Reading Freedman

Duty and healing: foundations of a Jewish bioethic
Benjamin Freedman
Edited and with an introduction by Charles Weijer
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The publication of Benjamin Freedman's *Duty and Healing* is cause for both joy and sorrow. Freedman was a brilliant clinician and bioethicist at McGill University, and there is much to rejoice about in the fact that his voice is now to be heard in a systematic representation of great power, lucidity and persuasion. And so it is sad to note that he died in 1997 at the age of 46. This posthumous volume, edited by Freedman's disciple, Charles Weijer, could very well have been the introduction to more and even better work had the author lived. Yet, despite its being in some ways a literary debut, the book is well written and stands on its own merits. The use of real clinical cases, especially, makes for a fascinating interplay between theory and practice throughout.

Freedman identified himself as an Orthodox Jew, implying a full commitment to the primary moral authority of the biblical–rabbinic tradition expressed in Jewish law (Halakah). His first task in *Duty and Healing* is to show how one engages in the theory and practice of bioethics from the perspective of this ancient (but never antiquated) tradition. His second task is to show how this tradition approaches bioethical questions very differently from what he calls "secular" or "Western" ethics. His third task is to show how these two approaches, despite their philosophical opposition, can often be "complementary rather than contradictory."

The theoretical key to all three tasks is contained in Freedman's reliance on "Jewish legal sources whose appeal is to reason" and which, therefore, are "of more than parochial interest." He wants to show how the Jewish ethic of duty is inherently a more rational approach to some of the most important issues in contemporary bioethics than the secular ethic of rights (which also justifies itself by rational criteria), and how the ethic of duty and the ethic of rights can nonetheless inform one another. In this task — a refreshing one in view of Freedman's orthodoxy — the author not only presents the Jewish tradition but reinterprets it on some central points. In so doing he is not at all timid in criticizing the less sophisticated views of some of the most prominent contemporary spokespersons for that tradition in the popular area of bioethics.

The practical key to Freedman's project lies in the issue he grapples with more than with any other: informed consent. That patients have the right to determine the course of their own medical treatment seems to imply that the duty of medical personnel is to inform them of their reasonable options so that they, not the medical personnel, have the final say as to what is done to their bodies. This right is usually based on the principle of patient autonomy. That is, the right to informed consent seems to be justified by the idea that, in the end, the patient owns his or her own body and thus has the ultimate responsibility for it. This justification, however, is diametrically opposed to the Judaic idea that one's body belongs to God, and that one's first duty is to keep the body alive no matter what. Furthermore, since it is assumed that medical personnel (being "scientific") know more about the patient's bodily situation than the patient (being "subjective") does, they have the authority to command the patient, so to speak, to follow their regimen in the name of God. Following this theoretical dichotomy, how could someone committed to traditional Judaism possibly accept the notion of informed consent at all? On rational grounds, it would seem that the idea of autonomy is more humane, since it does not burden patients with more responsibility for their own bodies than they can realistically bear.


Fred Sebastian

What Freedman brilliantly argues, however, is that the idea of ultimate duty to God (and then to others) does not necessarily preclude informed consent; in fact, it can actually be shown to offer a better, more rational, basis for it. Thus Freedman learns something significant from the secular approach without capitulating to its philosophical foundation. He speaks of the patient as "a responsible steward of his or her own body" and of patients as "prudent caretakers." By this he means that the first responsibility for the care of the patient's body lies with the patient. After all, patients have the most extensive and intensive experience of their own lives and are thus the best judges of what they can endure and of how they can live and not just exist. Freedman wisely points out that too many traditionalist Jewish ethicists emphasize the duty to preserve life at the expense of other duties, especially the duty to treat pain. Moreover, he notes that, since the outcome of medical treatment is far less certain than many traditionalists (with their general lack of "professional exposure to health care settings") seem to think it is, medical personnel have far less authority than they did when medicine came across as a more self-confident enterprise. His model of care,

A. M. Todkill

then, is far less authoritarian and much more based on mutual consultation than the traditionalist approach. Freedman invokes the theological concept of a "covenant" to denote the relational nature of care.

One advantage of Freedman's relational emphasis is that it makes room for the patient's family. The secular approach, founded in the notion of patient autonomy, deals very awkwardly with the most intimate social context of most people's lives: their families. The concept of autonomy is most useful in structuring relationships between the individual and the State, not the more thickly intimate human relationships between ourselves as communal (meaning historical) beings. Our families lie at the core of our communal nature. Families, with their duty to care for each member, should have more responsibility in making medical decisions involving their own kin than most secularists would allow.

My only real criticism of Freedman's work is strictly philosophical. I disagree with his sharp distinction between an ethic of rights and an ethic of duty. If a duty is what I owe somebody else (the Hebrew word *chovah* means, first, "debt" and, by extension, "duty") then doesn't that other person have a right to my duty? (The modern Hebrew word for "right," *zekhut*, literally means "privilege," something one is entitled to ask for.) Otherwise, duties are arbitrary, and that goes against Freedman's desire to present the Jewish tradition as having a rationale. Nevertheless, that philosophical quandary does not detract from the value of so much else in this book. Freedman certainly fulfilled his objective of showing how "Religion [in his case, Judaism] can provide a fuller understanding, by placing the questions raised within a global and even cosmic context."

David Novak
J. Richard and Dorothy Shiff
Chair of Jewish Studies
University of Toronto
Toronto, Ont.

Room for two views

In search of aequanimitas

Thou must be like a promontory of the sea, against which, though the waves beat continually, yet it both itself stands, and about it are those swelling waves stilled and quieted.
— Marcus Aurelius, as quoted by Osler in *Aequanimitas and Other Addresses*, 2nd ed., 1906

Sir William Osler is a figure for whom I have an ambivalent affection. I have come to view him as one might an elderly male relative, an uncle perhaps, who possesses both great acumen and an embarrassing tendency to make statements that betray his old-fashioned prejudices. He gets dragged out at family occasions to give speeches that are duly applauded, and because everyone admires him so much they are willing to overlook his little foibles.

I'm no expert on Osler, nor am I one of those fanatics who join societies to ponder his words of wisdom. But, like most Canadian physicians, I have encountered him from time to time over the span of my career, like a particularly persistent patient who keeps popping up in the emergency room, demanding to be seen.

I first made my acquaintance with Dr. Osler in medical school, when I was given a collection of his writings, *Aequanimitas and Other Addresses*. "Many young men," he says in the preface, "… have written that the addresses have been helpful in forming their life ideals." Whenever I didn't feel like studying, I would read one of Uncle Will's essays — in retrospect, a more productive use of my time than memorizing the tributaries of the superior mesenteric artery.


Fred Sebastian

Osler had none of our modern scepticism about Duty, Honour and Virtue. In his stilted Victorian manner, he preached "loyalty to the best interests of the noblest of callings, and a profound belief in the gospel of the day's work." Wagging his finger, he reminded me again and again of the high purpose to which I was committed.

I was particularly struck by the valedictory address given in 1889 at the University of Pennsylvania. In it, Osler spoke of "aequanimitas," describing an "imperturbability … indissolubly associated with wide experience and an intimate knowledge of the varied aspects of disease." With aequanimitas, "no eventuality can disturb the mental equilibrium of the physician; the possibilities are always manifest, and the course of action clear." Gotta get me some of that, I thought.

At that time, during my preclinical years, it was hard to imagine I would ever be able to do the things expected of physicians, much less with serenity and confidence. Aequanimitas, as I understood it, represented an acceptance of whatever might result from a particular action, without the burden of anxious rumination and indecision. An attractive notion, to think of attaining such a state. But I also had a suspicion that Osler might have considered me one of those students "who, owing to congenital defects, may never be able to acquire it." I was, after all, female, and all of his writings (with the exception of those intended for nurses) seemed only to address young men. Uncle Will, for all his encouraging words, might be less wildly supportive were we to meet face to face.

At times I wondered if I could ever live up to Osler's standards. My only consolation was that he would have considered my classmates to be equally poor specimens. Perhaps the medical students of the past were made of sterner stuff. Certainly, they must have had a better classical education to understand the obscure literary allusions that embellish his addresses. I remember my first night on call as a clinical clerk. If Uncle Will had been there, I would have

received a firm scolding as I hid in the call room. "The first essential is to have your nerves well in hand," I could hear him saying. "Even with disaster ahead and ruin imminent, it is better to face them with a smile, and with the head erect, than to crouch at their approach."

Osler could be annoyingly condescending toward patients at times, but he also spoke of "the need of an infinite patience and of an ever-tender charity toward these fellow-creatures." He reminded me of "the likeness of their weaknesses to our own," something I tried to remember when I started my psychiatry residency and encountered so many patients, especially those who were anxious and depressed, who needed a bit of aequanimitas themselves.

Through the intervening years, I came across Osler's name in many contexts — in history of medicine lectures, reference books, the name of a hospital. Osler quotations prefaced articles like verses from scripture. It was akin to seeing the name of a colleague in print: Hey, I know him. I felt a bit of pride, a bit of resentment.

And somehow, so gradually that I hardly noticed it, I cultivated a degree of aequanimitas. Perhaps I should not have been surprised; after all, Osler said that "with practice and experience the majority of you may expect to attain [it] to a fair measure."

But sometimes I think Osler's notion of aequanimitas is flawed. Surely nothing short of pathological denial can give rise to the peacefully enlightened state he attributes to Antoninus Pius as he lay dying: "about to pass *flammantia moenia mundi* (the flaming rampart of the world)" with "the watchword, *Aequanimitas*" on his lips.

Still, I want to believe. Because there are days — when patients' conditions are deteriorating, family members are lining up to see me, computer printers are jamming — when it helps me to imagine myself rising above the troubled waters of the hospital "like a promontory of the sea." All about me, the swelling waves are stilled and quieted, and there I stand, with Uncle Will at my side, my hand outstretched in a benediction, my face glowing in a state of perfect aequanimitas.

Lara Hazelton
Psychiatrist
Halifax, NS

Learning to act like a doctor

> Imperturbability ... is the quality which is most appreciated by the laity though often misunderstood by them; and the physician who has the misfortune to be without it, who betrays indecision and worry, and who shows that he is flustered and flurried in ordinary emergencies, loses rapidly the confidence of his patients.
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> Keen sensibility is doubtless a virtue of high order, when it does not interfere with steadiness of hand or coolness of nerve; but for the practitioner in his working-day world, a callousness which thinks only of the good to be effected, and goes ahead regardless of smaller considerations, is the preferable quality.
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> — William Osler, *Aequanimitas*, 1889

As a student, I was given very little guidance in the management of my own emotions, or those of my patients. When I was a resident I had to tell a young wife that her husband had died from an embolus. She arrived unsuspecting on the ward, and I told her bluntly that, while we try in such cases to prevent sudden death, we are not always successful, and that with her husband we were not successful. She stared at me for a moment and then, bursting into tears, flung herself into my arms. I was inept and inexperienced, but I just held her until she stopped sobbing.

Recently, I learned that a friend of mine has inoperable cancer. He has been told he has less than a year to live. Breaking this unexpected news, his physician described the condition and its implications clearly and straightforwardly. What impressed my friend was the physician's imperturbability, especially as he himself was devastated and wept copiously in the doctor's office. The physician remained focused on the illness, apparently ignoring the effect the information was having on his patient. Later, my friend met with a radiotherapist who, although he was extremely busy, spent time discussing the treatment, its role in pain control, side effects, and my friend's feelings and fears. As they talked, he even put his arm around my friend's shoulder. My friend wonders why physicians are so afraid of showing their feelings. Close physical contact is an effective way of expressing compassion and is probably genuinely therapeutic as well.

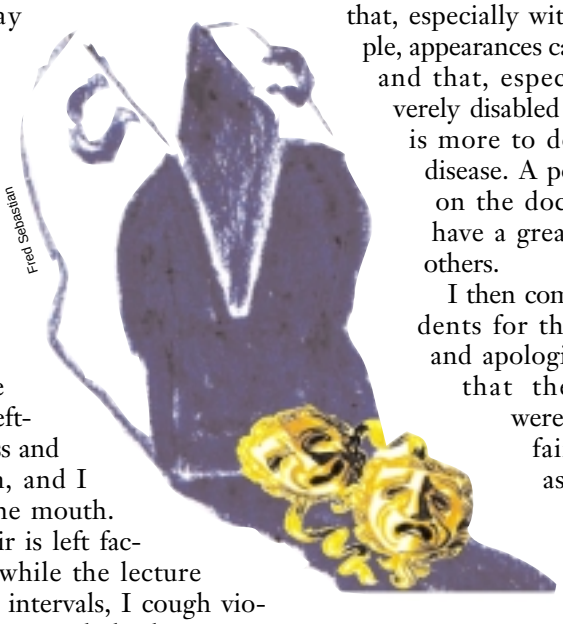
William Osler recommended that his students manifest a quality of imperturbability, which he called aequanimitas. This term conveys a sense of compassion, of sensibility to suffering, coupled with control in its expression. The first passage cited above implies that a person is by nature imperturbable or not. The second passage suggests that a student, however sensitive, can and should learn to act even callously if the patient's need calls for it. Can, and should, imperturbability be taught? Can a student who lacks a "keen sensibility" learn nonetheless to show compassion? One wonders if Osler's teachers taught him compassion and imperturbability, or if he was by nature endowed with them. How do we teach students to act the part of a compassionate physician, allowing the expression of feeling to the extent required for the patient's good? And when should physicians simply act like themselves?

Nowadays, we try to focus students' attention on effective and compassionate care. We try to show that pity alone, or a feeling of helplessness, is unjustified. At our school, healthy people are trained to act the part of a patient with a specific condition, thus allowing students to conduct an examination without exhausting a sick person. These portrayals are convincing because, apart from specific symptoms and signs, the "patient" gives a history from his or her own life. Because they are trained in a particular way, these actors are referred to as "standardized patients." Since my

retirement, I have acted both roles: that of teacher, and that of standardized patient.

Within a few weeks of starting their medical training, students are introduced to the basic concepts of geriatric medicine. The whole class is assembled for an introductory lecture on the prevalence of illness in the aging population and on issues of concern in this area of practice. These include the common prejudice that the illnesses of later life cannot be cured and that little can be done for severely disabled patients. The use of standardized patients is mentioned briefly.

After this introduction, the class is divided into small groups, who then pass from one "experience" to the next. These include interviewing a healthy elderly woman living alone, discussing medication problems with a pharmacist, trying to find one's way while wearing glasses with greased lenses, and interviewing a disabled old man. My part is to portray the old man.



During the introductory address, I am brought in, slumped in a wheelchair, wearing pyjamas and dragging one foot on the floor. I have left-sided weakness and parkinsonism, and I drool from the mouth. My wheelchair is left facing the wall while the lecture continues. At intervals, I cough violently and appear to choke, but no one pays any attention.

After the introduction, the groups interview me for about 10 minutes each. Although I appear so incompetent, I turn out to be a well-informed science teacher and a widower who lived alone before being brought to hospital because of frequent falls. I want to return home, but the hospital staff are arranging for me to go to a nursing home. I insist I should be allowed to go home. The attendant with me signals to the students that I am confused. When my wife is mentioned, I begin to sob.

Some of the students are speechless before this pitiful case. Their earnest faces peer at me; tears well in their eyes. Others, although visibly affected, continue the interview and focus on possible solutions, home care, safety devices, getting neighbours involved, and so on. Some students are so angry at the way I have been treated that they seek out the organizers of the session to express their feelings.

When every group has finished, I am wheeled into an adjacent washroom, where I quickly shave, put on a suit and tie and my steel-rimmed glasses and return to the class as a professor of medicine. There is great astonishment, as very few suspected I was a standardized patient. The purpose of the exercise it to emphasize that, especially with elderly people, appearances can be deceiving and that, especially with severely disabled patients, there is more to do than treat a disease. A positive attitude on the doctor's part can have a great influence on others.

I then commend the students for their sensitivity and apologize if they feel that their emotions were played on unfairly. However, as I explain, although pity is a natural reaction, it does not benefit the patient. Emotional involvement is desirable, but one must acquire imperturbability so that one can continue an interview and get the facts. An interview is not a conversation. But, beyond that, compassionate physicians will allow their sensibility to show, and will respond to the patient's emotional needs while also providing broad-based and effective care.

Colleagues in another faculty have questioned the ethics of involving students in an unexpected emotional scene. The objection is not that the standardized patient appeared so real that the students became emotionally involved, but that I then returned and showed them that I was "only" playing a role. The interview, they argue, had already taught the students that appearances can be deceiving, so my returning as professor of medicine only served to show that wilful deception is acceptable. We teach our students by what we do as well as by what we say.

But I believe that playing the role of patient enabled me to experience both the sensitivity of the students and their ability to control their feelings, and to encourage their compassion while promoting self-control. Returning in the role of teacher and physician shows that these, too, are roles that can be learned. In the physician's role, it is not deception to show genuine compassion while maintaining an imperturbable demeanour. Controlled emotions can provide the energy the physician needs to develop and implement a treatment plan, set an example for others, and overcome institutional apathy or disinterest.

Patients vary, of course, in the extent to which they welcome expressions of concern and close physical contact. Clearly, every patient is different, and the physician's role must be modified to meet the needs of each one. We must sensitize our students to the varied reactions of our patients, and teach them to respond in every case with sympathy, compassion, and a fair measure of aequanimitas.

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Ronald Bayne
Emeritus Professor of Medicine
McMaster University
Hamilton, Ont.