Compassion as a basis for ethics in medical education

Carlo Leget, Gert Olthuis

J Med Ethics 2007;33:617–620. doi: 10.1136/jme.2006.017772

The idea that ethics is a matter of personal feeling is a dogma widespread among medical students. Because emotivism is firmly rooted in contemporary culture, the authors think that focusing on personal feeling can be an important point of departure for moral education. In this contribution, they clarify how personal feelings can be a solid basis for moral education by focusing on the analysis of compassion by the French phenomenologist Emmanuel Housset. This leads to three important issues regarding ethics education: (1) the necessity of a continuous attention for and interpretation of the meaning of language, (2) the importance of examining what aspect of "the other" touches one and what it is that evokes the urge to act morally and (3) the need to relate oneself to the community, both to the medical community and to collectively formulated rules and laws. These issues can have a place in medical education by means of an ethical portfolio that supports students in their moral development. First, keeping a portfolio will improve their expression of the moral dimension of medical practice. Second, the effects of self-knowledge and language mastery will limit the pitfalls of emotivism and ethical subjectivism and will stimulate the inclination to really encounter the other. Third, it will show medical students from the start that their moral responsibility is more than following rules and that they are involved personally.

Emmanuel Housset, who published a remarkable study in which he reflects on compassion as a basis for morality.¹ Then we shall clarify how we think this approach can be made viable for professional education during internships.

ETHICS FOR UNDERGRADUATE MEDICAL STUDENTS

In teaching and discussing medical ethics with medical students, one meets a number of barriers.² Some of these are related to the age of the students. Aristotle noticed long ago that good ethical deliberation requires a certain age. More fundamentally, however, there seem to be four widespread ideas that hamper ethical conversations before they have really begun. These ideas are tied to certain moral presuppositions in contemporary North Atlantic culture.

The first widespread presupposition is that ethics is a matter of personal feeling. As one of our students put it, "Like all ethical points of view it is a matter of personal feeling and belief and not of scientific foundation." The problem of an emotivist viewpoint such as this is that morality becomes a private matter without any political (in the philosophical sense) dimension. Those who hold this view withdraw themselves into their private universes, unwilling to acknowledge the influence of the culture by which they are surrounded.

The second presupposition is that of students who think that some issues have no ethical dimension because they are already covered by legislation—that people are entitled to think about ethical subjects according to their beliefs, as long as they do not break the law. The problem with this viewpoint is that it overlooks the inter-relation of ethics and law. Both in the Netherlands and in Belgium, for example, there is a clear relation between public morality and legislation as regards end-of-life matters.³ For many students, however, it is difficult to understand the relation between personal convictions and the community.

A third problem is the widespread consequentialistic point of view by which the meaning of an act is limited to its consequences. Many students find it hard to distinguish between putting an end to life (the physician inducing death) and taking care until the end of life (the disease inducing death). Although they admit that the distinction is vital in the legal difference between a natural and an unnatural death, in the end they think there is no moral difference, especially when a patient is severely suffering.

A fourth way in which the ethical conversation can be frustrated is when students say that their conviction is based on their religious belief. In the

When first-year medical students are asked why they have chosen to study medicine, they often express a desire to help people. This motivation can be considered an important source for both morality and moral education. To our knowledge, however, this source is hardly tapped in the medical curriculum. We feel that this is peculiar, since being a physician is a demanding profession as regards ethics and emotions. It is all the more strange knowing that many medical students (and even physicians) consider medical ethics an enterprise that has little relevance to their professional work.

In this contribution, we aim to reflect on the inter-relation of some issues that have been isolated from one another, with the result that both the professional and moral education of interns and the place of ethics in the medical curriculum have become problematic. We shall begin with some experiences with medical education in the preclinical phase. These experiences lead to the question as to what the foundation of ethics can be. We shall discuss this question by reference to the work of the French phenomenologist

See end of article for authors' affiliations

Correspondence to: Carlo Leget, Radboud University Nijmegen Medical Centre, Department of Ethics, Philosophy and History of Medicine, 137 EFG, PO Box 9101, NL - 6500 HB Nijmegen; c.leget@efg.umcn.nl

Received 7 June 2006
Revised 25 September 2006
Accepted 2 October 2006

Netherlands, religious convictions are respected among medical students. This respect, however, is connected with a negative concept of freedom that does not lead to a real conversation among students. The idea of a community is understood as a collection of individuals who do not bother one another and are free to believe what they want as long as they do not harm others. Moreover, this religious domain is not open to reasonable debate, contrary to what many students in our secularised country think.

This short sketch introduces some important themes that are important for medical ethics education. The relation between reason and emotion is important for young physicians who are confronted with moving events, because it raises the question as to what extent emotions may have an impact on moral decisions. The idea of the community is relevant to the institutional context in which young physicians learn to develop their professional attitude. The subject of the meaning of actions is related to the symbolic dimension of medical actions that students should be aware of. The issue of respect is important as regards the basis of the relationship between physicians and patients.

As we said, the idea that ethics is a matter of personal feeling is the most fundamental dogma. Accepting its firm roots in contemporary culture, in this contribution we shall clarify how personal feelings can be a basis for moral education by focusing on the analysis of compassion by the French phenomenologist Emmanuel Housset.¹ Much has been written on the role of compassion in ethics.⁴⁻⁷ The challenge Housset presents is that he proposes to make compassion a basis of morality after a subtle phenomenological analysis. At first sight, this is a precarious enterprise—for those who are familiar with the history of philosophy, and also for those who speak with physicians and patients.

UNDERSTANDING COMPASSION

A first set of reasons that disqualifies compassion as a solid basis for morality is related to compassion as an emotion. Suddenly coming up as a feeling, compassion has a great impact on our thought and presents itself as an urgent factor that touches our moral intuitions. How long-lasting compassion really is remains to be seen. The emotion can rise and disappear like burning straw. Its inevitability, however, is in conflict with the fact that morality is based on freedom, choice, discernment, decision and reason. This raises the question, can compassion be a direct source of morality, not being based on human freedom? What should we make of this instinctive reaction that endangers our autonomy and reasonableness?

The second reason why compassion does not seem to be a solid basis for morality is connected with the position of the other person. Compassion seems to be a sort of self-affection by which no real relation is established. The other person's misery that affects me is not really the misery itself, but my appreciation of this misery. Thus, I feel miserable because of my own appreciation. This means that primarily I am involved with myself, and this is an egoistic enterprise. There is no real encounter between the person who suffers and the observer who is confronted with suffering.

If compassion were to play a fundamental role in ethics, this would require a specific relation between emotion and reason on the one hand and the relation to other persons on the other. Housset, in his phenomenological analysis, shows that there are many ways in which compassion can be a poor basis for morality. But he also stresses that this should not prevent us from understanding the importance of the originary experience of compassion. This experience is harder to grasp than we usually think. Jean Jacques Rousseau, for example, has shown that morality is more than a feeling but that it cannot function

without emotions. The problem of his philosophy, however, is that he is a prisoner of the idea that emotions are passive and reason is active. According to this opposition between emotion and reason, he cannot but see compassion as a passive feeling that becomes morally relevant only when reason brings it to a higher plane. In the end, however, this compassion of Rousseau remains a self-affection of reason by which the other person is not really encountered, unless in so far as the image of the other person is construed by reason. Can this self-affection ever be overcome?

In a clear preface to Housset's book, his former teacher Jean-Luc Marion situates the analysis of his pupil in a broader perspective, departing from the question as to how the other can appear or—in terms of phenomenology—become a phenomenon. Marion distinguishes four possibilities. The first way is by intentionality, as with any other object. The problem of this appearance is that the other person is reduced to what is grasped by my intentionality. The second way is when the other person is intentionally appreciated for that person's individual and unique properties. Although there is no object-reduction of a subject here, this second way still does not arrive at the other person. One ends up with the properties of the other person, and no human being is equal to his unique properties. Thus, both approaches fail by attempting to reach the *alter ego* by departing from the *ego*. A third way is that proposed by Emmanuel Lévinas. Here the other manifests himself departing from himself and imposing his point of view on me. The face of the other and his look result in the address, "Thou shalt not kill". This address results in a radical and universal deontology of the other. The problem, however, is that this third way results in a radical appeal that leads to universality and—again—not to the individual person. The only way in which the other person appears departing from an individualised *alter ego* and is known as such is by compassion as an originary experience—the fourth possibility.

Housset warns against the widespread error by which compassion is considered to be derived from something else: as an emotion that is useful for the survival of the species, as a product of our imagination, and so on. He thinks these are explanations that make the mistake of explaining before understanding: they overlook the fact that compassion is an originary experience that remains a mystery in our thinking. The great mystery remains the following question: how is it possible that suffering that is not mine can upset me and tie me to what is morally good?

In order to approach the mystery, Housset builds on Malebranche's analysis of the inner self. He clarifies how at the core of the inner feeling in its most subjective form there, is always a moment in which I am withdrawn from myself. In this sense, the structure of compassion reveals the structure of each feeling: someone who has the experience of feeling something is simultaneously outside himself and having an inner experience. Thus, compassion happens inside me and opens up to the outside world. The paradox in this originary experience of compassion is that I discover myself to accept access to the other individual person as someone who causes me pain and sorrow.

What happens in compassion can be appropriated in a second movement of intentional activity. This moment of subjectivation, however, is a second movement, based on an originary, non-intentional experience. Thus, compassion is not something that I produce inside myself by self-affection; it is something happening inside me. When it happens, the distinction between my inner self and the outside world vanishes.

Compassion is a premoral emotion insofar as it is an originary experience of someone else's misery. The emotion becomes a moral emotion at the moment when the other

person's misery is consciously accepted. This, again, is a morally sensitive process. Noticing someone else's misery without appropriating it is a matter of respect. But do we not run the risk of losing contact with the other person? Is it not true that the unconditional openness to the otherness (*alterité*) of the other person can be a way of avoiding a real encounter? Of course the word *respect* can be the name of keeping other persons at a distance. Real respect, however, entails the acknowledgement of the otherness of the concrete other person. Housset connects this with the birth of moral conscience. In the diffidence that is the answer to the otherness of the other person, I respond to a command that does not originate in myself. This opens up the domain of freedom and ethics.

Thus, compassion is an important source and basis of moral education. First, it helps one to remain close to one's inspiration and motivation: by "being moved", one is set in motion towards morally good action. Second, it remains close to the suffering of a concrete and unique other person, without the risk of a universal appeal that results in losing sight of both the concrete other person and one's own limitations. Third, it helps one to experience, understand and stay aware of the non-negotiable, non-appropriable and non-calculable core of morality.

ETHICS FOR UNDERGRADUATE MEDICAL STUDENTS REVISITED

How can Housset help in confronting the problems that we discovered in teaching medical ethics to undergraduate medical students? In the first place, Housset shows that words are valuable and that inflation of words hampers discussing ethics. The word *respect* is easily used in discussions, but it can have various contents. The same goes for *compassion*. What we need in discussions is a permanent hermeneutics of these words. Such a hermeneutics is an exercise in simultaneously listening well and thinking precisely. Physicians are not required to become philosophers, but they should be able to listen very carefully and be aware of the multilayered content of words. And to understand the inner feelings of their patients and themselves, they need a certain level of education and refinement in their thinking.

In the second place, Housset's analysis shows that compassion is not a degrading emotion, but a source of morality. Although it is acknowledged that ethics is a matter of one's own feeling and belief, one's self cannot be thought of as an isolated core of subjectivity. Real compassion is no self-affection but—as we have seen—a coinciding of otherness and intimacy. There is a real connection with the world that enables morality. It is important to be aware of the fact that when one is touched by someone else's misery, the otherness inside oneself is revealed. The moment that one is struck by real compassion cannot be decided as an intentional act. Nevertheless, one is touched in one's most subjective inner core. Of course, there is always the possibility of cutting oneself off to feelings of compassion, on the one hand, or enjoying self-affection, on the other. Both options, however, are perversions of the originary experience.

All this means that compassion is the foundation of a form of community. In a premoral sense, this is the case because—as we have seen—the originary experience of compassion reveals that I am connected with another person, even to the degree of accepting that person's pain and sorrow, before I even realise it. By consciously accepting the other person's misery—the moral act of compassion—I am accepting the premoral sense of community. Subsequently one discovers a moral responsibility for how this premoral community is fostered, threatened or denied by the institutional dimension of society. Because of that personal responsibility, morally speaking, as a physician

one cannot hide behind the law or the institutional context of the hospital. There is always a moral choice in adopting a role, a position or a profession.

PROFESSIONALISM AND ETHICS

During their training, medical students have traditionally been confronted with a radical switch from the preclinical to the clinical stage. Some medical schools are seeking to ameliorate the radicalness of the switch by introducing integrated curricula with clinical experience beginning in year 1 and intensifying towards the senior years. As interns, for the first time students are being addressed in their role as a doctor with accompanying responsibilities and "real" moral problems. Interns can perceive feelings of uneasiness regarding certain treatments or regarding supervisors or patients. Many students experience a need to be able to act in a morally responsible way. However, as we notice in clinical ethical training, it often remains a problem for them to adequately express what they feel and think. How, then, can ethics education contribute to the ability of students to express and reflect on both their doubts and uneasiness, and on their "moments of growth"?

Whoever reads about the place of ethics in medical education comes across a near unanimous judgment: ethics education is essential for medical students, but several factors prevent it from getting the place it deserves.⁸⁻¹² We have mentioned some firmly established cultural presumptions of students. In addition, the curricula are filled with courses oriented towards knowledge and skills and producing a heavy workload and time constraints. The emphasis is on "doing", which leaves little space for the distancing and reflection that ethics requires. Various solutions have been proposed: changing the student selection process, broad ethics education during undergraduate and clinical training (aimed at both theory and argumentation), more support of the institutions, creating an ethical learning climate, less immersion and more (free) time for reflection, better evaluations in bedside teaching, a more efficient organisation of ethics education, and more ethics deliberations during internships. The essential question for us, however, is how to prevent medical students' originary desire to help people from being blurred during their training. How can that originary motivation serve as a starting point for the moral development of doctors-to-be, interns who are able to express and reflect on what they encounter in their experiences in practice?

PORTFOLIO LEARNING

Moral understanding—ethics—has to do with perceiving.¹² In the same way as caring is an activity that can be learnt, perceiving the moral dimension of medical practice is also a skill that can be acquired to a greater or lesser extent. While the direct relationship between ethics and the clinic is emphasised in the medical curricula, Housset's analysis makes clear that the ability to perceive that moral dimension is also connected with an understanding of one's own moral consciousness. His phenomenology of compassion reflects that a better understanding of what moves me as a medical student or an intern (what evokes my desire to help others?) makes me more aware of the otherness of the other and thus teaches me to see what I can mean for that other person, also from a moral perspective. In other words, Housset's analysis shows that the person I want to be (someone who helps others) is closely related to the way I practise medicine. Good professionals are eventually "born" in practice, but in a moral respect, that process will be improved when it is clear that personal life is closely related to the desire to help other people and when one has developed the ability to care for oneself through self-reflection and an understanding of one's own moral consciousness.¹² How can that be integrated in day-to-day medical education?

The appropriate educational tool for that seems to be a "portfolio". This may be described as a collection of evidence that is maintained and presented for a specific purpose.¹³ In medical ethics education, that purpose may be to give insight into critical events in the moral development of a medical student. This development can be stimulated by both fictitious events (films, books) and personally experienced ones (first experiences in practice, first anamnesis). A portfolio is a narrative undertaking that embraces two important dimensions: it reflects the education evolution of the author and it contains a chronological series of commentaries and personal notes on (both fictitious and real) patients and their families.¹⁴

Several studies demonstrate that keeping a record of personal reports and reflections on what one encounters in practice from the very start of medical school is meaningful as a continuous stimulus for professional development and increases self-knowledge.¹³⁻¹⁷ Self-knowledge, as we argued on the basis of Housset's analysis of compassion, is the basis of personal moral development. Keeping an ethical portfolio from the start gives students the opportunity to monitor their own moral learning and to understand how they relate to others (both patients and colleagues). Thus the *learning process* is central to portfolio learning, and not so much a result of studying. With an ethical portfolio that has been created in the undergraduate years, internships can be more instructive in a moral respect than before. The mere fact that students will be able to better express what they were engaged with in those years will contribute to that.

Given the great number of medical students and the results-oriented approach that many of them have, the use of portfolios alone can never guarantee that the originary experience of compassion is developed as a basis for moral development. Since morality is based on human freedom and maturity, a portfolio build on compassion can succeed only in a climate of confidence and respect, where good role models are willing to invest in personal contact. Only then can the originary experience of compassion develop into a virtue that, as a moral attitude, is a part of the personal and professional identity of the physician.¹⁸

Authors' affiliations

C Leget, G Olthuis, Radboud University Nijmegen Medical Centre, Department of Ethics, Philosophy and History of Medicine, Nijmegen, The Netherlands; g.olthuis@efg.umcn.nl

Competing interests: None.

REFERENCES

- 1 Housset E. *L'intelligence de la pitié: phénoménologie de la communauté*. Paris: Cerf, 2003.
- 2 Leget C. Avoiding evasion: medical education and emotion theory. *J Med Ethics* 2004;**30**:490-3.
- 3 Schotsmans P, Meulenbergs T, eds. *Euthanasia and palliative care in the Low Countries*. Leuven: Peeters, 2005.
- 4 Duyndam J. *Denken, passie en compassie: tijdreizen naar gemeenschap*. Kampen: Kok Agora, 1997.
- 5 Nussbaum MC. *Upheavals of thought: the intelligence of emotions*. Cambridge: Cambridge University Press, 2001.
- 6 Nussbaum MC. Responses. *Philos Phenomenol Res*, 2004;**68**:473-86. Answers the critiques of Aaron Ben-Ze'ev, Nancy Sherman and John Deigh in this issue..
- 7 Weber M. Compassion and pity: an evaluation of Nussbaum's analysis and defense. *Ethical Theory Moral Pract* 2004;**7**:487-511.
- 8 Loewy EH. Education, practice and bioethics: growing barriers to ethical practice. *Health Care Anal* 2003;**11**:171-9.
- 9 Singer PA. Strengthening the role of ethics in medical education. *CMAJ* 2003;**168**:854-5.
- 10 Perkins HS, Geppert CMA, Hazuda HP. Challenges in teaching ethics in medical schools. *Am J Med Sci* 2000;**319**:273-8.
- 11 Novack DH, Epstein RM, Paulsen RH. Toward creating physician-healers: fostering medical students' self-awareness, personal growth, and well-being. *Acad Med* 1999;**74**:516-20.
- 12 Andre J. Learning to see: moral growth during medical training. *J Med Ethics* 1992;**18**:148-52.
- 13 Mathers NJ, Challis MC, Howe AC, et al. Portfolios in continuing medical education—effective and efficient? *Med Educ* 1999;**33**:521-30.
- 14 Finlay IG. Portfolio learning: the humanities in medical education. In: Evans M, Finlay IG, eds. *Medical Humanities*. London: BMJ Books, 2001:156-66.
- 15 Gordon J. Assessing students' personal and professional development using portfolios and interviews. *Med Educ* 2003;**37**:335-40.
- 16 Lonka K, Slotte V, Halttunen M, et al. Portfolios as a learning tool in obstetrics and gynaecology undergraduate learning. *Med Educ* 2001;**35**:1125-30.
- 17 Finlay IG, Maughan TS, Webster DJT. A randomised controlled study of portfolio learning in undergraduate cancer education. *Med Educ* 1998;**32**:172-6.
- 18 Gardiner P. A virtue ethics approach to moral dilemmas in medicine. *J Med Ethics* 2003;**29**:297-302.

Correction

There was an error in the July issue of the journal (English V, Hamm D, Harrison C, et al. Ethics briefings. *J Med Ethics* 2007;**33**:433-4.) The authors incorrectly stated that euthanasia is currently legal in Sweden. The article should have read that euthanasia is currently legal in Switzerland.

doi: 10.1136/jme.2007.021071corr1