

Suffering and the moral orientation of presence: lessons from Nazi medicine for the contemporary medical trainee

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ABSTRACT

Medical trainees should learn from the actions of Nazi physicians to inform a more just contemporary practice by examining the subtle assumptions, or moral orientations, that led to such heinous actions. One important moral orientation that still informs contemporary medical practice is the moral orientation of elimination in response to suffering patients. We propose that the moral orientation of presence, described by theologian Stanley Hauerwas, provides a more fitting response to suffering patients, in spite of the significant barriers to enacting such a moral orientation for contemporary trainees.

INTRODUCTION

As the 75th anniversary of the beginning of the Doctors' Trial at Nuremberg approaches, a vital question for the medical trainee is how to learn from the involvement of Nazi physicians in the Holocaust to inform more just and humane contemporary practice. For this exercise to prove effective, however, she is called to the uncomfortable work of searching for the subtle (and perhaps surprising) commonalities she shares with the perpetrators, rather than triumphantly naming the overt differences. Such an undertaking requires that she move beyond examination of the grotesque actions of the Nazi physicians to the foundational beliefs underlying them, where such commonalities may remain tacit or simply unrecognised. The crucial question at hand, then, is perhaps best articulated by the bioethicist and medical historian Warren T Reich, who asks, 'What ideas, what ethos of ideals, what *moral orientations* could have accounted for the terrible medical choices of the Nazi medical doctors?' (emphasis added).¹

Moral orientations are 'moral values that have a consistent guiding orientation toward an individual's moral cognition and behavior'.² Moral orientations serve as guiding frameworks that play a central role in moral decision-making and specifically impact how individuals approach and resolve moral dilemmas.³⁻⁵ Examples of prominent moral orientations include a 'justice' orientation, which focuses on individual interests in approaching moral dilemmas⁴ and a 'care' orientation which attends to fulfilling responsibilities to others in moral decision-making.⁵

It is only through consideration of these and other salient moral orientations that the contemporary trainee can truly understand where those latent commonalities persist, and where she is called to act differently.

The purpose of this essay, which will proceed in three parts, is the evaluation of different moral orientations that may be brought to bear on a crucially important and unfortunately common moral situation: the engagement of the physician with the suffering patient. First is an examination of the moral orientation of 'elimination' of suffering, which operated among Nazi physicians. Second is a brief consideration of where this moral orientation of 'elimination' persists for the contemporary trainee. Third is the description of an alternative moral orientation for the contemporary trainee to consider, that of 'presence', proposed by theologian Stanley Hauerwas. We present an argument for the importance of the moral orientation of presence in spite of the barriers to its exercise in contemporary medical training. While we believe that this exploration of the moral orientation of elimination and argument for its alternative of presence applies to all medical practitioners, we will focus in particular on the role of medical trainees, given the formative moral process that medical training entailed both for Nazi physicians¹ and for contemporary trainees.⁶

NAZI MEDICINE AND THE MORAL ORIENTATION OF ELIMINATION

In contrast to narratives which depict Nazi medicine as amoral, there were firm ethical commitments of Nazi doctors which led to physicians becoming the professionals with the highest proportion of participation in the Third Reich.^{7,8} Chief influences forging this ethic were those of eugenics science, social Darwinism and utilitarianism, collectively informing the moral priority of the societal *Volk* over the individual, and the extolment of the 'fit' at the expense of those who were deemed burdens on the state.^{1,9} As evidence of these moral commitments, many German physicians stated that they practised conscientiously, even as they were directly involved in practices causing the death of individuals.¹⁰ Yet how could this moral posture of destruction towards the 'unfit' square in a morally intelligible way with German physicians' ethical obligations to the society and individuals they served?⁷

A key move in conferring moral rationality was the use of language which championed the relief of suffering for the 'unfit'. This philosophy was operative in Germany prior to the rise of the Third Reich, implicit in the influential German philosopher Friedrich Nietzsche's denigration of the weak and extolment of the *Über-mensch*.¹¹ The sentiment became more explicit in Adolf Jost's 1895 'Das



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Rcht auf den Tod' (The Right to Death), where the author drew heavily on eugenics and utilitarian language to advocate the killing of those deemed unfit, yet stated this would be achieved through compassion and relief of suffering of those killed, a mode of understanding subsequently adopted by Nazi physicians.¹² The formative work entitled 'The Permission to Destroy Life Unworthy of Life' by lawyer Karl Binding and psychiatrist Alfred Hoche further developed these sentiments, arguing that the elimination of those with incurable illness, psychiatric disorders and intellectually disabled children would improve the *Volk* but also serve as a compassionate response towards these suffering in a 'higher morality'.¹²

Buttressed by such a foundation, Karl Brandt, the chief medical administrator of Germany and physician instrumental in creation of the infamously euphemistic 'Euthanasia' programme, argued that his actions conveyed 'pity for the incurable'.¹³ This initiative, which fell under the code name 'Aktion T4', involved the German Reich Ministry of Interior ordering physicians to report infants born with stigmata suggestive of congenital, developmental and neurological disorders to central Nazi physicians who would decide their fate.^{14 15} Hitler himself appealed to the moral code of German physicians by using the language of 'mercy death' in his promulgation of the Euthanasia programme, and the emphasis on relief of suffering was harnessed to justify the 'Favor of Death' for a baby requested to be killed by the Nazis.¹⁴

While these examples serve as a cursory exploration of Nazi ethics, they do provide important insight into how physicians came to sanction and participate in the murder of patients. The language of relief of suffering for the 'incurables' represents a moral orientation towards suffering that we will term 'elimination', by which the resolution of suffering is brought about by the elimination of the sufferer.

CONTEMPORARY MEDICINE AND ELIMINATION OF SUFFERING

While the contemporary trainee may reject the notion that such a moral orientation persists today, it is precisely here that she is called to the hard work of identifying the uncomfortable commonalities mentioned previously. The moral orientation of elimination is hardly surprising when one considers the central challenge that suffering poses to our very self-understanding as humans. Theologian Stanley Hauerwas argues that the uniqueness of individual pain and suffering always engenders isolation due to our inability to share these experiences, thus threatening our identities as communal beings.¹⁶

Due to this central threat to our individual and communal identity, suffering often engenders a desire to respond by those who witness it. This is particularly true for those in a healing profession, such as the field of medicine. Bioethicist Gerald McKenny argues that the desire to relieve suffering, sometimes to an excessive degree, is one of the central projects of contemporary medicine.¹⁷

The moral orientation of elimination does, in fact, represent one possible response to this call.¹⁷ While this moral orientation for contemporary physicians would hopefully not evolve to justify acts as egregious as those of Nazi Germany, it is nonetheless important to consider where this moral orientation is operative today.

An important example of the moral drive to eliminate suffering is found in physician and patient beliefs about suffering manifest in the opiate epidemic. The imperative for physicians to act in the face of pain serves as one of the several cultural backdrops against which the opiate epidemic arose.¹⁸ Following the discovery and

subsequent widespread manufacture of narcotic medications, the expectation to harness such substances given their perceived efficacy and safety gained traction among physicians.¹⁹ Increasing attention to the pain of patients became so central to practice that pain came to be viewed as the 'fifth vital sign' in the latter decades of the 20th and early 21st centuries.²⁰ As the pernicious effects of these drugs became better understood, physicians were faced with the problem of refusing patients medications which seemed to provide relief but caused clear damage.¹⁹ Trainees today still directly grapple with this issue as they recognise the tension between the desire to relieve pain and the limits of such an endeavour, and the ease with which such an emphasis on relief can lead to unintentional elimination.^{21 22}

An example of the drive to mitigate suffering that also involves elimination of the sufferer can be found in the contemporary conversation surrounding physician-assisted suicide (PAS) in the USA. Central arguments in favour of PAS rely heavily on the language of suffering and the presumed injunction of the physician to relieve suffering, even as evidence suggests that relief of suffering is not the primary reason patients choose to end their lives, but rather the loss of autonomy and control.²³ As different countries move to legalise PAS for children and for those with psychiatric conditions, this moral orientation of elimination raises key questions about the limitations of such an endeavour.^{24 25} The language used in defence of PAS frequently assumes the elimination of suffering to be central to its perceived rhetorical efficacy.²⁶

In a more subtle way, the language of suffering informs the approach to caring for the increasing proportion of patients with disabilities and complex medical needs, particularly in the paediatric population.²⁷ It is important to note that physicians and family members frequently have different perceptions of quality of life and suffering endured by patients.^{28 29} Such a reality ought to give pause to physicians who may presume suffering (and the imperative to act on it) in patients based on internal biases about the nature of a meaningful life.³⁰ Moreover, caring for patients with chronic needs including disability often proves challenging for clinicians given the frequent medical complexity of these patients.^{28 31} In such cases, practitioners must be wary of conflating presumed suffering in patients with their own sense of 'suffering—' or learning to 'bear with' such patients.¹⁶ Those patients with chronic conditions who may be perceived as suffering and who cannot be satisfactorily 'fixed' may prove especially challenging to medical professionals who perceive their own identities as healers, or those who cure.^{16 31}

HAUERWAS AND THE MORAL ORIENTATION OF PRESENCE

Speaking on the issue of disability, but in an observation which also may pertain to the area of narcotic medication and PAS, theologian Stanley Hauerwas notes that too often 'it seems odd that in the name of eliminating suffering, we eliminate the sufferer.'¹⁶ Hauerwas notes that one of the main goals of contemporary medicine is to alleviate such suffering, which of course is something that should be pursued in the course of caring for patients. Yet the physician who harnesses all resources in the course of her duties to relieve such suffering may paradoxically do more harm than good. For example, in the preceding example detailing narcotic prescription, it is clear that an overzealous desire to address bodily pain and the suffering this causes may, in some instances, generate harm and in some instances even the death of patients. As a consequence, we recognise that the elimination of suffering for the physician 'must surely be a

qualified aim'. Yet what sort of moral orientation might allow for this qualification?

In his collection of essays aptly titled 'Suffering Presence', Hauerwas engages this question through his phenomenological account of the experience of suffering and explores how this informs both the patient–physician relationship and the essence of medical practice itself.

As previously mentioned, Hauerwas claims that suffering presents a fundamental problem as it threatens our status as communal beings due to the isolation it produces, for:

No matter how sympathetic we may be to the other in pain, that very pain creates a history and experience that makes the other just that much more foreign to me. Our pains isolate us from one another as they create worlds that cut us off from one another.¹⁶

This suffering does not merely impede our communication and thus self-understanding as people in community; it actually engenders a sense of repulsion in the healthy who interface with the sick. We are repelled because of the difficulty we see the other experiencing and because the suffering other reminds us of our own finitude and contingency. This repulsion is intensified for medical trainees as it also threatens our perceived power and agency and identity as healers, and we are left wondering how we might 'be present to the ill day in and day out without learning to dislike, if not positively detest, our smallness in the face of pain'.¹⁶

Yet in the midst of this repulsion lies the sacred opportunity for the physician. For just to the extent that suffering threatens to isolate those afflicted, the physician's refusal to abandon the patient helps maintain the suffering patient's membership in community and the physician's professional self-understanding. It is this distinctive 'privilege and burden' of being with the suffering which characterises the dual opportunity and difficulty of the physician's role:

It is the burden of those who care for the suffering to know how to teach the suffering that they are not thereby excluded from the human community. In this sense medicine's primary role is to bind the suffering and the nonsuffering into the same community.¹⁶

The role of the physician, then, rather than attempting to eliminate suffering at all costs, is to act to bridge 'the immense gulf between the world of the sick and the healthy'.¹⁶ Physicians thus help maintain the humanity of their patients even while the suffering their patients endure threatens to 'obliterate' their patients' very identity.

Contrary to a medical training system which might construe physicians fundamentally as those who intervene, heal, fix and *do*, Hauerwas' view of the constitutive role of the physician is one who provides presence: 'I take [the activity of the physician to be] characterized by the fundamental commitment to be... in the presence of those who are in pain'.¹⁶ Rather than proffering designs of eliminating suffering, 'the physician's basic pledge is not to cure, but to care through being present to the one in pain'.¹⁶ Such a commitment reflects a form of moral friendship and an epistemic humility lacking in contemporary medicine, that the total relief of suffering is practically impossible and that its pursuit is hubristic at best and destructive at worst.

In the scandalous claim that the physician's role is best understood as 'human presence in the face of suffering', Hauerwas argues that doctors might learn to say that 'our presence is our doing'.¹⁶ In a contemporary medical culture which focuses so heavily on the 'doing', the notion that a physician's primary

commitment might be presence is jarring. Importantly, such a moral orientation does not neglect the attempt to ameliorate suffering, but it recognises that the practice of presence is morally prior to the attempt to cure and qualifies the curative aim.

EFFORTS TOWARDS PRESENCE IN CONTEMPORARY MEDICINE

It is important to note that elements of Hauerwas' description of the importance of presence in the face of suffering have found traction in certain areas in contemporary medicine. First, the proliferation of palliative medicine as an increasingly important subspecialty service is one such example. Palliative medicine, which focuses on relief of symptoms and improved quality of life, rather than explicitly curative measures,³² emphasises the importance of therapeutic presence to patients.^{33 34} While ethical issues surrounding end-of-life care and symptom relief have caused palliative medicine to also serve as a new locus for the limits of our call to relieve suffering, nevertheless, the specialty's emphasis on time spent with patients amidst a medical culture which allows increasingly less time for such encounters³⁵ attests to recognition of the importance of practitioner presence.

Second, the orientation of presence exists in the increased attention to 'ethic of care' in contemporary medical bioethics. The concept of an ethic of care arose in the medical world from nursing literature, with an emphasis on protecting patients' dignity in a medical culture which may too often complicate practitioners' abilities to empathise with their patients.^{36 37} An ethic of care places on emphasis on attention to patients' cultural, spiritual and psychological factors to allow for enhanced communication and the ability to provide comfort and assuage patient fears.^{38–40} Such an ethic recognises the crucial role that time and presence plays to allow for attention to patients' individual needs beyond merely their medical conditions. It seems that without explicit emphasis of the importance of an approach similar to an ethic of care, contemporary clinicians would struggle to see either the importance, or even the possibility, of time spent with patients that is not spent on the acts of diagnosis or treatment.

CHALLENGES TO A HAUERWASIAN POSTURE FOR LEARNERS

While certain niche arenas, like palliative medicine and the ethic of care, recognise the need for practitioner presence, this is not yet normative in contemporary medicine, nor is it emphasised for trainees. Indeed, lest Hauerwas' view of the physician as one who is daily present to suffering be written off as banal or generic, students of medicine ought to first recognise how radical this depiction is. This should be made apparent by the various realities of medical training that make the practice of suffering presence exceedingly difficult.

First, the contemporary medical trainee spends relatively little time at the bedside, where the daily encounter with the suffering other occurs. Heavy inpatient census, note writing and other clerical duties often preclude time spent providing direct care with patients.⁴¹ In a profession (and training environment) which constantly pulls trainees further and further away from the bedside, we recognise that there are significant systemic challenges to providing presence, even if we desire to do this.

Second, the very formulation of the patient–physician relationship is changing. The hegemony of autonomy threatens to pose the physician–patient relationship as that between to voluntary members, rather than a traditional covenantal understanding.^{16 42} The language of 'provider' and 'consumer' construes this relationship as one predicated on finance, and exchange construes medicine as business rather than a moral

practice.^{43–45} An increased emphasis on population-level health, quality improvement and other ancillary concerns (even if they are important) may distract from the primacy of the patient–physician relationship. Amidst these challenges to the traditionally understood fiduciary commitment to the patient, the commitment to presence to suffering may be viewed as detracting from these perceived competing commitments.

Third, for those trainees who employ such an orientation, medical training may not provide the moral resources to protect them from the ‘destructive’ effects that presence to suffering might entail.¹⁶ As Hauerwas argues, for those whose jobs involve daily presence to suffering, a robust and traditioned moral community is required to sustain this taxing work. Contemporary medicine, however, is frequently suspicious of the involvement of traditioned moral communities and the particularist language these communities entail.^{46–47} As Hauerwas notes, without ‘something very much like a church’ to sustain trainees in this orientation of presence, physicians are subjected to the threat of their own ‘[moral] obliteration’.¹⁶

CONCLUSION

It is our hope that the methodology of examining the moral orientation of Nazi physicians, rather than the egregious acts themselves which tend to garner most attention, allows for more productive, if challenging, reflection on how contemporary trainees may learn from Nazi medical ethics. The moral orientation to suffering, in particular, proves a challenging one to face when we recognise the many ways we may be dissuaded from providing presence, and the significant challenges to actively doing so.

Indeed, in the face of substantial challenges to a moral orientation of presence to suffering, we garner an appreciation for how truly difficult this work is. It also becomes evident that an alternative moral orientation of elimination need not be assumed and exercised for overtly malevolent purposes as in Nazi Germany—it may simply be easier to forego the practice of presence to suffering, which requires the virtue of patience, one in short supply in the efficiency-crazed milieu of medicine today.⁴⁶

Yet it is often the good and the true which proves most taxing, for as T S Eliot remarked, ‘humankind cannot bear much reality.’⁴⁸ Ultimately, the commitment to presence rather than elimination of suffering affords a sorely needed epistemic humility in contemporary medical training; that we as physicians cannot ultimately eliminate suffering in spite of the vast promises of contemporary biomedicine.¹⁷ Thus, an orientation of presence offers what our patients need, and what we need to properly understand the nature of our professional commitments and the limits of our technological and intellectual prowess, areas where Nazi physicians sorely lacked such wisdom.

It is worth noting that, given the previously mentioned temporal and bureaucratic pressures faced by physicians today, other medical practitioners may in fact be better equipped to provide such presence. This may include medical students or other health professional students with more discretionary time in the course of their clinical duties. Bedside nurses almost certainly provide such presence on a more regular basis than physicians, and physicians and physicians in training would do well to recognise both the importance and difficulty of this work—and perhaps look to such nurses as moral educators in this regard.

One final point is in order. It is crucial to note that these instances of the relief of suffering will disproportionately affect those patients who are the weakest and most vulnerable.

In the same way that children with disabilities were the first targets of Nazi physicians, children, individuals with disabilities, those with psychiatric illnesses, the impoverished and disenfranchised will naturally be ones for whom discussions of suffering will arise. This is particularly true for medical professionals for whom lives of relative health, independence, intellectual aptitude and comfort may cause us to detect suffering where it does not actually exist. It is in engaging questions of suffering with these vulnerable populations that we must be particularly wary of the temptation to leverage our technological prowess in lieu of the hard-earned virtues of patience, charity and constancy which enable us to be present even, and perhaps especially, when faced with the limits of our curative powers.

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