Journal of Medicine and Philosophy, 0: 1–22, 2012
doi:10.1093/jmp/jhs007

Liars, Medicine, and Compassion

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This paper defends an account of compassion and argues for the centrality of compassion to the proper practice of medicine. The argument proceeds by showing that failures of compassion can lead to poor medical treatment and disastrous outcomes. Several case studies are discussed, exemplifying the difference between compassionate and noncompassionate responses to patients seeking help. Arguments are offered in support of approaching reports of persistent pain with a trusting attitude, rather than distrust or skepticism. The article concludes by suggesting educational improvements to encourage compassion.

Keywords: *compassion, distrust, lying, malingering, medical education, pain, trust*

The central aim of this paper is to draw wider attention among philosophers to an important and recurring problem in medicine: namely, the distressing predicament of many patients who seek help for pain, in particular, pain the cause of which is not immediately evident. Most broadly, I will argue here that training in the virtues should be part of a medical school curriculum. In particular, I will argue for the centrality of compassion in a right conception of a good physician. My hope is that the paper may serve to support the efforts of those working to effect change in the medical field, as has the work of philosophers who have labored to heighten our moral sensitivities in other domains, including justice for disabled persons and the treatment of non-human animals.[1]

The argument proceeds in part by pointing out that failures of compassion can lead to poor technical decisions in medicine. I illustrate this point by presenting certain patient case histories, including centrally one in which an individual who seeks assistance for physical pain is rebuffed by medical professionals and, by some, taken to be a liar.[2] The diagnosis I offer of this patient's poor treatment and medical outcome is in terms of a moral failing

on the part of those from whom she seeks help, in particular, a failure of the virtue of compassion. By way of broader analysis of the issues that play out in the examples—including sustained attention to the experience of being treated as a liar and reflection on the nature of compassion itself—I bolster the case for the centrality of compassion in medicine.[3]

The first section of the paper examines Martha Nussbaum's influential account of the nature of compassion and draws upon contemporary emotion theory to defend an alternate approach. In the second section, I apply the account of compassion by offering an analysis of certain detailed patient case histories. In the third section, I reflect on the experience of being treated as a liar and connect such treatment with the account of compassion, demonstrating ways in which failures of compassion compromise medical care. The fourth section considers and responds to objections. The final section makes some suggestions for positive change.

I. THE NATURE OF COMPASSION

I turn first to an abstract discussion of the nature of compassion. To begin consider an influential Aristotelian account. This account, in my view, is both overly complex—in its cognitive dimension—and lacking in a key component, namely an action-guiding or motivational one.

Consider first the roots of the account. Aristotle (1926, 1934) writes: "Let compassion be a sort of distress at an apparent evil, destructive or distressing, which happens to someone who does not deserve it, and which one might expect to happen to oneself or someone close to one, and this when it appears near." (Rhetoric, 2.8, 1385b13-16) In a series of books and articles, Martha Nussbaum has worked to analyze and defend compassion and a cluster of related emotions, as part of a larger aim of restoring the emotions to a central role in ethics and public life.[4] Nussbaum begins to reconstruct Aristotle's analysis of compassion by describing it as follows.

Aristotelian Account of Compassion (AAC): Compassion is a painful emotion directed at another's suffering or misfortune that involves three beliefs: (a) the belief that the suffering is not trivial but, rather, serious; (b) the belief that the suffering is undeserved; and (c) the belief that the suffering is something that might happen to oneself or someone close to one.

Each of the belief conditions identified by Nussbaum as necessary for compassion is subject to challenge. Compassion, arguably, requires none of the beliefs specified in AAC. First, some individuals evidently do experience compassion when others suffer relatively non-serious setbacks. For instance, a professor might have compassion for a distraught student who has studied hard for an examination but has failed it, even though the professor believes that, in the entirety of the student's life, the particular failure in question is rather insignificant. The professor may be sure that, at some point in the

future, when the student has the emotional distance to look back on the event, he will not find the examination failure to be worthy of his present distress; in the scope of things, it may be recognized for what it is: not all that important, in fact. Nonetheless, there does not seem to be anything inconsistent in thinking of the professor's emotion concerning the student at present—as the student becomes tearful and expresses anxiety about his parents' reaction—as one of compassion.

A different sort of case involves, not the assessment of non-seriousness based on the projected distance that time will bring, but rather an assessment of triviality made relative to the circumstances of the assessor. For instance, suppose that one has a colleague whose home plumbing system has broken, damaging his new wood floors. I think it is sensible to construe the emotion one feels toward him, in his rather inconvenient circumstances, as compassion, although one might at the same time take his suffering to be, in the grand scheme of things, not especially serious. This might be so if one is, oneself, dealing with a disabling physical injury or with a frightening medical diagnosis of one's infant. Of course, one would not, out of decency, tell one's colleague that his trouble is trivial—one would not trivialize it to his face—but nonetheless, one might believe it to be so, relatively. This judgment, it seems, does not rule out an experience of compassion towards him. Likewise, a mother might have compassion toward her child who has skinned his knee. The child's tears and screams show his distress; the loving mother responds compassionately toward him, though she believes the wound to be nonserious relative to other injuries.

Second, there seems to be nothing in the logic of the emotion of compassion itself that rules out feeling compassion for those who are to some extent at fault for being in the situation in which they find themselves. One's feeling compassion for another who is badly suffering with a drug addiction is consistent with one's believing that the addiction is traceable in relevant ways to his own voluntary actions. Likewise, volunteers who teach prison inmates may feel compassion for prisoners whom they see as deserving of their punishment. Furthermore, parents may feel compassion for their teenage children as those children carry out hours of community service, which the parents view as an appropriate requirement following culpable wrongdoing.[5]

Third, one might experience compassion for another without believing that a similar misfortune might befall oneself or someone close to one. To take a theological example, the person of God, as depicted in the Scripture and tradition of certain major religions, is compassionate toward human beings in distress, without Himself being vulnerable to such distress. As a non-theological example, notice that those of us who live in relative wealth, and with many available resources, can experience compassion for persons in poverty, hunger, and disease in other parts of the world, even though we recognize that such a situation will not afflict us or those to whom we are close, given our networks of support.[6]

These objections do not depend on the claim, sometimes acknowledged by Nussbaum herself, that it is too strong to assert that compassion must involve beliefs of the three identified sorts. We can weaken the alleged cognitive features of the emotion, so that they need not be beliefs but rather appraisals or states of awareness, where appraisals and states of awareness fall short of belief (see, e.g., Nussbaum, 2001, p. 306). Along these lines, one might take up Robert Roberts's suggestion that emotions involve not beliefs but "construals," so that in order to be in a state of fear, for instance, one need not believe or judge that a suddenly appearing barn spider is dangerous, but rather one must see it as or "construe" it as dangerous.[7] On a modified version of AAC designed to accommodate non-belief cognitive components, then, compassion is a painful emotion directed at another's suffering or misfortune that involves three appraisals or construals.

Modified AAC: Compassion is a painful emotion directed at another's suffering or misfortune that involves three appraisals or construals: (a) a construal of the suffering as serious rather than trivial, (b) a construal of the suffering as undeserved, and (c) a construal of the suffering as something that might happen to oneself or someone close to one.

Each of the objections to Nussbaum's account of compassion I have offered, however, can be developed in terms of appraisals or construals, rather than beliefs. For instance, one need not appraise another's suffering as being not his own fault in order to experience compassion toward him. Hence, Modified AAC in not fully satisfactory.

If compassion is not to be characterized in terms of the particular cognitive components Nussbaum identifies, nonetheless it clearly does have one constitutive component that might be described as broadly cognitive: namely, the recognition, appraisal, or acknowledgment that another person (or sentient creature) is indeed suffering.[8] If this is correct, then a person who fails or refuses to appraise another's situation as one involving pain, suffering or distress cannot experience compassion for that other person or creature.

Is this, then, how we should understand compassion: as a painful feeling occasioned at the awareness or recognition of someone else's suffering or misfortune? This characterization is on the right track, but it is incomplete. To see why, consider the following description of compassion given by Rousseau: "Compassion is a natural feeling, which, by moderating the violence of love of self in each individual, contributes to the preservation of the whole species. It is this compassion that *hurries us without reflection to the relief of those who are in distress*" (italics added).[9] Rousseau here describes compassion as a natural tendency to an affective response to another's distress, and he links the feeling to action on behalf of the sufferer, aimed at relief of the distress.

In contemporary emotion theory, particular emotions are typically characterized both in terms of local appraisals—the characteristic triggers for the emotion—and in terms of local tendencies for action—the immediate

behavioral inclinations generated by the emotion.[10] Although there are important differences among their accounts, many emotion theorists (e.g., Lazarus, 1991; Ekman, 1992; Griffiths, 1997; Haidt, 2003; Prinz, 2004) focus on relatively proximal inputs and outputs of the emotional system. Fear, for instance (say, of a wasp), is characterized by a perception, recognition, or appraisal that there is an immediate danger (posed by the wasp) and by the action tendency to escape the danger.

I suggest that we use this work on emotions to understand the emotion of compassion as follows.

Rousseauian Account of Compassion (RAC): Compassion is a painful feeling occasioned by the awareness or recognition of someone's suffering or misfortune that triggers action aimed at alleviating the suffering.

The virtue of compassion, we might say, is the disposition to experience compassion at the right occasions and to direct it toward the right ends (see, e.g., Nichomachean Ethics 1106b21-7). RAC characterizes the emotion of compassion as involving an effective impulse to help alleviate the recognized suffering, where the term 'effective impulse' means, not necessarily one that leads to effective alleviation of the distress, but, rather, one that is effective in leading a person to action in an attempt to assist. The compassionate person, in other words, is stirred by the suffering of another and is moved to some type of positive involvement out of recognition of the other's suffering.

This is the compassion I am concerned to champion in medicine. Compassion, as understood on RAC, is not pity. Ordinarily, we understand pity as an attitude closely related to compassion—in that it involves awareness of another's suffering—but not identical to it since pity is consistent with condescension: with looking down on another from a moral or psychological high ground. Furthermore, pity may not be connected to any inclination toward positive involvement on the sufferer's behalf. Compassion thus is more closely tied, than is pity, to respect for the sufferer, where respect is understood, roughly, as a matter of giving particular consideration, regard, or esteem.[11] A respectful person considers others to be worthy of high regard. She defers to them as the experts in what they themselves feel and think, and she refrains from interfering with their autonomy. These attitudes and actions are often not found in those who pity others.[12] In part in virtue of its close connection to respect, it is compassion—and not pity—that has a crucial role in an appropriate conception of the good physician.

On our understanding of compassion, then, it is similar but distinct, as well, from empathy. Empathy may be understood, roughly, as an emotional engagement in which one comes along side another, treating her as a peer—distinguishing it from pity—and that aims at identifying oneself with the other, to some extent fusing oneself with the other as one—distinguishing it from compassion.[13] The empathetic person, in aiming to identify with a

friend who has experienced a severe loss, for instance, will join the friend in activities that express sadness and distress, perhaps crying or sitting side-by-side in mourning. By contrast, the compassionate physician need not, for instance, weep along with a weeping patient or in any way attempt to fuse himself with her. Instead, what compassion requires of the physician is that he feels moved by the pain of the patient and, out of this feeling, attempts to assist in alleviating the suffering. If the physician himself cannot rid the patient of the suffering, compassion requires that he work diligently to find someone who can.

In order to develop an argument for the centrality of compassion to good medicine, in the following section I discuss examples of both failures of compassion and compassionate responses to patients in pain. For the purpose of illustration, I focus on three particular cases. Note, however, that roughly one-quarter of Americans (26%) aged 20 years and over—an estimated 76.5 million Americans—report that they have had a problem with persistent chronic pain.[14]

II. COMPASSION AND PATIENTS IN PAIN

In each of the following cases, the subject has the same initial symptoms, in particular, pain in the mouth. This initial shared situation is a common one; though as will become evident, it does not elicit uniformly appropriate medical response. I begin with the particularly distressing case.

Case 1: Grace

Grace, a young college professor, has a tooth that is throbbing and sensitive to cold, heat, and pressure. She consults her dentist. After an examination, the dentist prescribes a crown procedure, which he subsequently performs. The procedure itself is severely painful, and in the following week, Grace's pain becomes increasingly intense. She is unable to concentrate on her work and has difficulty sleeping. The dentist is unresponsive to Grace's descriptions of the severity of the pain, assuring her that the tooth "will calm down."

As the pain does not subside, the following week, the dentist performs a root canal on the tooth. Since he is unable to anesthetize the area during the procedure, the 3 hours it takes to drill the tooth and to file, bleach, and fill the nerve canals are exquisitely painful. As Grace's body tremors and tears run down her cheeks, the dentist remarks that Grace must be "incapable of getting numb."

In the months following the root canal procedure, pain remains and spreads to the entire side of Grace's mouth. Her dentist, in response to numerous phone calls for help, advises waiting. After 3 months, during which Grace consumes only soft foods, such as oatmeal and mashed potatoes, the dentist refers her to an oral surgeon for extraction of the tooth. The extrac-

tion reveals a lingering infection left after the root canal. The extraction, intended to provide relief, in fact increases, and does not alleviate, the pain.

Over the course of the subsequent months, Grace's pain spreads to the other side of her mouth and face, which her dentist says "is not possible." Grace consults other medical professionals. Additional dental procedures, suggested by several dentists and physicians, ultimately leave Grace with two extracted teeth and constant, intense burning pain across her face, lips, teeth, and gums, superimposed with electric shocks of agonizing force. She is left unable to write or teach, unable to chew, and unable to leave the house without a tight covering over the face for protection from breezes, cold, and heat.

Grace consults medical professionals of various kinds: internal medicine, oral surgery, endodontics, neurology, pain management, and rheumatology. A few of the consulted physicians exhibit some interest in Grace's predicament but none take ownership of the problem, instead, after a brief appointment, reporting simply "I can't help you," before passing her on to someone else. Some order tests, which rule out conditions ranging from sinus infection to multiple sclerosis to Sjogren's disease, but they produce no consistent and accurate diagnosis, and provide no effective treatment. Some consultations generate circuitous referral patterns: The primary care physician refers to the endodontist ("the problem must be dental"), who refers to the ENT specialist ("the problem must be medical"), who refers back to the primary care physician. The appointments with those to whom Grace is referred take weeks, and in some cases months, to attain. Many of those physicians meet her panic and distress with skepticism and suspicion.

The following, for instance, recounts the conversation in one of her appointments, early on in the quest to find help. Although different clinicians were subtler in communicating their disbelief in Grace's suffering than the one in the following exchange, the encounter unfortunately is not unique but was, in various incarnations, the norm.

Grace: "Please help me. I have lost twenty pounds. I cannot teach or write."
Physician: "Rate your pain on a scale from one to ten."
Grace: "The pain varies in intensity from a five to a ten. Right now, it is an eight."
Physician, with a distrusting look: "People in level-eight pain are screaming and pulling out their toenails. I am certainly not prescribing you any medication."
Realizing that she is now suspected of being a drug-seeking addict, Grace replies, with as little movement of her face as she can manage, so as not to inflame the pain and induce strong electrical shocks: "I am a tenured professor, a mother and a reserved person. This pain is the worst I have ever been in, worse than childbirth."
The physician laughs and says: "I had patients like you when I worked on a psychiatric ward."

Now, it may be easy for some of us not to allow comments such as this one to have an emotional effect. If, however, one imagines oneself in the position

of Grace—someone who feels alone, whose nights are spent pacing in pain unable to sleep, whose background stands as evidence of her sanity and honesty, whose hopes have been attached for weeks to the prospect of getting help from this appointment, and who will now go home no better off than before she came—one can appreciate how devastating the physician's words can be.

Before continuing Case 1 to its eventual outcome, let us contrast the above partial case history with two others, each of which has a positive outcome. Doing so will assist our reflection on what goes so wrong for Grace.

Case 2: Brian

Consider a middle-aged tax attorney, Brian, who consults his dentist concerning his toothache.[15] As in Case 1, the tooth is throbbing and sensitive to cold, heat, and pressure. After examining the painful tooth and listening to Brian's description of his symptoms, Brian's dentist concludes that a root canal procedure is needed. She explains the way in which the symptoms will be alleviated by the procedure and attests to the procedure's difficulty. She shows concern for Brian's need to return to work and, given that he has been avoiding irritating the tooth with solid foods, his need to return to a normal diet. On these bases of accurate information and concern, the dentist secures for him a prompt appointment with a specialist, an endodontist, who performs a successful oral surgery. Brian's pain is alleviated and his normal life resumes.

This, of course, is the way in which one would like things to turn out when one has a toothache oneself. We might entertain the possibility that Grace's symptoms had a different etiology than those of Brian. Consider, then, the following case as an alternative contrast to Case 1.

Case 3: Virginia

Virginia, a retired accountant, has a toothache. Her dentist listens carefully to her descriptions of the character of her tooth pain (poking, burning) and, on the basis of them, concludes that the problem is not dental in origin. The dentist conveys to Virginia that neither a crown nor a root canal procedure will help and so she does not drill on Virginia's teeth. Instead, she prescribes anti-inflammatory medication and arranges a consultation with an internist for the following day. The dentist personally phones the internist and discusses the possibilities of sinus infection and trigeminal nerve disorder.

The internist, seen the subsequent morning, is moved by Virginia's obvious distress and considers her report that the anti-inflammatories have been unhelpful. He rules out a sinus infection as inconsistent with the character of the pain she describes. He reports that, in preparation for her appointment, he has done reading on the trigeminal nerve system. He then makes a phone call himself, to arrange for Virginia an appointment with a knowledgeable

neurologist on that very afternoon, sensing the urgency of her situation. The neurologist recognizes her problem, affirms her level of excruciating pain, gives her his home phone number, and prescribes effective anti-seizure medications appropriate for treating trigeminal neuralgia. Within 2 weeks, Virginia's pain is controlled, and her life is resumed. Her days become pain free.

Notice that there are two central possibilities as to the source of Grace's initial problem. Either the toothache pain was dental in origin—having as its source inflammation or infection of the nerves within the tooth canals—or it was more broadly neurological—having as its source a problem in the trigeminal nervous system further back toward the brain, owing perhaps to a vein or artery pressing on a section of the trigeminal nerve prior to its branching into the face. If it was the former, then Grace ought to have been treated as Brian was in Case 2. If it was the latter, then Grace ought to have been treated as Virginia was in Case 3.

As it turns out, Grace's situation was, in fact, akin to Brian's in Case 2. To continue Case 1 to its eventual outcome:

> For Grace—after twelve months of seeking help in larger cities, and in different states, than her own, and after being treated with a measure of distrust and a lack of engagement by twenty-three clinicians in total—it takes a trip to a team of specialists in neurology and orofacial pain at the Mayo Clinic in Rochester, Minnesota, to bring a diagnosis of trigeminal sensory neuropathy: peripheral tissue and nerve damage from traumatic dental work, affecting the sensory nerves of the face. "We believe you in your accounts of your experience," she is told, "We see many cases like this every year. You have the most painful condition known to medical practice. We are sorry. You may be in pain indefinitely."

All told, it is 2 years before Grace is successfully treated with a mixture of medications that control the pain and enable her to return to work. Nonetheless, she is left with an invisible disability: her everyday activities—of eating, kissing, speaking, experiencing changes in temperature, and walking in a draft—are occasions of pain.

The correct diagnosis in Case 1, then, was not classic (Type 1) trigeminal neuralgia, which has hope for surgical correction via microvascular decompression surgery, but, instead, trigeminal sensory neuropathy caused by "dental disease and treatments," as noted by Mayo clinicians, which does not.[16] As was not true in the cases of Brian and Virginia, Grace was subjected to a series of poor medical decisions, which resulted in inappropriate dental procedures and expenses, delays, escalation of pain, and increased neurological damage, ultimately producing a permanent non-operable disability.

At this juncture, one might think that the case of Grace is an unrealistic example or one that is implausible except as an aberration. Unfortunately, this is not so. In fact, Case 1 is an actual patient history, and its part in a larger pattern is borne out by visits to chronic pain support groups across the United

States.[17] One can easily uncover in only a few hours of research, countless patient accounts similar to that of Grace, including accounts by friends and relatives of individuals who have committed suicide, in severe pain and frustration over lack of validation, and help from the medical profession.[18]

How do we best account for the defects in medical care in Case 1? In short, what went wrong? One might suggest that Brian and Virginia were simply lucky to consult dedicated medical professionals who had plenty of time to attend to them and that Grace had the misfortune of encountering some rare "bad apples" among physicians.[19] The fact that Grace consulted quite a high number of medical professionals in various specializations, in different parts of the United States, before finding effective help at the very top of the medical profession, however, makes the rare bad apples thesis suspect. It is incredible to suppose that each of the 23 various physicians Grace happened to consult, prior to those at the Mayo Clinic, were "rarities" in terms of manner and practice. Even if they were rare, however, it nonetheless would be beneficial to examine how we might achieve what I am sure we would all agree to be the worthwhile goal of eliminating such patient histories.

Our examination of the nature of compassion in section I points the way toward preventing repetitions of cases like Case 1. Some of the medical professionals Grace consulted did not believe that she was really in pain. Others believed that she was in pain, but they did not care: they evidently did not feel bad about it or they were not moved to try to help (or both). A clear source of difficulty in the case, the defect of limited practitioner knowledge, might easily have been fixed by research and direct consultation with each other on the part of the physicians from whom Grace sought help. This research, communication, and follow-up would have been prompted had the practitioners taken a compassionate interest in her situation.

On our account of compassion, Virginia's dentist (Case 3) exhibits compassion in paying attention, believing her patient's report concerning the quality and urgency of her pain, and making a phone call on the patient's behalf to arrange a prompt appointment with an internist. Virginia's neurologist exhibits compassion in validating her descriptions of the severity of her pain and in providing for her continued support to the point of being available to her by phone at all hours. Brian's dentist (Case 2) shows compassion in listening thoughtfully to what he says, attending carefully to the character of the pain he describes, and in being sufficiently moved by the awareness of his suffering to secure a prompt appointment with a specialist who can alleviate his pain. Notice that a compassionate physician, on RAC, need not be a "touchy-feely" sort. The feeling that is partially constitutive of compassion may be experienced without one specific facial manifestation.[20] What is needed, rather, is a humane engagement with another human being, one that enables a painful recognition of the fact that the other is suffering and that is sufficiently powerful to prompt personal involvement in securing relief.

One cannot experience compassion for another if one does not believe that the other is suffering.[21] Given the invisibility of pain, in cases in which a patient's pain has difficult-to-discern causes, recognition that another is suffering requires taking the patient at his or her word. Unfortunately, for many patients in persistent pain, the very fact that they have been assertive in seeking help from as many professionals as they can, rather than retreating in depression at home, becomes, in the eyes of some of those consulted in subsequent medical appointments, supposed "evidence" that the pain has no cause and thus as "substantial reason to suspect malingering." This is unfair. Patients are doubly damaged by this way of reasoning: first, in many cases, they are not cared for appropriately by the initially consulted physicians—not accurately diagnosed and followed up [22]—then, they are incorrectly treated as dishonest by subsequently consulted practitioners. Rather than supporting a case for patient dishonesty, it could just as well be the case that prior diagnostic opinions were incorrect and that previous "treatments" were harmful.[23] Mistrusting patients in persistent pain makes it impossible, given the nature of compassion, for medical practitioners to experience compassion toward those patients. This block on compassion is worthy of further exploration.

III. ON BEING TREATED AS A LIAR

The medical term for lying in a clinical setting, "malingering," refers to a patient's fabricating symptoms for ulterior motives, such as obtaining drugs, avoiding work, getting financial compensation, or gaining sympathy or attention. One might object to my use of the term "liar" in speaking of medical patients, on the grounds that the term "liar" has overly negative connotations not had by the term "malingerer." These pejorative connotations, one might object, unduly affect our consideration of the relevant issues.[24]

Suppose one understands a lie as an untruthful statement intended to deceive. One might add that a lie usually is intended also to maintain a secret or to avoid something negative, such as punishment. If this is what a lie is, then it seems to me that malingering is just lying in a particular context, a clinical one. "Fabricating symptoms" is one way of making untruthful statements intended to deceive. Furthermore, falsely presenting symptoms, as the malingerer does, is intended to maintain a secret (e.g., he or she is not really ill) and usually is done, as is lying, to avoid something negative (such as drug withdrawal, having to go to work, or being ignored by relatives and friends). Perhaps one will respond by saying that the term "lying" suggests conscious deception, whereas "malingering" applies both to conscious and unconscious deception in a clinical setting. This may be right. Nonetheless, when one is an honest patient in pain who is treated as a malingerer, the effect is the same as being treated either as a liar who consciously promotes a deception or as someone who is somewhat deranged, in presenting falsehood

but unintentionally doing so. The implication, either way, is that one is not representing the truth.

In the remainder of this section, I reflect on what it is like for a person who is telling the truth about his or her experience to be treated as deranged or as a liar. This will serve, I hope, both to engender compassion for patients with difficult-to-diagnose pain and to make clear the depth of the wrong that can be committed in failing to take them seriously at their word.

Notice initially that a deranged person is one whose perception of the world is skewed. He is in some large measure out of touch with reality. The liar, by contrast, does not necessarily lack access to the truth about the relevant matter; instead, he falsely represents some matter to others. In other words, a liar is not mistaken, but rather attempts to manipulate others' view of reality so as to skew their beliefs. Our attitudes toward the deranged are normally tempered by pity; they do not provoke our ire because we see them for what they are. We recognize that they cannot serve as reliable sources of information. The liar, however, can so serve, but for whatever reason he refuses to do so. As Harry Frankfurt has expressed the matter, the liar "arrogates to himself something like the divine prerogative of creative speech, simulating the omnipotent will by which God (according to Genesis) brought a world into being merely by stipulating that it should be so."[25] The goal of the liar is to impose a false view on someone else.

It is no wonder, then, that to be accused of being a liar—either implicitly, by nonverbal behaviors conveying suspicion, or explicitly, by verbal expressions of distrust—can be such an affront to our self-understanding. To be treated as a liar is to be accused of being manipulative and intrusive, in that, in lying, one inserts oneself into another's private realm of thought, getting in the way of his own attempt to make rational sense of the world. To be taken to be a liar is also to be accused of being proud, since the liar condescends to his victims, believing himself to have the power to construct, in part, their view of reality. When one is not a liar but, in fact, a sane truth-teller, the assumption that one is a liar implies, falsely, that one has such arrogance. For at least these reasons, being taken as a liar, when one is not, is deeply offensive.

The term "offense," however, does not fully capture the experience. Being treated as either deranged or a liar is phenomenologically complex, particularly in the medical context. There, it feels a bit like being stripped. That is to say, not only are one's standing in the community, one's career and education, and often even one's clothing, all stripped away, but further lost, at the time, are one's connections to other trusting human beings, including, in many cases, one's family members and friends. To the physician who treats one as a malingerer, the facts of one's being embedded in a community as a good parent and friend and one's being accomplished in one's profession, make no difference. There one is, a human being in all one's frailty, in severe distress and needing help from one with the power to help, subjected to human distance and mistrust.

The experience is profoundly alienating and profoundly lonely. In the face of such invalidation, one's feeling of being a respected member of the human community is undermined and discarded. The experience can lead to exhausting self-doubt. One might become frantic, wondering if one's treatment as a malingerer arises in virtue of some accidental feature, such as one's age or gender or disheveled appearance. A patient might wonder, for instance, if she would be treated with the same attitude of mistrust, were she male; perhaps her physician is working with a stereotype of an exaggerating hysterical woman. At some level aware of such false assumptions, she might feel the need to downplay her pain and distress, out of fear of being dismissed as unstable or as "beyond the pale," not someone with whom the physician can identify.

Furthermore, in a patient in need of care, particularly in one in extreme pain, the realization that one is not believed by precisely the person who can help creates a sense of panic and duplicity. The situation is like the experience of being followed around in a shop when one is not a shoplifter: in getting the unmistakable impression that one is suspected of being a shoplifter, one may become so self-conscious as to begin to feel suspicious, precisely in virtue of being suspected. As a distrusted patient, one begins to see oneself from the outside, envisioning the other's perspective. This moving outside oneself, imaging how one might appear, causes a layer of distance from one's experience and a feeling of being a fake. This may, in turn, contribute to making one look like a fake, confirming the other's misassumption, as the assumer at some level begins to observe the two-layered presentation: the patient reporting the pain, at one layer, and the patient aware of the assumer's mistrust, distant from the subjective experience of the pain and realizing the need to prove it, at the other.

Being treated as a liar, then, is not only offensive in its implicit accusations but further it puts an unfair burden on the victim, for she does not know what she needs to do to prove her innocence and honesty.[26] It demands that she know the assumer's preconceived ideas about what it would look like to be telling the truth: displaying certain expected pain behaviors—screaming or wincing or crying—or using just the right expected words—"excruciating," "sharp," "biting"—to describe her experience. These unspoken demands add an impossible task to the situation, which, in the case of the disbelieved patient in distress, is the already difficult one of coping with her pain itself. Notice that screaming and crying cut both ways: they might produce another's belief in the pain but, on the other hand, they might lead to the conclusion that one is deranged. An insightful patient is aware of this dilemma.

IV. OBJECTION AND REPLIES

We have seen reasons in support of an injunction against failing to take patients in pain at their word. However, an important line of objection is rooted

in this fact: we all know that people generally and patients, in particular, do on occasion misrepresent the truth. In some cases, patients are dishonest so as not to look foolish for the reckless behavior that caused their medical needs. In other cases, patients are inaccurate in their reports in order to get what they want. Some are hypochondriacs. In extreme cases, patients suffer from Münchhausen's Syndrome. Hence, one might object, it is only a philosopher who is disengaged from the reality of the daily practice of medicine who would enjoin medical practitioners to take patients who report persistent pain at their word in order to enable treating them with compassion.

This is certainly an important line of objection. Its proponent might develop it further by pointing out not only the fact that physicians must deal regularly with malingering patients but also that trusting each patient would leave doctors vulnerable to being manipulated. Given practical realities, medical professionals have good reason to limit their prescriptions and referrals, and maintaining a prima facie skeptical attitude toward patients in undiagnosed and intractable pain is required in order to comply with these limitations.

We can give several responses to this line of objection. First, the supposition that one can distrust the reports of certain kinds of patients, those in persistent pain, while maintaining acumen in discerning the truth, is naive.[27] Second, for this reason, maintaining a distrusting habit of mind impairs a physician's ability to provide appropriate medical care. The physician may become reckless, for instance, in ordering expensive and unnecessary tests, tests that in some cases are harmful to the patient, such as needless exposure to radiation and further painful stimuli barraging the central nervous systems of those in difficult-to-diagnose pain. Mistrust of patients in difficult-to-diagnose pain on the part of physicians makes truth-tellers vulnerable to circuitous referral patterns and to delayed, false, and incomplete diagnoses. In these ways among others, treating patients as liars clearly taints medical care.

Third, doubting the veracity of the reports of patients in difficult-to-diagnose pain carries a risk of causing permanent neurological damage. Inappropriate medical response can, in fact, lead to patients' experiencing severe permanent pain. Increasing scientific evidence supports the conclusion that ineffectively managed acute pain can cause neuroplastic changes that hyperexcite the central nervous system, leaving one with a permanent chronic pain disorder.[28] Given this evidence, leaving another human being in physical agony, in situations in which one can help, is immoral: it risks ruining an individual's career, a family's livelihood, and a life in pursuit of joy.

Fourth, adherence to a mindset according to which previous unsuccessful medical visits serve as evidence for patient malingering arguably harms a medical practitioner's character. It turns him into an adversary, rather than a companion or partner, with respect to his patient, thereby disadvantaging him in an endeavor to treat others as worthy of respect, which surely includes taking others as experts concerning their own experience. Assuming

that others are inaccurate in reporting what they experience is self-protective: it insulates one from assuming any burden for those needs. In taking the stance toward a patient that her symptom reports are untrue, the physician has set up a barrier of mistrust between himself and the patient and thereby, as I have argued, has made it impossible for him to experience compassion toward her since he does not recognize her suffering. As a result, the physician may become inhumane in leaving a patient in untreated pain.

Fifth, the presumption that persistent pain patients are malingering undercuts patient autonomy since patients cannot decide on their own what to do in medical settings if they cannot get themselves heard and believed in the first place.

In sum, then, even if malingerers did, in fact, outnumber truth-tellers in the patient population, their existence should not condemn truth-tellers to being treated as deranged or as lying until proven otherwise, as the associated costs are simply too high. It is difficult to understand why those within the medical profession who are working for change do not receive more support and why the calls for radical change are not more widely known and heeded. As physician Joann Lynn remarks in a different context: "One should not be able to know these things and [yet] not feel an obligation to work for improvements."[29]

V. IMPLICATIONS FOR MEDICAL TRAINING AND PRACTICE

An implication of our discussion is that the following messages are among those that must be delivered to medical students and practicing physicians. The considerations apply more broadly, as well, to all of us in our public and private lives. One message is this: one should not assume that all individuals behave in the same way when in pain. Some persons are indeed expressive and dramatic, but others have stoic and introverted personalities not given to public displays of emotion. Human beings can bear intense pain without behaving as one might expect.[30]

A second point is this: it is a mistake to make hastily formed assumptions concerning the character of a patient, in particular, assumptions that the patient is inferior in intellect, trustworthiness, knowledge, talent, or emotional maturity to oneself. One would think that it should go without saying—yet it evidently bears repeating—that a person's being disheveled, poorly attired, or exhausted and in severe distress does not grant one the right to dismiss, fail to treat, or inappropriately refer him. It is an unfortunate fact that we tend to form judgments rapidly on the basis of a situation's initial appearance; however, regular conscious work against this tendency is warranted on the part of those in medical positions who have the potential to inflict irreparable harm. Although these points may be commonplace ones to knowledgeable specialists and to those in the highest ranks of the medical

profession, this sermon has evidently not reached the laity, so to speak. Local urgent care centers, emergency rooms, and private offices in internal medicine, family practice, dentistry, and neurology are filled—as recounted by patient story after patient story—with doctors who have not heard, or have not taken to heart, the message.[31]

Proposals for practical remedies should be grounded in the following conceptual points. One cannot experience a painful feeling at another's distress and be moved to help alleviate it—the hallmarks of compassion—without first believing in the distress, which in many cases requires taking the patient at her word and having the humility that prevents one from assuming that one can discern the answers to unasked relevant questions by a glance. Arrogance and self-absorption, as an empirical matter, hinder compassion. Those who are arrogant and self-absorbed become so full of a sense of their own ambitions, accomplishments, and prestige that they can fail to notice the needs of others, whom they may see as less worthy of respect and consideration than themselves and their "peers" (those who share their wealth, power, prestige, and other accidental traits).

An antidote—humility—seems most often built in a human character through personal experience with hardship and pain. It goes too far to suggest as a practical implication that physicians be subjected, for instance, to nurses in training as they miss veins in clumsy attempts to draw blood, leaving bruising and swelling or that dentists have their teeth drilled with inadequate anesthetic. Nonetheless, as routine parts of medical education, there should be mock sessions in which students take turns at being patients, while the acting physician systematically belittles symptoms, causes pain, and treats patients with disrespect. Other sessions ought to model more appropriate behavior. Such curricular programs and others, including increased patient contact earlier on in medical school training, have been implemented in recent years in medical schools across the nation. They should be common to all medical institutions.[32]

Outside curricular changes and training sessions, mentoring programs to provide experienced and compassionate role models are clearly important.[33] Appointing appropriate mentors requires recognizing the relevant traits. In a study completed at a major Israeli teaching hospital, Shimon Glick and his colleagues found that what they call "empathetic-compassionate physicians" as identified by peer survey, "tended to be younger, Israeli educated, had a higher degree of self-confidence and a low level of anxiety." They also had "less stereotyped attitudes toward patients," valued "willingness to assume responsibility," tended to consult other physicians more frequently, and "were less offended by patient requests for such consultation" compared to other groups. They more frequently reported "a dominant maternal influence on their behavior" and "had a higher proportion with religion as a dominant influence."[34]

Further work on means for producing more such physicians is important. Glick (1993) identifies as critical to the success of Israeli medical programs

the appropriate selection of students for admission, using a process that relies heavily on personal interviews. In the course of such interviews, "specific evidence of empathic behavior in the candidate's record is sought, and penetrating questions are often asked to elicit attitudes in the areas under concern."[35] By contrast, Yale University Professor of Medicine Howard Spiro points out regarding the dominant American process:

> We doctors are selected by victories: We reached college because we were bright and competitive in high school, and we reached medical school through competition and hard-edged achievements. . . Residencies teach the same tough message. . . Isolation, long hours of service, chronic lack of sleep. . . turn even the most empathic of our children from caring physicians into tired terminators.[36]

Restructuring the medical school admission process in productive ways, widespread mentoring programs, change in reward structures for medical school faculty, and practicing physicians, among other strategies,[37] should go some way toward ameliorating the situation Spiro describes. The point is that, because a physician's failures with regard to compassion have such serious effects—not only on patients' psychological well-being but also on their bodily integrity, health, and comfort—discussions of the relevant norms, and training in the virtues, must be central to medical training and medical practice. These matters should not be peripheral, not just the material of electives and not only the subject of a weekend seminar.

VI. CONCLUSIONS

My goal has been, in part, to draw wider attention to the fact that failures of compassion can lead to poor technical decisions and outcomes in medicine. If I have been right in the identification of one of the character traits at the root of the poor treatment and result in the case of Grace set out above, then there are important implications not only for medical school training but also for the health care choices each of us makes. It is common for us to conceive of persons as good in certain of their roles, in part, in virtue of the extent to which they are compassionate: the good parent, for instance, is compassionate toward his or her children, and the good rabbi and priest are compassionate toward congregants and parishioners. [38] Many of us, however, ignore compassion in the selection of our physicians, viewing the trait as a bonus feature, not one requisite for competent medical care.[39]

We are now in a position to see that when we do so, we risk more than we may have been aware. The fact that one's physician is a compassionate individual is not simply a dispensable luxury, something that makes one's appointment pass more pleasantly. Instead, selecting a physician who is compassionate is crucial to protecting one's health and well-being. Any of us might, at any time, find ourselves in the position of suffering a condition that is not verifiable by technological methods, including certain peripheral nerve

injuries, severe headaches, interstitial cystitis, trigeminal neuralgia, and fibromyalgia. In such instances, the last thing we need is to find ourselves in the hands of a physician who will not feel moved by our plight, who will treat us as a liar, or who will not make an effort to help. Failures of compassion make us vulnerable not only to offenses to our dignity and psychological health but also to poor technical decisions with potentially disastrous outcomes for our physical well-being.

If more compassion is inserted into the process of medical examination, diagnosis, and treatment, surely some of these problems can be solved. The more that can be done to admit people into the medical profession who are emotionally mature and sensitive, with low levels of arrogance and high levels of compassion—and to cultivate these traits while they are in the profession—the better off all of us will be.

NOTES

1. See, for instance, Becker (2005); Silvers, Wasserman, and Mahowold (1998); Eva Feder Kittay, "At the Margins of Moral Personhood," *Ethics* 116 (October 2005): 100–131; T. Regan, *The Case for Animal Rights* (Berkeley: University of California Press, 1983); Peter Singer, *Animal Liberation*. New York: New York Review, distributed by Random House; R. G. Frey, "Animals," in T*he Oxford Handbook of Practical Ethics*, ed. Hugh LaFollette (Oxford: Oxford University Press, 2003), pp. 161–187.

2. I give attention to the notions of *liar* and *malingerer* below.

3. For discussion, see Charon (2006), Spiro (1993), Lown (1996), Halpern (2001), and Osler (1932).

4. Nussbaum (1986, 1994, 1996, 2001).

5. For further defense of this particular line of objection and other insightful discussion of Nussbaum's account, see Weber (2004). Weber does not challenge, as I have challenged, Nussbaum's seriousness requirement.

6. In Nussbaum (2001), she rejects the similar possibilities requirement (defended in Nussbaum, 1994, 1996) in favor of a *eudaimonistic* judgment requirement, according to which one's experiencing compassion requires that one consider the relevant suffering as a significant part of one's own scheme of ends and goals.

7. See Roberts (1988).

8. Nothing of importance to the central aim of this paper hangs on whether the account of compassion I endorse is classified as "cognitivist" or "noncognitivist."

9. See Rousseau (1913).

10. On some theories (e.g., Prinz, 2004), emotions can also be triggered directly by perceptions.

11. The ways in which one might fail to treat others with respect in the medical setting include one's treating them not merely as, as it happens, less in possession of the particular knowledge and skills one has, but as inferior to one as persons—as less valuable and less worthy of consideration, such that one is free and within one's rights to mock, invalidate, manipulate, dismiss, and fail to attend to them. On an application of Dillon's (2001) analysis of three types of self-respect, it is recognition respect that expresses of another, "She matters because she is a person." Evaluative respect expresses, "She matters because she has merit," and basal respect expresses simply, "She matters."

12. On one prominent proposal, it is our ability to act autonomously—to direct our lives on our own without undue external interference—that is the distinctive feature of us as persons, grounding in part our claim to special respect. For recent discussions of the nature and importance of autonomy, see Taylor (2005) and Ekstrom (2005a, 2005b).

13. Compare *The Oxford English Dictionary* definition of empathy as "the power of projecting one's personality into (and so fully comprehending) the object of contemplation." Halpern (1993) understands empathy differently, and she urges its use in medicine. She writes: "The goal of clinical empathy is to understand, in a detailed, experiential way, what the patient is feeling." Empathy, says Halpern, "is more like daydreaming—one imagines what it is like to be in an experience." Consider, by contrast, the words

of endocrinologist Landau (1993), who writes of the "deempathization" required to enable physicians to make sound, scientifically based medical decisions: "Physicians who deliberately cultivate empathy, who place themselves in the patient's position, will not be able to reliably fulfill all of these [professional] requirements . . . . Whenever the physician is empathetic . . . wisdom dictates that every effort should be made to minimize the emotion . . . Fortunately, there are a number of circumstances in which empathy is virtually impossible: in pediatrics, a heterosexual dealing with a homosexual, a woman physician dealing with male sexual drive, a man caring for a woman in labor or at menopause." As Landau, in this passage, speaks of empathy rather than compassion, he may not oppose the direction of the argument in this paper.

14. National Center for Health Statistics, United States, 2006, "Chartbook on Trends in the Health of Americans." Hyattsville, MD: 68–71 (http://www.cdc.gov/nchs/data/hus/hus06.pdf). According to the International Association for the Study of Pain (IASP), chronic pain disables more people than cancer or heart disease, and it costs Americans more than both combined. For relevant statistics, see "Pain Facts and Stats" (at http://www.painfoundation.org/learn/publications/files/PainFactsandStats.pdf) and "ABC Poll Shows Nearly Four in Ten Americans Suffer from Pain on a Regular Basis" (at http://abcnews.go.com/Health/PainManagement/story?id=732395).

15. No attempt is made here to analyze the ways, if any, in which the age and gender differences among the patients and dentists in these cases are relevant to the diagnoses and outcomes. It is notable, however, that although women tend to seek help for pain more frequently than men, they are less likely to get adequate treatment. Some physicians evidently assume that women can tolerate more pain or that they exaggerate their level of pain. See "Despite Reporting the Same Pain to Their Doctors Sooner, Women Receive Less Attention Than Men" (at http://www.abcnews.go.com/GMA/PainManagement/story?id=736939); see also "The Girl Who Cried Pain: A bias against women in the treatment of pain," *J. Law Med. Ethics* 29 (2001): 13–27.

16. For diagnostic classifications of the Trigeminal Neuralgia Association, see http://www.endthepain.org. For information on nerve injuries from dental work, see http://www.sciential.net/lingualnerveinjury.htm and http://www.umanitoba.ca/cranial_nerves/trigeminal_neuralgia/manuscript/types.html. See also Weigel and Casey (2000).

17. Other pain patient narratives may be found in at http://www.experienceproject.com/groups/Suffer-From-Chronic-Pain/13643. See additional personal stories at http://www.aolhealth.com/condition-center/chronic-pain/personal-stories and at http://blog.beliefnet.com/beyondblue/2008/01/chronic-pain-and-depression-th.html.

18. Various studies have reported that physical illnesses or uncontrollable physical pain are major factors in up to 70% of suicides. See, for instance, Mackenzie and Popkin (1987). On connections between suicidal ideation, suicide attempts, completed suicides, and inadequately controlled severe pain, see http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2614911/?tool=pmcentrez.

19. In response to the presentation of an earlier version of this paper, this suggestion was made by a member of the audience, which included several physicians on the faculties of leading American medical schools.

20. In their article, Mitcham, Morse, and Van der Steen (1998) make a case of the importance of compathy, defined as the physical manifestation of caregiver distress that occurs in the presence of a patient in physical pain or distress. My point is that a physician might be compassionate without being compathetic in their sense.

21. Or one must appraise or construe the other's situation as one involving suffering.

22. The initial dentist who treated Grace was insufficiently attentive to Grace's description of the character of her pain (in fact, she required a root canal, rather than a crown) and subsequently was unresponsive to her reports of continued pain following his dental procedures. It was as if he was himself in denial: he did not want it to be the case that she was still in pain.

23. Notice that the doctors at the Mayo Clinic did not take the fact that Grace had consulted numerous clinicians as evidence of patient malingering or as reason not to engage with her with compassion.

24. My thanks to an anonymous referee for prompting this terminological discussion.

25. See Frankfurt (1999).

26. Compare Davis's (2005) discussion of the "burden of proof" often imposed on individuals with invisible disabilities such as chronic fatigue syndrome, severe fibromyalgia, posttraumatic stress disorder, and mild traumatic brain injury.

27. The problem is illustrated in the following Chinese folktale: A certain man lost an axe. He at once suspected that the son of his neighbor had stolen it. When he saw the boy walking by, the boy looked like a fellow who had stolen an axe; when he listened to the boy's words, they sounded like those

of a boy who had stolen an axe. All his actions and manners were those of a boy who had stolen an axe. Later, when digging a ditch, the man found the lost axe. The next day he saw again his neighbor's son, but in all the boy's manners and actions, there was nothing like a boy who had stolen an axe. The boy had not changed, but the man himself had changed. And the only reason for this change lay in his suspicion. Retold by Warren Horton Stuart, quoted in William J. Bennett, *The Book of Virtues* (New York: Simon and Schuster, 1993), pp. 647–8.

28. See Salter (2004), Sessle (2000, 2005), and Woolf and Salter (2000).

29. Lynn's (1993) remark is in regard to deplorable care of the dying.

30. An estimated 96% of the nearly one in two Americans (133 million) who have a chronic medical condition live with an illness that is invisible. They do not use a cane or any assistive device and may look perfectly healthy. (2002 U.S. Census Bureau) See "Chronic Care in America: A 21st Century Challenge," a study of the Robert Wood Johnson Foundation & Partnership for Solutions: Johns Hopkins University, Baltimore, MD (September 2004 Update) (Cited at www.restministries.org/invisibleillness/statistics.htm).

31. For numerous patient accounts, see the forums of Brain Talk Communities, started at Massachusetts General Hospital (http://braintalkcommunities.org), which include discussions of pain associated with a wide range of neurological and other medical conditions. See also Voices of People with Pain, stories from the American Pain Foundation (http://www.painfoundation.org/support/voices/). For further information on the difficulty pain sufferers have in finding doctors who effectively treat their pain, see "Chronic Pain in America: Roadblocks to Relief" (http://www.ampainsoc.org/links/roadblocks).

32. See Rogers (2006). Dean of the Stanford Medical School Philip Pizzo remarks that "engaging the public trust requires that the medical profession rewrite itself" and says that such effort is "where the interplay between compassion and science becomes so important" (p. 52).

33. Compare Glick (1993).

34. Ibid., p. 94. Consider this moving portion of a prayer used by Mother Teresa of Calcutta for daily use in her Home for the Dying: "Sweetest Lord, make me appreciative of the dignity of my high vocation, and its many responsibilities. Never permit me to disgrace it by giving way to coldness, unkindness, or impatience."

35. Ibid., p. 95.

36. See Spiro (1993).

37. In a beautifully written recent book, Charon (2006) develops and champions a conception of medicine practiced with what she calls narrative competence, which is the ability to "recognize, absorb, interpret, and be moved by the stories of illness." Medicine practiced with narrative competence, she suggests "will more ably recognize patients and diseases, convey knowledge and regard, join humbly with colleagues, and accompany patients and their families through the ordeals of illness. These capacities will lead to more humane, more ethical, and perhaps more effective care." Although neither the emotion of compassion nor the virtue of compassion plays a central role in Charon's development of her view, nonetheless the methods she advises for training in narrative competence are promising with respect to the development of compassion. Charon writes: "We teach our students fundamental skills of close reading and disciplined and considered reflective writing . . . We introduce them to great literary texts and give them the tools to make authentic contact with works of fiction, poetry, and drama. We present complex theory from literary studies and the narrative disciplines . . . . As a result, we deepen our students' capacity to hear what their patients tell them."

38. Notwithstanding those convinced by the derisions of compassion and pity expressed, for instance, by Rand and Nietzsche. Cf., Ayn Rand, *The Virtue of Selfishness, Atlas Shrugged, The Fountainhead;* Friedrich Nietzsche, *Daybreak, Beyond Good and Evil.*

39. Several colleagues have remarked that they would prefer to have a physician who is highly skilled and most often right in medical judgment, even if his "bedside manner" and psychological temperament are questionable. Clearly, however, our ideal physician need not have just one of the positive attributes without the other: expertise need not rule out compassion nor the other way around. In fact, lack of compassion can undermine medical competence in ways I have suggested.

ACKNOWLEDGMENTS

I am indebted to philosophers Larry Becker, Mark Bernstein, Lee Brown, Kelly James Clark, Max de Gaynesford, Brie Gertler, Alan Goldman, Maria Merritt, Michael Murray, James S. Taylor, Leopold Stubenberg, Eleonore Stump, and two anonymous referees for thoughtful comments and encouragement.

Sincere thanks, also, to Kevin Reid, D.M.D., M.S., and Marcia Ribeiro, M.D. For research assistance and discussion, I am grateful to medical student Long Vinh. Special thanks for support to Teresa Ancellotti, Linda Decker, and Jennifer Utne. An earlier version of this paper was presented at the American Philosophical Association Central Division meeting in Chicago (March 2006) at a special session arranged by the A.P.A. Committee on Philosophy and Medicine. I thank audience members for their helpful comments on that occasion. Work on this paper was supported by a summer research grant from The College of William and Mary, which I gratefully acknowledge.

REFERENCES

Aristotle. 1926. *The Art of Rhetoric*. Translated by J. H. Freese. Cambridge, MA: Harvard University Press.

———. 1934. *Nicomachean Ethics*. Translated by H. Rackham. Cambridge, MA: Harvard University Press.

Becker, L. C. 2005. Reciprocity, justice, and disability. *Ethics* 116:9–39.

Charon, R. 2006. *Narrative medicine*. Oxford: Oxford University Press.

Davis, A. 2005. Invisible disability. *Ethics* 116:153–213.

Dillon, R. 2001. Self-forgiveness and self-respect. *Ethics* 112:53–83.

Ekman, P. 1992. An argument for basic emotions. *Cognition and Emotion* 6:169–200.

Ekstrom, L. W. 2005a. Alienation, autonomy and the self. *Midwest Studies in Philosophy* 29:45–67.

———. 2005b. "Autonomy and Personal Integration." In *Personal Autonomy: New Essays on Personal Autonomy and its Role in Contemporary Moral Philosophy*, edited by James S. Taylor, 143–61. Cambridge: Cambridge University Press.

Frankfurt, H. 1999. "The Faintest Passion." In *Necessity, Volition, and Love*, edited by H. Frankfurt, 95–107. Cambridge: Cambridge University Press.

Glick, S. M. 1993. "The Empathic Physician: Nature and Nurture." In *Empathy and the Practice of Medicine*, edited by H. Spiro, M. G. McCrea Curnen, E. Paschel, and D. St. James, 85–102. New Haven, CT: Yale University Press.

Griffiths, P. 1997. *What emotions really are*. Chicago: University of Chicago Press.

Haidt, J. 2003. "The Moral Emotions." In *Handbook of Affective Sciences*, edited by R. J. Davidson, K. R. Scherer, and H. H. Goldsmith, 852–70. Oxford: Oxford University Press.

Halpern, J. 1993. "Empathy: Using Resonance Emotions in the Service of Curiosity." In *Empathy and the Practice of Medicine*, edited by H. Spiro, M. G. McCrea Curnen, E. Paschel, and D. St. James, 160–73. New Haven, CT: Yale University Press.

———. 2001. *From detached concern to empathy*. Berkeley: University of California Press.

Landau, R. 1993. "And the Least of These Is Empathy." In *Empathy and the Practice of Medicine*, edited by H. Spiro, M. G. McCrea Curnen, E. Paschel, and D. St. James, 103–9. New Haven, CT: Yale University Press.

Lazarus, R. 1991. *Emotion and adaptation*. Oxford: Oxford University Press.

Lown, B. 1996. *The lost art of healing: Practicing compassion in medicine*. New York: Random House.

Lynn, J. 1993. "Travels in the Valley of the Shadow." In *Empathy and the Practice of Medicine*, edited by H. Spiro, M. G. McCrea Curnen, E. Paschel, and D. St. James, 40–53. New Haven, CT: Yale University Press.

Mackenzie, T. B., and M. K. Popkin. 1987. Suicide in the medical patient. *International Journal of Psychiatry in Medicine* 17:3–22.

Mitcham, C., J. Morse, and W. Van der Steen. 1998. Compathy or physical empathy: Implications for the caregiver relationship. *Journal of Medical Humanities* 19:51–65.

Nussbaum, M. 1986. *The fragility of goodness: Luck and ethics in Greek tragedy and philosophy*. Cambridge: Cambridge University Press.

———. 1994. *The therapy of desire: Theory and practice in Hellenistic ethics*. Princeton, NJ: Princeton University Press.

———. 1996. Compassion: The basic social emotion. *Social Philosophy and Policy* 13:27–58.

———. 2001. *Upheavals of thought*. Cambridge: Cambridge University Press.

Osler, W. 1932. *Aequanimitas with other addresses to medical students, nurses, and practitioners of medicine*. 3rd ed. Philadelphia: Blakiston.

Prinz, J. 2004. *Gut reactions*. Oxford: Oxford University Press.

Roberts, R. 1988. What an emotion is: A sketch. *Philosophical Review* 97:183–209.

Rogers, D. 2006. Strong medicine. *Stanford Magazine* 35:50–7.

Rousseau, J.-J. 1913. *The Social Contract and Discourses*. Translated by G. D. H. Cole. London: J. M. Dent & Sons.

Salter, M. W. 2004. Cellular neuroplasticity mechanisms mediating pain persistence. *Journal of Orofacial Pain* 18:318–24.

Sessle, B. J. 2000. Acute and chronic craniofacial pain: Brainstem mechanisms of nociceptive transmission and neuroplasticity, and their clinical correlates. *Critical Reviews in Oral Biology Medicine* 11:57–91.

———. 2005. Awareness of pain awareness. *Journal of Orofacial Pain* 19:5.

Silvers, A., Wasserman, D., and M. Mahowold. 1998. *Disability, difference, discrimination: Perspectives on justice in bioethics and public policy*. Lanham, MD: Rowman and Littlefield.

Spiro, H. 1993. "What is Empathy and Can it be Taught?" In *Empathy and the Practice of Medicine*, edited by H. Spiro, M. G. McCrea Curnen, E. Paschel, and D. St. James, 7–14. New Haven, CT: Yale University Press.

Taylor, J. S. (Ed.) 2005. *Personal autonomy: New essays on personal autonomy and its role in contemporary moral philosophy*. Cambridge: Cambridge University Press.

Weber, M. 2004. Compassion and pity: An evaluation of Nussbaum's analysis and defense. *Ethical Theory and Moral Practice* 7:487–511.

Weigel, G., and K. Casey. 2000. *Striking back: The trigeminal neuralgia and face pain handbook*. Gainesville, FL: Trigeminal Neuralgia Association.

Woolf, C. J., and M. W. Salter. 2000. Neuronal plasticity: Increasing the gain in pain. *Science* 88:127–34.