Reflections on Humanizing Biomedicine

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ABSTRACT Although biomedicine is responsible for the “miracles” of modern medicine, paradoxically it has also led to a quality-of-care crisis in which many patients feel disenfranchised from the health-care industry. To address this crisis, several medical commentators make an appeal for humanizing biomedicine, which has led to shifts in the philosophical boundaries of medical knowledge and practice. In this paper, the metaphysical, epistemological, and ethical boundaries of biomedicine and its humanized versions are investigated and compared to one another. Biomedicine is founded on a metaphysical position of mechanistic monism, an epistemology of objective knowing, and an ethic of emotionally detached concern. In humanizing modern medicine, these boundaries are often shifted to a metaphysical position of dualism/holism, an epistemology of subject knowing, and an ethic of empathic care. In a concluding section, the question is discussed whether these shifts in the philosophical boundaries are adequate to resolve the quality-of-care crisis.

IN A MOVING STORY OF a consultation for a second opinion over a diagnosis of amyotrophic lateral sclerosis, Mary O’Flaherty Horn (1999), the patient (and a practicing internist), relates the inhumanity and degradation with which she was treated by health-care providers. For example, during a procedure for testing the motor nerves “Dr. L”—the physician conducting the test—addressed his comments to attending residents instead of to her. “I might not have been pres-
ent,” observes Horn, “except for the obvious need for my muscles” (p. 940). At one point during the procedure her hospital gown accidentally shifted above her hips, but as she tried to reposition it Dr. L “snapped, ‘Don’t move!’” (Horn 1999, p. 940). In reflecting on the experience, Horn questions whether the residents learned to treat patients with compassion and fears that compassion is being lost in the bustle of medical practice.

Horn’s experience is certainly not unique or even uncommon. The question posed in this paper is “why?” Why should modern medicine provide such competent technical care and yet fail to provide the humane care patients also need? Philosophy, especially a philosophy of medicine, should contribute a response, and while hardly complete, such a contribution should at least indicate the conceptual infrastructure needed to promote the kind of health care required in the United States to address the ire and consternation of so many to what is often perceived as inhumane care. To that end, I contrast and analyze two philosophies of medicine, one that falls under the general heading of “biomedicine,” and the other, for lack of a better term (and telling in itself), “humane medicine.”

Today, biomedicine is the prevailing approach to medical knowledge and practice within the United States, as well as in other Western and developed countries. It is also quickly becoming the principal approach in Eastern and underdeveloped countries. Starkly put, the patient is reduced to a physical body composed of separate components that occupy a machine-like structure. The biomedical practitioner’s emotionally detached concern is to identify a patient’s diseased body part(s) and to treat or replace the diseased part(s) in a fashion analogous to a mechanic. The outcome of this intervention—curing the patient—derives from specifically diagnosing a diseased or dysfunctional part(s) and then treating, scientifically, the cause of the disorder. The results are commendable: to cure disease, to relieve pain, and to prevent death.

Although biomedicine has been heralded for enhancing the longevity of life, and even though many would not consider it as starkly portrayed above, it has still left many patients dissatisfied with their own health care. “In spite of remarkable advances in medical therapy and in development of fantastic diagnostic devices,” claims Franz Ingelfinger (1978), “American society appears increasingly disenchanted with the physician” (p. 942). In response, a number of medical practitioners and pundits have proposed humane modifications to biomedicine, in order to restore the dignity of both patient and physician (Cassell 1991; Engel 1977; Foss 2002; Marcum 2008; Tauber 1999, 2005; Toombs 1993). Humane practitioners do not reject biomedicine but enlarge its scope to incorporate the patient’s psychological and social aspects.

Although a few humane practitioners, such as those advocating complementary and alternative medicine, want to replace biomedicine, most of these practitioners, like George Engel or Eric Cassell, “wish simply to humanize technomedicine—that is, to make it relational, partnership-oriented, individually responsive, and compassionate” (Davis-Floyd and St. John 1998, p. 82). They real-
ize that biomedicine’s technological advances have made modern medicine effective and simply wish to add a human face to its practice. In a humane approach, the patient is recognized as a person occupying a lived context or a socioeconomic environment.

Under a humane practitioner’s empathic gaze and care, clinical tools are employed, and the informed and autonomous patient is relieved of symptoms and at times even healed, using evidence-based or traditional medical therapies. The general concern goes beyond the biochemical or biophysical problem to address the patient’s disease in a fuller context, the context of the illness experience. Specifically, not only is the disease diagnosed, but the patient’s experience of his or her illness is considered important as well. Indeed, this comprehensive, humane approach orders diagnosis and therapy, and although it generally relies on evidence-based or traditional medical therapies, it employs others if they seem appropriate. In short, the physician is a health-care provider with many technical, intellectual, and emotional skills and resources, who believes that illness seldom can be reduced to a simple disease category.

In this article, I offer portraits of the idealized biomedical physician and humane practitioner. These portraits are reduced to essential characteristics, in order to expose the underlying philosophical structure for each. Such an approach allows a clearer description of their respective features, and following their description, I consider the implications of this approach for revising biomedicine. To that end, I explore the philosophical boundaries of humanizing biomedicine, especially in terms of metaphysics, epistemology, and ethics. First, the shift in biomedicine’s metaphysical positions and presuppositions, as well as its ontological commitments, to more humane ones are investigated, for they determine the entities that compose a medical worldview. Next, I examine the epistemological boundaries surrounding biomedicine’s humanization, particularly those powered by methodological procedures undertaken by epistemic agents to create and establish medical knowledge and practice. Finally, I explore the ethical implications of shifting biomedicine to one dedicated to a more holistic approach (especially in terms of the physician-patient relationship). In a concluding section, I discuss the question of whether biomedicine can be made more humane, in order to address the quality-of-care crisis.

**Metaphysical Boundaries**

Contemporary biomedicine is composed of a metaphysical position best defined as mechanistic monism (Davis-Floyd and St. John 1998; Foss 2002). By *monism* is meant the notion or principle that there is one ultimate substance that constitutes the world. The notion of *mechanism* refers to the parts and processes that make up an entity and the relationship among these elements. For many biomedical practitioners, a mechanism is the means by which to account for a natural entity or phenomenon (Machamer, Darden, and Carver 2000). The bio-
medical worldview is modified in humane medicine with a metaphysical position that is generally dualistic, being composed of two non-reducible entities—the body and the mind (Foss 2002). Other humane practitioners work from a holistic position, in which a person or self represents an integrated whole not only in terms of the individual but also with respect to the individual’s environmental context or lifeworld—a prescientific world radicalized to expose the meaning structures of a person’s life (Toombs 1993).

The chief metaphysical presupposition of biomedicine is reductionism (Dupré 1993; Sachse 2007). Reductionism refers to the reduction of other nonphysical disciplinary terms and theories to the terms and theories of the physical sciences, although it can also be ontological in nature, in which higher order or complex entities are determined by lower order or simple entities (Marcum and Verschuuren 1986). Even though humane practitioners appreciate biomedicine’s metaphysical presupposition of reductionism and the gains it provides for the technical side of Western medicine, they often reject it as an insufficient presupposition for medical knowledge and practice. They generally subscribe to emergentism, in which properties of the system are not determined by the properties of the individual parts but transcend them (Clayton 2004). In other words, a higher-order property of a complex entity (CE1) is emergent if it is possible for another complex entity (CE2) to lack that property, even though CE2 is composed of the same components as CE1 and has a structure identical to CE1.

The ontological commitment of biomedicine is physicalism, or its older denotation, materialism (Davis-Floyd and St. John 1998; Foss 2002; Nagel 1965). Accordingly, matter and its attendant manifestation of energy and the forces that interact among and on material entities are what make up the world. Humane practitioners share to some extent biomedicine’s ontological commitment to physicalism or materialism; however, this commitment is tempered by including a patient’s psychological or mental state—and for some, a spiritual state (Engel 1977). Often humane medicine includes a patient’s integrated systems as etiological factors in diagnosis of illness and as therapeutic factors in its treatment. By incorporating the system’s dimension of a patient, humane medicine is grounded by an ontological commitment to organismism (Marcum and Verschuuren 1986; Gilbert and Sarkar 2000). Organicism is a notion that necessitates organic unity. It represents the organismal unit as an integrated whole rather than as a collection of loosely connected individual parts. It emphasizes an organism’s overall structure or organization, in contrast to simply its composition or individual organs. Thus, to understand an organism one must know how it functions as an integrated system, rather than as a collection of individual organs or organ systems.
Biomedicine is based on objective or scientific knowledge and relies on the technological developments in the natural sciences (Davis-Floyd and St. John 1998; Montgomery 2006). For example, the randomized, double-blind, concurrently controlled clinical trial is considered the “gold” standard for establishing the efficacy of a new drug or surgical procedure. Such scientific practice defines acceptable knowledge and practice of biomedicine. Biomedical knowledge is also generally based on mechanistic causation. Finally, epistemic claims in biomedicine rely on the logical relationship of propositional statements, which are acquired from laboratory experiments and clinical studies (Murphy 1997). The trajectory of biomedical knowledge is from the physician-scientist’s laboratory to the patient’s bedside. There is often little room to this approach for the physician’s or the patient’s intuitive or emotional dimensions, and consequently biomedical knowledge is generally impersonal.

Biomedical knowledge is expressed in terms of mechanistic or bottom-up causation, for mechanisms play a crucial role in the biomedical explanation of disease (Davis-Floyd and St. John 1998; Foss 2002). Biomedical practitioners are often interested in identifying just the physical causes or entities and processes responsible for a patient’s disease. Just as natural scientists account for phenomena with respect to material elements and mechanisms, so biomedical clinicians explain disease in terms of material entities and mechanisms. Once the causal mechanism for the disease is determined, treatment is often based on chemical or physical intervention, either in the form of a pharmaceutical drug or a surgical procedure.

Practitioners of humane medicine certainly accept biomedicine’s epistemological standards, but they also include subjective knowledge or information about an individual patient in the healing process (Davis-Floyd and St. John 1998). This information is not just about a patient’s biological state, but more importantly about the experiencing person, who is suffering from an illness. In humane medicine, information about the patient as a unique person is also required to treat successfully an illness and the suffering associated with it. Eric Cassell (1991) recognizes three kinds of patient information, including “brute” facts, the moral, and the aesthetic. While brute facts about a patient’s disease are necessary for the practice medicine, they alone are often inadequate to heal a patient. Both the patient’s moral and aesthetic values, claims Cassell, must be included in order to discover and treat illness and to relieve the suffering associated with it.

In contrast with biomedical knowledge’s bottom-up causation, the type of knowledge obtained in humane medicine depends on top-down causation, where a patient’s psychosocial realities are an important factor in diagnosing and treating illness (Davis-Floyd and St. John 1998; Foss 2002). For example, Stephen Toulmin (1979) argues for a richer notion of medical causation than just somatic causation. It must also include a patient’s lifestyle, employment, personal characteristics, temperament, and so on. Medical causation, then, is more than the con-
sequence of scientific technique; rather, it is informed by a patient's psychological state and social status.

Finally, humane medicine shares many epistemological features with biomedicine, such as that logic is important for practicing medicine; however, it also relies often on a humane practitioner's empathetic intuitions (Davis-Floyd and St. John 1998). Such intuitions are not necessarily obstacles to sound medical judgments, but when sensibly restricted by the epistemic and empirical boundaries of biomedical practice, they enable a humane practitioner to evaluate information about a patient's illness that may place laboratory test results within a larger, more meaningful context. This subjective knowledge obtained from a practitioner's use of intuitional resources is not constrained by objective or quantifiable test results but is also needed to maintain a patient's dignity (Tauber 1999).

**Ethical Boundaries**

The ethical stance of the biomedical practitioner is often emotionally detached concern for a patient's diseased body (Davis-Floyd and St. John 1998; Lief and Fox 1963). This practitioner's solicitude for a patient's body and its part(s) is disconnected from the emotions of either the patient or physician, because emotions are thought to interfere with the disease's accurate diagnosis and treatment. Because this attitude stresses the mechanistic nature of a patient's body and the scientific problem-solving aspect of medical practice, diagnosis and treatment of a patient's disease are puzzles that concern the physician-scientist as a mechanic (Bayles 1981). As a mechanic operating from an ethic of concern, the biomedical physician's “clinical gaze” is generally focused only on a diseased body part, to the exclusion of a patient's overall experience of illness and suffering. In addition, as Kay Toombs (1993) asserts, a clinician's gaze is directed to the body's interior, so that a patient becomes an objective, transparent body.

A humane practitioner's gaze, by contrast, is empathic. This gaze, according to Toombs, is founded on certain features of the patient's illness, including losses of wholeness, certainty, control, freedom to act, and the familiar world. The loss of wholeness reflects a disruption in a patient's bodily integrity, which often leads to a loss of control in terms of bodily functions. Besides these losses, illness is also associated with a loss of freedom to accomplish common tasks. The loss of certainty relates to recognition of a patient's mortality. Finally, illness leads to a loss of the familiar world in which a patient lives. By being made aware of these features of illness and how they influence a patient's psychosocial life, the humane physician can more adequately attend to a patient's suffering rather than only to the pain caused by a diseased body.

Instead of being exclusively concerned in an emotionally detached manner, the humane practitioner also cares empathically for the health of the patient as a person (Halpern 2001). The basis for this care is the emotional life of a patient, as well as a physician's own subjectivity. Ian McWhinney (1988), for example,
proposes a patient-centered clinical method to reform biomedicine: “The physician is enjoined to discover the patient’s expectations, his feeling about illness, and his fears. He does this by trying to enter the patient’s world and to see the illness through the patient’s eyes” (p. 225).

Although humane practitioners do not abandon the goal of a scientific cure, when possible they do strive to obtain such a cure within a caring ethos (Davis-Floyd and St. John 1998; Peabody 1984). Patients expect a physician to cure not only the diseased body but also to address humanely the person who is suffering from an illness: “most patients believe that doctors should do more than simply intervene mechanically in the disease process,” according to Cassell (1991), “rather, they expect the doctor to help them find and remedy the factors that led to the illness, and assist them in returning to their best possible function” (p. 111). Thus, in addition to the technical aspects of curing the disease, an ethic of empathic care guides humane medicine in relieving the patient’s suffering and restoring wholeness or well-being, both emotionally and existentially. Is this a reasonable approach to the current quality-of-care crisis?

**Humanizing Biomedicine?**

Can humanizing biomedicine adequately address the quality-of-care crisis facing modern Western medicine? The economists and managers of health care would dismiss this question as irrelevant to the realities of the health-care industry, which demand strict technical virtuosity, allow only short visits, and serve the economics of mass consumerism. The physician in that scenario plays an instrumental role in which little compassion is generally allowed, because, simply put, compassion often costs time, and time almost always costs money. On the other side of the divide, those who argue for a compassionate ethos believe that recognition of the patient qua person and a physician’s empathic care of a patient may help to alleviate the alienation that often characterizes today’s health-care system. Both positions are “correct,” but here I am concerned solely with the idealized portrait of the caring physician; to what extent that portrait might be realized is another kind of problem. Suffice it here to outline the missing features in the biomedical practitioner’s portrait, and then attempt to seek ways of ameliorating those deficiencies and of answering the following key questions.

1. **Is inclusion of a patient’s psychosocial disposition or lived context sufficient to remedy biomedicine’s profoundly limited vision of human nature?** Medical school curricula have recently readdressed this question, and reform has been directed at instructing students in the broader aspects of care (Campo 2005). Unfortunately, little data exist as to how effective such educational interventions have been.

2. **Can the humane practitioner’s warm, friendly touch remedy the cold indifference of biomedical technology?** The answer to such a question must be sought
in the institutions of patients and their caregivers, where literature citing the abuses of contemporary biomedical technologies, as illustrated in Horn's testimonial, radically differ from those testimonials of empathic physicians (Groopman 2001). This issue falls in the folklore category of medical narrative, and again, little empirical data are available (Barry et al. 2001).

3. **Most importantly from a philosophical perspective, do the overall metaphysical, epistemological, and ethical boundaries of biomedicine make its philosophical commitments incompatible with humane alternatives?** I think not. The question is not a battle between irreconcilable positions, but rather one of how to meld two differing visions of medical care.

My thesis builds on an expanded idea of medicine: the perspectival shift required for modern Western medicine is not just from biomedicine to one of its humane versions, but from a medicine concerned only with logos (rationality), or even with ethos (character), to a medicine rooted in pathos (passion). For the underlying problem, especially for biomedicine, is that both its logos and ethos are disengaged from its pathos. Biomedicine is a tool, as it were, and as such it does not necessarily represent the most appropriate attitude for being used as a tool, in that a tool per se is devoid of providing a proper attitude for its use, especially use with human beings (Heidegger 1996).

Biomedicine then must be rooted not only in an objective or a neutral attitude, but it must also embrace a compassionate attitude that shares existentially—not simply technically—with a patient’s suffering. As Tauber (2005) so aptly articulates the problem: “the science and technology of diagnostics and therapeutics are the ‘hard’ currencies of the doctor, and the ‘soft money’ used to develop interpersonal relations and the accompanying humane attentions simply do not purchase what is truly important” (p. 48). Accordingly, reconnecting biomedicine to pathos ultimately allows a physician to discern what is “important” in health care.

The argument rests on defining the boundaries of care: if care is directed solely at the domain of biological dysfunction, death, and dying, then the mechanics of biomedicine certainly address that domain. If, however, clinical medicine directs itself to the person, and not just to the biology of disease, then the tools of clinical science must be coupled to a humane attitude of care. In short, defining medicine in one way or the other determines how medicine regards its mission and how it proceeds to fulfill it. Assuming a more comprehensive humane horizon for care, contemporary biomedicine must attain a receptive and responsive pathos to direct its rationally oriented logos and character-driven ethos, before it can tackle the quality-of-care crisis.

**Why pathos?** Because pathos reflects a passionate or fervent—not simply an emotional or a desire-driven—way of being fully present that makes possible both accurate knowing or understanding and right doing or acting. In other words,
Pathos undergirds a way of sharing in and even being present to—and not just knowing accurately or acting appropriately in the presence of—the patient’s suffering caused by illness. This attitude has a long and complex heritage.

Traditionally, medicine represented a ministerial profession in which care and empathy, as well as competency and technical proficiency, were mediated via pathos. But with the secularization of medicine—along with the rest of Western society—since the Enlightenment, that pathos was eclipsed by utilitarian and pragmatic attitudes and approaches toward a patient as object—and often, although not always, a technical object at that. Consequently, technical proficiency and empathy are too often disengaged and regarded as distinct categories of care. They need not be—and contemporary medicine indeed requires a moral compass that can point to a single domain that includes both compassionate and technically competent care, and that is built with a pathos that can orient physicians to wise and loving treatment of patients. The transformation of biomedicine’s logos and ethos via pathos to produce a wise and loving humane clinical stance requires a clear declaration of humane virtues, not to displace medical science from its own success, but to enlarge its attention to a greater purpose, the care of the ill. These include wisdom and love, terms of virtue ethics seldom found in today’s clinical lexicon.

**Wisdom**

Many medical commentators not only acknowledge that there is a surplus of positive knowledge and information but that there is also a shortage of wisdom for applying such knowledge and information to the clinical scenario (Pollack 1999). The issue for biomedicine is how to move beyond positive medical knowledge and information to wise application of such knowledge and information to clinical practice. Pathos holds a key position in that transition.

According to Brand Blanshard (1967), wisdom reflects “sound judgment” with respect to the common sense dimension of life and its problems. Blanshard identified several components inherent to wisdom. The first is knowledge or facts, especially in adjudicating what is germane and important to the decision process. The next component, reflectiveness, involves a habit of weighing certain events and beliefs in terms of their foundations and consequences. It is critical for gaining interpretative knowledge, which is required for presaging the consequences of a certain set of beliefs and actions. The third component, judgment, requires an ability to negotiate disparate and often conflicting values and to make a decision, which respects the context that provides meaning. Finally, wisdom relies on trusting the beliefs that one accepts and the choices and preferences they inspire. This trust of one’s beliefs, choices, and preferences is based on one’s ability or capacity to reason correctly and accurately in the service of good judgments.

Zbigiew Szawarski (2004) applies these traits of wisdom to medicine and the healing professions. He makes a distinction between medical and clinical knowledge, with the former derived from scientific knowledge and the latter from in-
dividual patients. A wise physician, according to Szawarski, is one who can dis-
tinguish between these two kinds of knowledge, and in each clinical case he or
she is able to demarcate what is significant in the illness experience and what is
not. Of course, this assessment depends on a physician's reflectiveness upon both
medical and clinical information. Only a proper assessment of such information
can lead to a good and wise clinical judgment.

For Szawarski (2004), a physician's sound clinical judgment depends on his or
her experience, as well as the patient's experience: “In this sense, clinical judg-
m ent is indeed a fundamental principle of the art of medicine and involves sev-
eral more specific arts such as: the art of logical and critical thinking, the art of
seeing and understanding the meaning of signs and symptoms, the art of com-
unication, and the art of collecting and interpreting clinical data” (pp. 191–92).
Moreover, physicians must trust their medical and clinical knowledge, their re-
flexion on that knowledge, and their judgment based on it, or they are simply
ineffective in their practice. Finally, self-trust has therapeutic value: if physicians
do not trust themselves, why should their patients?

Missing in these descriptions is the quality of pathos, which makes possible
the transformation of facts, knowledge, and information into wise judgments,
because it serves as a means for "being-in-the-world" authentically. According to
Heidegger (1977), the crisis of Western civilization, of which the objectified
patient is but one example, results from the inauthentic objectification of nature,
persons, and self. As Svenaeus (2000) puts it, paraphrasing Hiedegger:

when we study our relationship to the world, we should not view the world as a
collection of objects outside of consciousness, towards which we are directed by
way of the latter. We should instead study the “worldliness” of the world, the way
we are in the world [being-in-the-world], giving it meaning through our actions;
the world indeed being nothing other than a cultural, intersubjective meaning-
structure, lived in by us and, ultimately, a mode of ourselves. (2000, p. 83)

Thus, some mediating or intervening insight or self-awareness is required to
bridge this chasm dividing experience and relationships, which, philosophically, is
a deliberate self-conscious examination of those factors that define authenticity.

Suffice it here to note simply that the faculty of understanding, in terms de-
defined as pathos, is a means of reaching into the human world and fully partici-
pating in it. In other words, on this interpretation true engagement with the
other—the patient—authenticates not only the legitimacy of the patient as a per-
son, but also fulfills the clinical scenario to which physicians themselves are com-
mitted. Assuming the success of that understanding, pathos makes accessible the
necessary and sufficient power or force to transform biomedical facts into wise
clinical insights, or in another parlance, authenticity. It permits the physician and
patient to interpret the clinical facts and then to outline a treatment plan that is
best and good for the patient in terms of his or her values and needs. All of this
is ultimately based on the physician's affective aptitude for empathic insights into
a patient's suffering, as well as motivation to relieve that suffering. Pathos represents the core of human knowing, in making possible wise decision and action.

Love

Love, as used in this setting, is not a maudlin sentimentality but rather a compassionate way of being that enters into a patient's world of suffering. Although there are several traditional types of love, including eros, philia, and agape, which have been applied to modern medicine (Mermann 1993), other forms, such as compassionate love, have been championed recently: “Compassion is not a simple feeling-state but a complex emotional attitude toward another, characteristic of imaginative dwelling on the condition of the other person, an active regard for his good, a view of him as a fellow human being, and emotional responses of a certain degree of intensity” (Blum 1980, p. 509). Importantly, compassion is not just heroic but also mundane, often composed of common acts of kindness and consideration. The root of compassion resides in our shared humanity, the awareness that misfortune may befall anyone at any time. For a physician or other health-care provider, compassion is as necessary for clinical practice as medical competency.

Compasionate love is richer and deeper than either empathy or sympathy, since it engages the authentic nature of a lover for a beloved, especially for the beloved’s suffering state. Lynn Underwood (2002) identifies several features of compassionate love, including a free choice for the other, an understanding of the other’s situation, a valuing of the other, an openness to the other, and a earnest response to the other. Moreover, proper motivation is essential for expression of compassionate love, especially in the clinic. One’s motive should center on the other’s needs rather than on one’s own.

Compasionate love permits a physician to be engaged emotionally in an appropriate manner for addressing a patient’s suffering and thereby allows for a connection at a fundamental level with that suffering. Thus, a physician who communicates compassionate love “has the capacity,” according to Dimitrios Oreopoulus (2001), “to experience the suffering of another and to experience something of the total impact of the illness, that is, the associated fears, the anxiety, and the illness’ assault on the whole person, reflected in loss of freedom and the patient’s sense of utter vulnerability” (p. 540). A physician so affected cannot help but react with authentic and genuine compassion to a patient’s suffering.

As for the conversion of facts, knowledge, and information to wisdom, so pathos transforms emotionally detached concern and even empathic care to compassionate love. Pathos, as the source of suffering love, is the force that motivates a physician to respond in a genuinely compassionate and selfless manner to a patient’s suffering. Pathos—as an authentic and a genuine way of “being-in-the-world”—affords physicians access to the necessary and sufficient power or force to transform either the biomedical or humane clinical gaze into a compassionate or loving one.
Pathos, through compassion, empowers a physician to respond to a patient, authentically, which means, again citing Heidegger (1996), an acknowledgment of one’s own presence (or commitment). This presence is a gift of self-giving on the part of a physician to meet not only a patient’s physical but also existential needs. Based on this gift, a partnership is formed so that a treatment plan is devised in light of what is best for a patient with respect to the patient’s values and needs. Pathos represents the core of human compassion, in making loving decision and action possible. Thus, it may be regarded as the essential foundation for the compassionate and loving clinical care of authentic practitioners.

Conclusion

When thinking in such existential and phenomenological terms as stated above, the philosophy of medicine expands the biomedical and pragmatic confines to include a wider universe of values and human attitudes, and by so doing addresses the quality-of-care crisis facing modern medicine. Redirecting clinical medicine towards a more humane ideal, pathos—linked to wisdom and love as guiding virtues—might well serve as a philosophical resource from which to rebuild not only the ethics of medicine, but also to redefine the epistemologies and metaphysics that guide modern medical discourse and practice. This notion of pathos, although abstract and elusive, serves this purpose admirably, because it functions as “ether” that pervades and infiltrates all corners of the medical setting.

The pathos of medical power derives from, and resonates with, the ancient calling of the healing arts. For the primordial human needs of a suffering patient still require attention, no matter how sophisticated medical science and technology might become. Without the guide of pathos, medicine runs the risk of succumbing to a technological ethos that would forever reduce persons to bodies and patients to diseases, when in fact healthcare providers ought to care for patients as persons. The interrelationship of humans depends on an ethic of synthetic relationships and care responsibilities. Medicine, if nothing else, is an exemplar of that existential, social fact, and to ignore that fact, or at least to subordinate it to other concerns, robs physicians of their most important asset—namely, their commitment to the welfare of human beings.

References


