still repressed), prejudices may lead to a kind of contempt for certain patients, such as the

case of James that opened this chapter. Many commentators have noted the prevalence

of a special language used by medical residents and house staff in referring to disheveled,

debilitated, perhaps alcoholic, perhaps incontinent elderly men as 'gomers', 'crocks', and

'gorks'.[104] These terms show a lack of respect for the patient as a person and appear to

provide sound reasons for a patient to experience feelings of humiliation.[105] As

Leiderman and Grisso note, "In caring for patients, health professionals are obliged to

violate strong cultural taboos against examining, penetrating, and handling the substances

of other human bodies."[106] All of these activities undertaken in the examination and care

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[104] See, for example, Leiderman, D.B. and Grisso, J.A. (1985) The gomer phenomenon. *Journal of Health and Social Behavior*, 26: 222-232. For the quintessential look at these issues through the eyes of a first year intern in a large urban hospital, see Shem, S. (1978) *The house of God.* New York: Dell.

[105] As a graduate student in medical history and ethics, I spent a few weeks going on hospital rounds with a team of physicians on a general medicine floor as part of a clinical practicum elective. I was the guest of a pleasant young doctor who had volunteered to be my preceptor, and with whom I eventually spent several weeks in his practice at the local public health AIDS clinic. The patients' conditions on the general internal medicine floor ranged from acute respiratory distress to post-liver transplants to full-blown AIDS. Several of the doctors with whom I did rounds referred to patients as 'gomers', 'crocks', and 'slugs'. One woman, in particular, who was having great difficulty being weaned from a respirator, was spoken about just out of earshot, "She is such a slug! She's not even trying to breathe!" One doctor said of one elderly man who had not been out of his hospital bed for almost a month, "I'm not going to bother even going in his room; he sure is a crock if there ever was one."

[106] Leiderman and Grisso. The gomer phenomenon. p. 223.

of the old, sick, and decrepit can lead to an objectification of the patient, one complete

with derogatory language and expressions of prejudices concerning those patients.

Routinely providing medical services of this kind may engender a certain callousness

toward patients over time by forcing physicians to confront their own mortality and

physical processes. They realize that they too will most likely suffer and certainly will

die someday.

Another example, this one from the clinical world of mental health practitioners,

supports the claim that prejudices expressed by the dominant partner in the therapeutic

relationship can have a humiliating impact. In a sociological study from the 1980's

looking at the effect of obesity on clinical judgments, investigators found that mental

health workers (including psychiatrists, substance abuse counselors, and family

therapists) are more likely to give a negative mental health assessment to an obese person

than to a individual of 'best-weight' or one who was 'overweight'. [107] Unknown to the

subjects (the mental health professionals), the cases presented to them were three

variations of the same individual. She was presented to the subjects through a written

case history of a 46 year old married white woman, with a photograph attached of the

'client/model' with her face photographically altered to make her appear of normal weight

in some versions of the photograph, overweight in others, and obese in the third. Thus,

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[107] Young, L.M. and Powell, B. (1985) The effects of obesity on the clinical judgments of mental health professionals. *Journal of Health and Social Behavior, 26*: 233-246.

the same individual with the same history but with an altered photograph was judged differently with respect to a putative psychological profile based on the perceptions of qualities and characteristics attributable to persons 'of that kind'.

Interestingly enough, the profile of the subject making the most negative psychological assessment of a middle aged obese woman is likely to be a younger woman of moderate weight. The investigation showed that older mental health workers, obese women, and men tended not to differentiate as much according to the weight of the 'model', and tended not to be as negative in their assessments of the obese model. The characteristics most often attributed to the obese model by female health care workers are "addiction, hypochondriasis, intolerance for change, obsessive-compulsive behavior, self-injurious behavior, sexual dysfunction, stereotyped behavior, and suspiciousness."[108] The prejudices were expressed without any direct contact with or knowledge of the actual characteristics of the model.

Practitioners occasionally write of their experiences with prejudice. In a rich, autobiographical narrative, Rafael Campo movingly recounts his personal story of (as he subtitles his book) "a doctor's education in empathy, identity and desire."[109] As he gradually comes to terms with his self perception and self understanding as a gay, Latino, Catholic doctor/poet, he describes the experience of feeling prejudice directed against him

[108] *Ibid.* p. 239.
[109] Campo, R. (1997) *The poetry of healing: a doctor's education in empathy, identity, and desire.* New York: W.W. Norton.

throughout his educational career, including college, medical school and residency. He

sees his life as a succession of struggles, attempting to overcome the stereotypical

prejudices that others around him, intentionally or unknowingly, attribute to those unlike

themselves; primarily straight WASPish intellectuals. Campo feels these prejudices of

others and is deeply affected by them. He anguishes over his coming out not only as a

gay man, but also as an artist, as both are crucial aspects of his identity which have

emerged against the background of his ethnic heritage, his religious upbringing and his

training as a physician.

As he describes his educational journey, Campo cannot help, in his extravagantly

confessional style, but reveal some of his own prejudices. He appears to accept them as

part of his humanity, while at the same time he struggles to transcend them. When he

refers to one of his AIDS patients as a "filthy junkie," and "little more than a disgusting

chore,"[110] while in the middle of another seemingly endless week of caring for patients as

an intern, he displays his prejudices, thereby distancing himself from the humanity of the

patient while simultaneously showing us his own.

Early in his career, he hopes that his own struggles with prejudice directed at him

will enable him to feel more empathy for those who would become his patients. Yet he is

overwhelmed at times by his moral and medical responsibilities in the face of tragic

conditions such as cancer and AIDS. When he says early in the book that he was "glad"

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[110] *Ibid.* pp. 36-7.

when "that despicable AIDS patient finally did die,"[111] he seems to be far from any sort

of empathic identification. As I noted in Chapter 2, attempting to practice empathy as a

sort of humanistic technique without confronting deeper psychosocial issues can be

fraught with difficulties.

Unconfronted prejudices may make the development of humanistic qualities

difficult in the medical relationship. This is because in displaying prejudice overtly as in

the case of Dr. Krieger and James, or even thinking prejudicially about someone as noted

above in the writings of Dr. Campo, there may be a lack of moral imagination that

prevents the prejudiced person from seeing the world of possibilities in another human

being. This has particular relevance in the medical setting. When physicians refer to

patients as 'gomers', 'crocks', and 'despicable people', they neglect to see the world as it

is for the patient. The expression of prejudices may cause humiliation for a patient as he

is marginalized and not valued as a whole person. The study of prejudice is seldom taken

into account in efforts to make medical practice more humane. In this chapter, I am

making the claim that displaying prejudice toward patients is a form of psychosocial

domination which may provide patients sound reasons to feel humiliated. To support

this claim in the context of my overall argument, I will argue in what follows that

prejudice is not a simple concept and is often more complicated than merely not liking

someone because they are different.

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[111] *Ibid.* pp. 55-6.

Prejudice

Prejudice is usually represented as the judging of another without a trial, and occurs when we pre-judge another without knowing her, group people together because they share the same ethnic heritage or treat an individual merely as an instantiation of one particular kind of person. In Elisabeth Young-Bruehl's recent provocative history and theory of prejudice, she notes (and critiques) the traditional psychosocial ways of thinking about prejudice: that prejudice is generally exhibited by an authoritarian personality, that the authoritarian personality is the product of an authoritarian society and there is a single kind of prejudice, generally ethnocentric in nature.[112] Prejudices are traditionally thought to be of one kind and to vary only by degree, that degree being a measure of the vehemence felt against another ethnic group. The targeted group has specific and identifiable differences, like ethnic heritage or skin color.

Young-Bruehl persuasively argues that prejudice does in fact vary in kind, not just in degree. Besides ethnocentrisms, which have diminished as the number of so-called "pure" cultural groups have declined, she focuses on a number of other kinds of prejudices, what she calls "ideologies of desire" or "orecticisms."[113] Orecticisms (pertaining to the desires) such as anti-semitism, racism, sexism and homophobia are

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[112] Young-Bruehl, E. (1996) *The anatomy of prejudices.* Cambridge: Harvard University Press.
[113] See Young-Bruehl, E. *The anatomy of prejudices.* pp. 28-35 for her discussion of ideologies of desire and pp. 184-198 for her introductory comments on orecticisms as distinct from ethnocentrisms. She creates the term "orecticism" from the Greek *orektikos*, meaning desirous or pertaining to the desires.

examples of 'ideologies of desire' and can be distinguished from ethnocentrisms in several

ways which revolve primarily around inclusion and exclusion. Young-Bruehl writes that:

> "Ethnocentrism is a modality of inclusion, a centripetal complex of wishes and
> values and behaviors. It depends upon already existing group identifications and
> promotes them. Ideologies of desire, by contrast, are exclusive. They magnify
> differences, taking physical and cultural variations that in and of themselves do
> not constitute differences in social organization, mores, or culture and turning
> them into *essential* differences. Such centrifugal and expansive ideologies whirl
> outward, casting off the Other as they go."[114]

At first glance, it would appear that the examples of prejudice in the medical setting given

above correspond to Young-Bruehl's description of orecticisms. Prejudices against

'crocks', 'gomers', the obese, and AIDS patients are directed at what Young-Bruehl calls

'constructed groups'. These prejudices are oriented toward the body and involve

constant body referencing. They involve a rejection of the Other as a fellow being and

tend to objectify the individual. Particularly in the example of the obese mental health

client, physical and cultural variations are turned into 'essential' differences. (Remember

the psychological characteristics attributed to the obese 'model'.) The prejudices

illustrated are not directed against any historical group and hence belong to a category

distinct from ethnocentrisms.

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[114] Young-Bruehl, E. *The anatomy of prejudices.* p. 187. Other pertinent distinctions, for example, are
that ethnocentrisms are "present-oriented" prejudices directed against real groups with real histories, social
traditions, etc. while orecticisms are prejudices directed against "imaginary or constructed groups", "set on
the future," "oriented toward the body and characterized by constant body referencing," and involving
"partial identification with the group or groups against which the prejudice is directed." See pp. 198-9.

This distinction is important because Young-Bruehl claims that the ideologies of desire are tied to certain specific personality traits which, instead of having a cultural (authoritarian) basis, apparently are deeply embedded in the process of psychological development. Although physicians and other health care workers are often seen as having cultural authority by virtue of their roles and may show prejudice on the basis of that authority, Young-Bruehl demonstrates that psychological development plays a stronger and more dominant role in the development of prejudices. In the process of psychological development (according to Freudian theory and developed by Young-Bruehl), certain responses to situations in early childhood have a marked impact on later growth and relations with others in the world. These relations with others can be and often are influenced by ideologies of desire. Of the major orecticisms mentioned above and explored by Young-Bruehl, the one most pertinent to this discussion is the obsessional.[115]

Following Freud's initial analysis, Young-Bruehl claims that the obsessional character is dominated by the superego, characterized by obsessional traits, primarily anal in focus, and is sometimes displayed as anti-semitism, an example of a prejudice against an imagined or constructed group. There is fertile terrain here in which to explore prejudices in medicine, in my view, because of the nature of the characteristics Young-

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[115] The other orecticisms of significance are the erotic, characterized by hysterical traits, displayed as racism, id-dominated, and oral/phallic in focus; and the narcissistic, which is characterized by narcissistic traits, displayed as sexism or homophobia, ego dominated, and phallic in focus. See Young-Bruehl, esp. pp. 200-52. While these, especially sexism and homophobia, are interesting avenues for exploration in the culture of medicine, a broader discussion is beyond the scope of this chapter.

Bruehl associates with obsessional behavior. For example, the obsessional character is described by Young-Bruehl as "regular or rigid in routines, well organized and dedicated to devices of organization, habitually punctilious and punctual or at least habitual in spending time (even if this means habitually late), usually neat, aversive to dirt, and efficient." They are "ceremonial and may have neurotic ceremonies that 'magically' protect them, like hand washing and other forms of germ fighting and cleansing." Obsessionals sometimes "keep disturbing questions of truth or morality at bay by making them into legal or technical questions, as they keep important decisions at a distance by breaking them up into smaller and more technical parts." They are stubborn and "find it difficult to admit defeat." They "tend to identify with particular roles or social categories" and "feel secure in carrying out what they take to be its requirements." Obsessionals are "often attracted to large bureaucratic institutions where they can be...enormously powerful in a small sphere of activity where they can treat people like scum, dirt to be cleaned up, or like uncivilized children."[116] Of course not all physicians and health care workers are obsessional or if they are, display all of these traits, but it is interesting that the above characteristics seem to be so descriptive of the individuals involved in the scenarios of prejudice presented earlier.

Young-Bruehl claims that the psychological explanation for prejudice in obsessionals (and all orecticists) is that while ethnocentrists feel shame for their

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[116] Young-Bruehl, E. *The anatomy of prejudices*. pp. 210-19.

prejudices, "orecticists feel guilt, and then repress their guilt *with their prejudices*".[117]

The way that obsessionals in particular repress guilt and express prejudices is to "purge

themselves of polluting thoughts and desires by displacing them onto others, who then

are experienced as dirtying and assertively polluting."[118] Campo does exactly this when

he writes:

> "I too fell prey to fears of AIDS, each emaciated body I encountered
> seeming a potential version of me. I saw my own face over and over again in their
> faces, the dark complexions, the mustaches, the self-deprecation. Incapable as I
> was then of loving my patients, I hated them instead for reminding me that I was
> no different, that despite my medical knowledge I was not invincible. My well-
> rehearsed internalized self-loathing dominated my emotional response to them. I
> wished that they would hurry up and finish dying, all of them in one fell swoop,
> and that they would take all the dying there was left in the world with them when
> they did."[119]

Campo struggles with his ethnicity and his homosexuality throughout medical

school and his early medical career. These influences seem to give rise to and direct his

prejudices against AIDS patients based on repression of guilt. Likewise, when a

physician calls an elderly patient a 'gomer' or a 'crock', the statement may be a

psychological mechanism to assuage guilt or 'self-loathing' when one recognizes in

himself the potential to be old, incontinent, and unwanted. This guilt may then become

the locus for the expression of prejudice.

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[117] *Ibid.* p. 189. (emphasis in the original)
[118] *Ibid.* p. 214.
[119] Campo, R. *The poetry of healing.* p 28.

Judging an obese patient more harshly with regard to psychological characteristics may be based on one's own obsessional characteristics that strive to ward off obesity but recognize its potential. (Remember that the individuals that judged the obese 'model' most harshly were younger women of moderate weight). Refusing to provide care for an AIDS patient, as in the case of James that opened this chapter, may indicate an overwhelming fear of confronting the realities of a devastating disease that impacts primarily homosexual men and those who share needles in the use of injectable drugs. The members of this constructed group are seen as 'other' by the healthy, 'normal' physician. Dr. Krieger may also be experiencing guilt due to his privileged position in society and may be repressing his guilt by being openly prejudicial. These exploratory comments are meant to stimulate reflection on the topic of prejudices in medicine and their sources, and are not meant to represent a comprehensive psychological profile.

I have attempted to show in this section through the case study of James and the discussion of prejudice that prejudice can be a source of psychosocial domination in the practice of medicine and that it stems from both ethnocentrisms and orecticisms. Psychological mechanisms that encourage a rigid separation of self and other can be detrimental in the medical relationship because they have the potential to cause a patient to experience feelings of humiliation. Displaying prejudice consciously or unconsciously is a behavior borne of dominance in an asymmetrical relationship and can lead to

psychosocial humiliation. I have argued that physicians should become aware of sources of humiliation such as deeply held prejudices, and seek to confront them in daily medical practice. In this way, respect for patients may be enhanced as practitioners actively try to challenge sources of humiliation in the culture of medicine. Perhaps only then will the prospects for making medical practice more humane be realistic.

Conclusion

I have attempted to accomplish two goals in this work. First. I have tried to show that currently popular efforts to make medicine more humane by introducing techniques such as caring, empathy, and mutuality into medical practice are based on a superficial diagnosis of the problem and hence are misdirected and inadequate. These efforts are misdirected because they implicitly encourage medical practitioners and scholars in the medical humanities to take for granted certain problematic structures and customs in daily medical practice. Based on current approaches discussed in the medical humanities literature, the treatment plan for medical practice has focused on compensating for these problems by encouraging the application of purportedly humanistic techniques in practitioners' interactions with patients. While these techniques are perhaps partially useful, they are inadequate, in my view, to address the enormity and complexity of the task at hand and can therefore only serve as temporary bandages. This approach merely treats the problem symptomatically and does not attempt to discover the underlying source or cause. Hence there is a need for a new diagnosis of the nature and cause of difficulties between doctors and patients in modern medical practice. For such a diagnosis to be of value, it must explain why certain problems in the doctor-patient relationship

appear to be intractable and why previous efforts have been misdirected and only

marginally useful.

Second, in providing such a diagnosis, I have focused on the doctor-patient

relationship as the site of various forms of medical domination. These forms of

domination give rise to varieties of humiliation that may, in practice, injure the self-

respect of patients. Using case studies, I have attempted to show that forms of

domination and humiliation exist on at least three general levels in our medical culture:

institutional, technological, and psychosocial. I have argued that because significant

discussion of the concepts of domination and humiliation has been absent from literature

describing the nature of problems that impede the doctor-patient relationship and

possible solutions, these factors should be considered in the course of seeking a better

diagnosis of the problem. Once a more accurate diagnosis is made, a correspondingly

more realistic and useful treatment plan can be developed and integrated into medical

practice. Because these powerful influences on the medical relationship are pervasive yet

seldom discussed in the medical humanities literature, there is thus a need to re-educate

practitioners to question the utility of commonly suggested approaches to making

medicine more humane. By recognizing and critically examining the pervasive forms of

medical domination as well as thoughtfully considering their ramifications in daily

practice, concerned practitioners can perhaps strive individually to reformulate a missed

diagnosis. Consequently, they may be inspired to recognize and challenge medicine's

humiliations.

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