Compassionate Response to Human Suffering: A Neglected Issue in Health Care Reform

James F. Bresnahan

The values that contemporary medical ethics espouse should be recognized as essential to the health care which should be made available to those presently without access.

At this point in our nation’s history, we have a recognized need to reorganize the medical care-giving sector of our society. This sector fails to deliver its services in a just manner in that it does not provide fair access to basic health care services for all members of our society. The 1992 federal elections demonstrated that reform toward this end has become politically and socially urgent. Many have long thought it is morally obligatory for our society to pursue this sort of reform. Indeed, it may well be that failure to achieve such a reform will produce a threat to the domestic peace of the United States. The only question now seems to be: “What shape will this reform take?”

The critical factors in making health care access reform both politically feasible and financially successful are economic in nature. Specifically, there is a great concern to limit or at least control increases in health care costs. Broadening access to health care while controlling its cost necessarily implies some form of limiting or rationing of health care services. There appears to be wide agreement that a fiscally feasible plan for universal access will not guarantee to everyone all of the health care services that a wealthy individual might want and be able to purchase in a free market. We should also consider a less often articulated concern as we seek to achieve universal access to health care. As I have previously argued, the first prerequisite of a concrete proposal to broaden access to health care should be that it preserve, if not enhance, the historic character of health care-giving as a fundamentally personalized, compassionate response to human suffering, especially to the suffering of the most disadvantaged. In other words, the reformed health care system should maintain or enhance the current system’s humane qualities.

Rather than demonstrating first a capacity for cost control, proposals for reform should be able to show how they will preserve the health care sector as an expression of our society’s fundamentally altruistic commitment to relieve human suffering. In this era of high-technology medical care and increased bureaucratic organizational structures needed to manage a complex division of labor, I discern a persistent trend to depersonalize health care-giving in the name of technical efficiency. We overemphasize the impersonal in the name of professionally-objective intervention to effect a cure. The increased attention to medical ethics in the last twenty years has been, at least in part, a response to this depersonalizing trend. I fear that if our quest for health care reform focuses primarily on cost control, it will only intensify trends which dilute the role of personal compassion in health care-giving; indeed, such an approach may even further brutalize health care-giving.

James F. Bresnahan, S.J., J.D., LL.M., Ph.D., is Co-director of the Ethics and Human Values in Medicine Program and a Professor of Clinical Medicine at the Northwestern University Medical School in Chicago, Illinois.
In what follows, I propose to explore evidence that the present demand for achieving universal access to health care expresses the altruism intrinsic to the religiously-motivated moral ideals of health care-giving that has developed historically in the West and as these ideas have carried forward into our modern secular era. I emphasize that much of the drive for greater access to health care comes from the health care practitioners themselves and is linked to the health care ethic of compassion.

I also call attention to the contemporary medical ethics movement within our health care sector as it works to preserve the medical moral tradition of compassion even as we experience contemporary dehumanizing pressures. These pressures derive from medical high technology and its companion, a bureaucratic organization of the division of labor required by high technology medical care-giving. We need conscientious care for the dying as much as cure-oriented intervention of the kind that seems to preoccupy significant numbers of health care persons and others in our society. We must avoid health care reform that further diverts energy and resources from labor intensive, humane responses to suffering in favor of depersonalized style of health care access.

I claim that we must attempt to broaden access to the health care giving sector of our society, but that in this time of economic constraint, we must also recognize that cost-control can threaten further to diminish the human, personalized ingredient in health care. If we fail to challenge proposed reform measures for their unresponsiveness to the humane aspects deriving from our historic heritage of compassionate health-care giving, we will be in danger of negating the central purpose of this proposed reform: equity for persons in need. We will be ensuring that reform in the name of justice eventually will fail. I believe, then, that we should treat the personalized compassion of health care giving as a non-negotiable element of reform. Compassion in health care giving, as a principal social carrier of altruism and personalism in our culture, legitimizes personalized compassion in the public life of our nation.

Justice and Reform

Reform proposals aimed at opening access to health care emphasize human need. Many Americans who need fair access are presently uninsured (an estimated 35 million) or are under-insured (an estimated 20 million). These persons cannot pay for health care in the way that the vast majority of persons now can and must, because of the high cost of diagnosis and treatment in health care. Persons who are caught in "job lock" because of pre-existing illness limitations on health insurance at the job to which they wish to change also need fair access. As a result, many people are denied access to a sector which clearly improves the length and quality of life. Today, however, access to health care is viewed as a basic right. In my opinion, such a view is required of our society as a matter of social justice.

The various proposals for health care reform assume that limited access to health care ignores or violates the moral requirement of justice. Whether articulated as principle or as virtue. Given the enormous advances in the capacity of medicine to improve both quality and length of life, the demands of justice are widely interpreted to mean that if we continue to exclude so many people who are in need of health care from ready access to the persons and institutions which provide it, we all become morally responsible for an injustice to them. What this implies, therefore, is a corporate responsibility for failing to repair systemic or institutional injustice when we become aware of the injustice, and recognize feasible ways to repair it, but still fail to take the needed measures.

I start from the thesis that the contemporary thrust for reform of health care in the name of justice arises now, first of all and most radically, from within the health care milieu itself. It is not a demand merely from outside. Illustrative of this is the fact that an entire issue of the principal journal of conservative-minded organized medicine was recently devoted to a variety of proposals for reform of health care, and a plethora of articles has been published in medical journals since then.

I wish to press the question about how reform in the name of justice will ultimately impact the moral idealism of the health care sector. To do so demands our attention to the historical heritage of our health care communities as well as to recent analyses of the health care milieu as we know it today.

Early History of Health Care-Giving in the West and the Development of Moral Ideals

We are fortunate to have a number of excellent studies on the history of health care-giving as well as on the characteristics of the health care sector today. These sources chronicle the development of care for the indigent and the motivation behind it, and record the almost universal sense of responsibility to participate in this activity. This is the history of care-giving as a function of various
communities — not only religious but also economic or civic — in the Christian era of the West.

We should look at health care-giving in broader terms, as a social activity more widespread than doctoring in the formal, professional sense, to find influences on our contemporary health care sector, including the modern profession of medicine itself. This historical perspective illuminates the origin of the contemporary moral ideal of practical health care-giving,19 that is, a compassionate concern to relieve suffering as a fundamental goal.20

William H. McNeill, the historian, makes observations of great interest in our quest to understand the moral heritage of contemporary health care institutions in his engaging study of the important impact on human history of “microparasitism” (invasion by disease entities), as opposed to “macroparasitism” (human intereners waging war, oppressing, enslaving, and exploiting fellow humans). He discusses the early history in the West of religiously inspired response to epidemic disease, especially the plague. For example, he examines the spread of infectious disease by the Roman imperial conquests and the subsequent invasions of migrating populations into the Roman Empire to populations lacking adequate immunity to those diseases. With regard to the spread of Christianity within the Empire, McNeill states:

One advantage Christians had over their pagan contemporaries was that care of the sick, even in time of pestilence, was for them a recognized religious duty. When all normal services break down, quite elementary nursing will greatly reduce mortality. Simple provision of food and water, for instance, will allow persons who are temporarily too weak to cope for themselves to recover instead of perishing miserably. Moreover, those who survived with the help of such nursing were likely to feel gratitude and a warm sense of solidarity with those who saved their lives. The effect of disastrous epidemic, therefore, was to strengthen Christian churches at a time when most other institutions were being discredited.21

McNeill goes on to speak of the importance of this ethic of care as a practical expression of solidarity that gave meaning to life in times of plague and war. In contrast, McNeill also discusses the claims of Christian apologists, who describe the pagan tendency to flee from the sick and injured.

Christianity was, therefore, a system of thought and feeling thoroughly adapted to a time of troubles in which hardship disease, and violent death commonly prevailed. . . . By comparison, Stoic and other systems of pagan philosophy, with their emphasis on impersonal process and natural law, were ineffectual in explaining the apparent randomness with which death descended suddenly on old and young, rich and poor, good and bad. In any case, it seems quite certain that the altered incidence of microparasitism upon Roman populations after A.D. 165 had a good deal to do with the religious and cultural history of the empire as well as with its social and political development.22

The ethic of care to which McNeill alludes here involves a moral ideal of self-risking compassion for the suffering — an ideal to which Christians did not universally subscribe, but which motivated the development of social institutions and practices shaped by this moral ideal.

It is not possible here to trace the development of the institutions for care of the sick under religious auspices that operated throughout the centuries. It is enough to note here that the ideal of compassionate hospitality developed not only as a characteristic of religious institutions (monasteries and convents had infirmaries and guest houses for ailing poor) but also inspired the founding of such institutions as Lazar houses (for lepers), hospices for the sick, "hôtels de dieu," and hospitals, often under the sponsorship of guilds and other non-ecclesiastical social groups. Compassion for the ailing poor is a fundamental element of social life, both urban and rural, from the Dark Ages, through the Renaissance, and into modern times.

This religiously-inspired tradition of generous response to persons experiencing the crisis of illness and injury extended even to self-risk when caring for the infectious sick and dying, even during time of plague. Thus we find in the Patriotic era the tenet that surrendering life in the practice of charity (love) when a person died from disease contracted in caring for the sick should be regarded as martyrdom.21 Parallel historical development of an ethic of care and an ideal of compassion for the sick can also be traced in Judaism24 and in Islam.22

The expectation that communal efforts to provide care should reach any and all persons in desperate need — universal access, as we call it — was fundamental to this entire historical tradition of health care provision in Europe, and indeed, in the entire Mediterranean world. It is true that, throughout this history, university-trained physicians were available mainly to the upper classes and those among the developing urban middle class with wealth whom doctors visited in their homes. It is also true that places of care for the poor provided by religious houses or guilds or municipalities constituted a kind of lower tier of health care.25 Nonetheless, the difference in the efficacy of health care then available to the rich, in contrast to that available to the poor, probably was due less to the expertise of these primitive physicians than to the greater resources
of food, shelter, and care of servants available to the rich.

This long history shows the constantly recognized moral obligation of communities to make available compassionate care to the ailing poor by devoting resources to make a basic health care available to the poorest and neediest. Linked to this moral obligation as well was the moral ideal of self-risking attendance to the sick. Such action expressing one's religiously inspired beliefs was a form of "orthopraxis" to be respected and lauded if not always dared to be undertaken.

Modern History of Health Care in England and North America

Paul Starr, Charles E. Rosenberg, and Rosemary Stevens, in their studies of modern health care, take note of the continuing presence in our time of a moral ideal of compassionate care for those who suffer. They argue that this continuing moral tradition includes, in varying degrees, an ideal of responding without discrimination to desperate human need, even at risk to the care-givers. All three describe the transformation of hospitals in the nineteenth and twentieth centuries into "doctors' workshops" — places of commercial activity increasingly dependent on large investments of capital and of labor. As a result, hospitals are subject to the influences of the business and commercial worlds, as well as government brokering of tax funds. But they point as well to the moral idealism which, though more and more secularized, has continued to express itself in the structuring and the conduct of these institutions.

Rosenberg traces the nineteenth and early twentieth century transformation of hospitals from places primarily for care of the poor to places welcoming paying patients. During this period doctors, especially surgeons, are the essential actors. They remain independent of the hospital administration and impose their standards of quality on the hospitals through their professional medical organizations.

The influence of explicit religious motivation in hospital administration declines as clinical skill and commercial pressures become the primary determinants of hospital activity. Yet Stevens, looking at the more recent past and present, speaks of the linked concepts of the "community role" and "voluntary mission" that continue to appear in the rhetoric of the leadership of the modern hospital. While this rhetoric appears more often in non-profit hospitals, it also occurs in those run for profit. Starr's account of the "making of a vast industry" captures the tension of commercial interests and scientific research interests, not only with the professional clinical priorities of physicians, but also with the voluntaristic expectations and motivations of the general public and of the hospital labor force working to care for patients.

The tradition of altruistic service, therefore, continues to play its role even as the modern American hospital also becomes a place of scientific discovery and technological innovation as well as a commercially productive "body repair shop," selling its services in the marketplace. I believe that this tradition of altruistic service still makes care-givers in our time irrepressibly uncomfortable with the exclusively technical delivery of treatment in response to human suffering.

The idea of patient autonomy which has dominated the development of modern bioethics within contemporary health care implies a deep concern to serve people because of their critical need, not merely to repair organ systems or to earn money. This ideal of compassion sits uncomfortably with the large-scale exclusion of people known to be in desperate need of the health care. As a result, we have seen the calls for universal access from within the ranks of health care-givers as an expression of a search for consistency in practicing the traditional moral ideals of compassion for all who suffer.

The Influence of the Recent Cultivation of Medical Ethics Within Medical Care and Medical Education

If the contemporary call for universal access to basic health care is linked, as I believe it to be, to the moral ideal of compassionate health-care-giving, then contemporary medical ethics ought to guide our health-care reform. The values that contemporary medical ethics espouse should be recognized as essential to the health care which should be made available to those presently without access. The values espoused by the recent ethics in medicine movement should be viewed as an essential ingredient of health-care-giving that should never be sacrificed in the name of cost control.

Concerns in health care education and practice about using ethical dialogue to preserve compassionate care are clearly illustrated by questions surrounding appropriate care for the dying. In the struggle to deal well with human dying, we find central themes
We cannot dispense with this moral ideal of responding generously to people in desperate need.

Conclusion
We have become so preoccupied with achieving a worthy goal — justice in access to health care — that we may overlook some possible dangers in reform. If the means further depersonalize health care, they will gravely impair the spirit of compassion found in the health care services that we seek to make more available to everyone in our society. Certainly, we have to test each proposed reform to assure ourselves that it will reach more people now excluded who are in need of the technical services of our health care sector. More importantly, however, each reform must preserve or enhance the compassionate characteristics that survive and enable the persons and institutions in our present health care-giving sector.

We cannot dispense with this moral ideal of responding generously to people in desperate need. It would be wrong to characterize this ideal as a merely anachronistic morality that must be pushed aside to achieve cost control. The morale of our health care milieu, insofar as it retains its moral concern for the good of the patient as a person, is at stake.

Health care must continue to mean accepting more in costs. Health care-givers must always strive to be more responsive to the needs of suffering human beings than to deserts of the rich and powerful in our society. Compassion, therefore, remains the essential element of what we really mean by "health care." If the means of our reform destroys this moral idealism, the reform will destroy more than it merits. Greater justice would be a short-lived dream, abandoned while the desperate struggle of the marketplace or the dead hand of bureaucracy stifles the noble ideals cultivated over a millennium-and-a-half.

Notes
2. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research produced the report. 
need for fair access to health care for all); Making Health Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship (1982) (using clinically astute studies on patients' informed consent in health care decision-making and on the problems of such decision-making with respect to life-prolonging treatments); Deciding to FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS (1983) (also using studies on patients' informed consent in health care decision-making); SUMMING UP: THE ETHICAL AND LEGAL PROBLEMS IN MEDICINE AND BIOETHICAL AND BEHAVIORAL RESEARCH (1983) (indicating that after completing two years of work under President Carter and two years under President Reagan, the President's commission moved from "individual" ethics of patient-care-giver interactions to the "social" ethics of the care-giving sector of society).

3. Sometimes the primacy of cost control economics is taken for granted; sometimes it is explicitly discussed in relation to limitation of available treatments (rationing). See William L. Kissick, Rationing or Resource Allocation in Health Care?, 7 TRENDs IN HEALTH CARE L. & ETHICS 25 (1992); Anne R. Somers, Toward a Comprehensive Reform of U.S. Health Care, id. at 29; Steffie J. Woolhandler, A National Health Plan for the United States, id. at 40.

4. See DANIEL CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY (1987) and DANIEL CALLAHAN, WHAT KIND OF LIFE? THE LIMITS OF MEDICAL PROGRESS (1990) (discussing proposals for reforming health care). The proposed Oregon Plan for widening access to Medicaid benefits by enumerating both the medical interventions that will be covered and those that will be excluded from coverage explicitly embodies the need for rationing. See Charles J. Dougherty, A Conference Report: Setting Health Care Priorities: Oregon's Next Steps, 21 HASTINGS CTR. REP. 1 (Supp. 1991); David C. Hadorn, The Oregon Priority-Setting Exercise: Quality of Life and Public Policy, id. at 11.

5. See Charles J. Dougherty, Ethical Values at Stake in Health Care Reform, 268 JAMA 2409 (1992) (discussing concern about moral ideals of health care-giving); see also John W. Glaser, Revisiting U.S. Health Care: Some Priorities from a Biblical Tradition 7 TRENDs IN HEALTH CARE L. & ETHICS 47 (1992) (examining the need for "metanoia" (conversion) with respect to commonly-held attitudes about living in a world of limits, the responsibility of all for the common good, "rescue-mania" in our health care sector, compassion for the poor, and death of the enemy).

6. See James F. Bresnahan & K. M. Hunter, Ethics Education at Northwestern University Medical School, 64 ACAD. MED. 740 (1989); James F. Bresnahan, Ethical Dilemmas in Critical Care Medicine, in CASE STUDIES IN CRITICAL CARE MEDICINE 412 (Roy D. Cane et al. eds., 1990).

7. See STANLEY J. REIBER, MEDICINE & THE REIGN OF TECHNOLOGY (1978); THE MACHINE AT THE BEDSIDE: STRATEGIES FOR USING

Technology in Patient Care (Stanley J. Reiser & M. Anbar eds., 1984).


10. Id.

11. Id. at 275.

12. See SECURING ACCESS To HEALTH CARE, supra note 2, at 199-206 (containing the only dissent of one of the commissioners, signalling the controversial nature of moral claims made in the name of justice). A useful discussion of justice and its meaning for health care is that of Tom L. Beauchamp & James F. Childress, Principles of Bioethical 256-306 (3d ed. 1989).

13. Note that we may or may not acknowledge responsibility for creating the system's injustice in the first place, since it may have developed gradually. The justice with which we are concerned here is sometimes called social injustice insofar as it is concerned with fairness in the distribution of socially-created benefits through modification of social structures in a society. Sometimes this justice is called distributive justice insofar as the government tries to provide fair distribution of the benefits of the common good among all who contribute to that common good. We are not concerned here with what is usually meant by the term, "justice," i.e., "commutative justice," the justice which results between individuals or groups who are obligated to pay each one other what they owe.

14. See generally 265 JAMA 2437 (1991) (this issue, No. 19, contains over ten articles which concern uninsured and underinsured Americans).

15. For instance, the New England Journal of Medicine and the Journal of the American Medical Association, are two weekly academic journals most widely read by physicians seeking to keep up with the latest medical developments. During 1991 and 1992, a reader could hardly find a month of issues in which some discussion about how to achieve health care reform did not appear in these journals.

16. Dougherty calls the values about which I am concerned "intrinsic" (i.e., inextricably linked to the good moral health of the health care sector) as opposed to "instrumental" (i.e., necessary to attain what is intrinsically important to the good moral health of health care). The "intrinsic values" he enumerates are 1) "respect for the dignity of persons," 2) "caring in therapeutic relationships," and 3) "protection of the least well-off." See Dougherty, supra note 5, at 2409.

18. I am not referring to traditional histories of medicine as a profession, which concentrate on the story of the professional education and activity of doctors in the Hippocratic tradition. These histories often refer in passing, however, to the formation of health care-giving activities not involving physicians of medieval and renaissance periods.

19. I assume moral ideal, not moral obligation, must be the subject matter of ethical reflection. See LON L. FULLER, THE MORALITY OF LAW (rev. ed. 1969) (distinguishing between a "morality of duty" (or obligation) and a "morality of aspiration" (or ideal), and insisting on the relationship between these two reciprocally interacting moralities).


21. MCEINN, supra note 17, at 121.

22. Id. at 122-23.

23. Such behavior is understood to constitute a self-risking out of love for one’s needy neighbor, empowered by one’s love of God and one’s trusting hope in God’s eternal care both of neighbor and of self. See F. X. Murphy, Martyr in 9 NEW CATHOLIC ENCYCLOPEDIA 312 (1967). See also Karl Rahner, Martyrdom, in ENCYCLOPEDIA OF THEOLOGY: THE CONCISE SACRAMENTUM MUNDI 937 (Karl Rahner ed., 1975).


27. STARR, supra note 17; ROSENBERG, supra note 17; STEVENS, supra note 17.

28. STEVENS, supra note 17, at 9.

29. STARR, supra note 17.


31. See Dougherty, supra note 5; see Glaser, supra note 5.

32. See James F. Bresnahan, Catholic Spirituality and Medical Interventions in Dying, 164 AMER. & EUROPEAN L.J. 670 (1991); Bresnahan, supra note 6; Getting Beyond Suspicion of Homicide: Reflections on the Struggle for Morally Appropriate Care of the Dying under High Technology Medical Care, 8 TRENDS IN HEALTH CARE L. & ETHICS 31 (1993).

33. It should be noted that after considering the question of the patient’s informed consent in medical decision-making, the President’s Commission turned to the problem of discontinuing so-called “life-prolonging” treatments as the most neuragistic manifestation of the difficulties of making health care decisions about relative burdens and benefits of proposed medical interventions. See supra note 2.

34. In the first article, ten physicians presented the problem of inappropriate prolongation of dying and made suggestions about ways to constrain excessive death-prolonging treatment. Sidney H. Wanzer et al., THE PHYSICIAN'S RESPONSIBILITY TOWARD HOPELESSLY III PATIENTS, 310 NEW ENG. J. Med. 955 (1984). In the second article, eight of those original ten, plus four additional physicians, suggested that very exceptional cases could exist in which it would be ethically right for a physician to assist a dying patient in committing suicide. Sidney H. Wanzer et al., THE PHYSICIAN'S RESPONSIBILITY TOWARD HOPELESSLY III PATIENTS: A SECOND LOOK, 320 NEW ENG. J. Med. 844 (1989).


