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UNDERSTANDING HUMAN EMOTIONS AND THEIR RELEVANCE FOR MEDICAL ETHICS

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Introduction

In a recent review article, entitled "Thinking about Death as a Wax Apple", Eric J Cassell examines an attempt by a philosopher to weigh the relative roles of 'reason' and 'emotion' in medical ethics. [1]The book under review, Thinking Clearly About Death by Jay. F. Rosenberg[2], places cognition and emotion in sharp opposition and considers emotion and feeling as something markedly inferior to rationality which provides the one and only mode for dealing with questions of medical ethics in general and issues pertaining to death and dying in particular.

In his review Cassell concedes, that analytic reason helps us get a clear idea of issues as euthanasia and the artificial prolongation of life. But he claims that the role of the analytic reason can be overdone and even take an excessive turn, specially when dealing with questions like death and dying. He further maintains that emotion and cognition are interactive processes. Cassell compares Rosenberg's attempt to think 'about death' devoid of the emotional component to the perfection of a wax apple-- "an abstraction so far removed from the real thing that gives us no insight into smell, savor, texture, or heft, without which we know nothing important about apples"[3].

It is the aim of this paper to examine the place of emotions in medical ethics within a larger framework : first to look briefly at the nature and logic of emotions, secondly to examine briefly the role of emotions in ethics and finally to discuss the role of emotions in a selected area of medical concern.

I

The place of emotions in man's life has been pushed aside and neglected due to a number of reasons : an overly narrow concept of rationality and an inability to discern the immensely complex but rich patterns found in the logic of emotions; a tendency to consider emotions as ethically undesirable, spiritually problematic and as necessary states of imbalance and agitation, without realising the creative role of the positive emotions; an inability to accept the position that the best way to deal with undesirable emotions is to understand them in their intricate patterns of emergence, expression and survival; a theoretical closure on emotions in ethics has been created by the spell of the emotive theory of ethics; the split between studies of emotions in the natural science and more humanistically oriented studies. Even our common sense and average use, metaphors such as, 'paralysed by fear', 'struck by jealousy', 'drowned by sworrow', etc,tend to give an excessively passive picture of the human person in emotional experience.

While emotions have a physiological aspect and are linked to desires, they also have cognitive and value components. The cognitive component of emotions has been highlighted by number of studies.[4] According to these studies, emotions have a background of belief, can be rational or irrational, they can be justified and their appropriateness to situations accepted. If we recognize some object as a 'snake' and if we believe that snake bites can be poisonous and a threat to life, the perception of the snake is interpreted as a 'danger' and thus the emotion of fear emerges. Indignation on the other hand for instance has a strong value component, for it is not a mere state of anger, but generated by a strong sense of good and bad, occasioned for instance by some thing like the breaking of a promise. A man is afraid because he sees the object or situation as dangerous., angry as he sees the situation as offensive, embarassed as he sees

the context as a situation in which he has lost face and so on. In addition to a clear cognitive component and related evaluations, there can be attitudes, dispositions, unconscious traits, unarticulated and dark cognitive sets which influence emotions, which form a rich and complex network.

There has been recent work on more positive emotions like compassion, generosity, gratitude etc. Compassion involves a sense of shared humanity, promotes the experience of equality, makes possible the imaginative entry into the suffering of others, a concern for the good of others, it has strength and duration and generates beneficient action[5]. Such a perspective on emotions is quite different from what is found for instance in a rigid Kantin view, which regards emotions to be of a lower order, capricious and lacking in a basis for the development of universal moral principles. Though some sympathetic and apparently compassionate responses can in actual expression turn out to be transitory and capricious, Blum notes that, "this is not so much a defect in the altruistic emotions per se as it is a sign of an inadequacy in the particular responses of the particular person".

Regarding the role of emotions in ethics and ethical reflection, Bernard William's paper on "Morality and the Emotions"[6] claims that an excessive concern with questions of language and semantics in moral philosophy has completely pushed the emotions out of the picture[7]. Concern with language and semantics have their legitimate role in ethics but to convert central issues of human relationships in the context of life-threatening illness and treatment to a 'wax-apple' is to turn a blind eye to the diversity of human resources and the variety of possible ethical perspectives. The recognition of moral emotions of care and compassion adds a sense of depth to the therapeutic alliance in the doctor-patient relationship. A new ethical perspective emphasising the importance of emotions and human relationships has been emerging

in writings like that of Blum, not to replace Kantianism and Utilitarianism but to avoid their deficiencies and supplement them[8]. It is the burden of this paper to focus interest on such a perspective and explore its relevance to the ethics of medical care. A great deal of writing in medical ethics has been concerned with such questions as whether life is to be saved or not, but the question what kind of person leaves the world can turn out to be equally important[9]. In the words of Bernie Siegel who makes a most humane presentation of his discoveries with the treatment of patients, ..." you become an individual to your physician and are treated as an individual, not a disease"[10]. The distiction between the doctor as a healer and the doctor as a mechanic runs throughout his work, and it implies that in making medical decisions which have moral implications, where possible we have to shift from the paradigm of the medical mechanic to the medical healer.

Taking ethical decisions in important context-bound situations call for a degree of moral seriousness and sincerity, especially in situations which demand appropriate action : "That consistent or appropriate action is the criterion of moral sincerity is an idea that has been constantly stressed in recent discussion. The point I want to make is that the appropriate action which is demanded by this conception of moral sincerity is something which, often, is not independent of the emotional element in a man's moral outlook".[11]

Thus we can agree with Bernard William's contention that the relevant unity in man's behaviour (the pattern into which his judgments and action fit), "must be understood in terms of an emotional structure underlying them"[12]. If we accept this general connection between emotions and the moral life, the development of an ethical perspective integrating their role into an ethical theory is a seminal idea, and an idea already developed by those like Lawrence Blum in his, Friendship, Altruism and Morality[13].

II

The relevance of emotions in dealing with moral dilemmas which so much dominate the field of medical ethics is the next step in our discussion. Carol Gilligan's discussion of moral dilemmas in her work, In a Different Voice[14] and Alastair Campbell's work Moral Dilemmas in Medicine[15] are two relevant studies which give a significant place to emotions. Gilligan says that there are two ways of talking about morality: when talking about morality, one can talk in terms of justice, the fair weighing and balancing of claims; the other way one cant talk about morality is to talk about care and response, problem of responibility in relationships. These different voices as it were could be identified in people's discussion of moral dilemmas. One focusing on not hurting, care and response as different from the voice that spoke of equality, reciprocity, justice and rights. "The discovery that these different modes of moral discourse appeared in conjuction with different ways of describing theself-as separate in relation to others and as interdependent -- revealed the common grounding of these distinctions in two different perspectives toward relationships"[16]. The first emphasises and is rooted in impartiality and objectivity, the capacity to distance oneself and determine fair rules for meditating relationships, the other is grounded in the specific contexts of others, the ability to perceive people in their own terms and to respond to their needs[17]. "For centuries these two lines of morality have wandered through the Western tradition, appearing in the contrast between reason and compassion, fairness and forgiveness, justice and mercy ..."[18]. Of course for Gilligan these distictions have a basis (though not exclusively) in differences between men and women. Leaving out some leeway for overdoing these distinctions, they offer two broad paradigmatic stances for dealing with moral dilemmas.

Gilligan presents the following moral dilemma[19] : A person called Heinz has to decide whether or not he should steal a drug, which he cannot afford to buy, in order to save the life of his wife.The issue is presented to two children for a response. Jake a boy of eleven years sees the problem in clear logical terms, as a conflict between the values of property and the value of life and upholds the value of life over property : "For one thing, a human life is worth more than money, and if the druggist only makes $1,000, he is still going to live, but if Heinz doesn't steal the drug his wife is going to die. Why is life worth more than money? Because the druggist can get a thousand dollars later from rich people with cancer, butHeinz can't get his wife again. Why not? Because people are different and so couldn't get Heinz's wife again".

Amy an eleven year old girl gives a different type of answer : "Well, I don't think so, I think there might be other ways besides stealing it, like if he should borrow the money or make a loan or something, but he really shouldn't steal the drug - but his wife shouldn't die either".

When asked a counter question from Amy why the drug should not be stolen, she considers neither property nor law, but the effect of theft on the relationship between Heinz and his wife : "If he stole the drug, he might save his wife then, but if he did, he might have to go to jail, and then his wife might get sicker again, and he couldn't get more of the drug, and it might not be good. So, they should really just talk it out and find some other way to make money". The two children look at the problem in different ways, Jake through the impersonal systems of logic and law, Amy personally through communication in relationships.

While Gilligan makes the distinction between the ethic of care and the ethic of rights, Campbell's book brings in a variety of alternative ethical conceptions and the discussion is close to medical ethics. He cites four orientations which can guide the process of taking ethical decisions for the purpose of resolving moral dilemmas in the field of medical care : Conscience theories, The Common Good of the Utilitarians, The Kantian notion of the moral law and the duty ethics and finally a very broad orientation which may be called the ethic of respect for persons[20]. This last orientation is some what loose but viable enough to assimilate Gilligan's ethic of care and a concept of inter-personal communication integrating both reason and emotion. The notion of 'respect for persons' is an orientation that has a certain looseness and it is a concept which can accommodate the Kantian principle of treating persons as 'ends in themselves' rather than treating them as means. But, Kant presented the idea that the guts of morality is to be found in the experience of doing ones duty for duties sake and his concept of moral law has an abstract character. Also the Kantian notion of obligation does not clear the way for the grasping of the moral significance of sympathy, compassion and concern.

III

In focusing attention on the theme 'understanding human emotions', we wish to emphasise a notion of the respect for persons that will do justice to both the rational and emotional aspect of morality. The two questions, "What is it that gives value to human life?" and "What can be done to enhance the quality of our human existence?" should be placed against the background of the"total human person", a notion which will place the role of human emotions in our lives within a holstic setting. Different forms of fragmenta-

tions have eroded our vision of life and the need to emphasise the importance of values as a corrective to the one track development of science and technology can be clearly seen in the field of medical technology. Recent work in emotion studies do emphasise the importance of human relationships as seen in the family, friendship and in the community[21]. An extension of this perspective to the doctor-patient relationship is imperative if we are to develop a viable ethic of medical care and medical service.

The moral territory traversed by certain emotions is important - respect and care, compassion and kindness, gratitude and humility. But they can conflict with certain core values - equality and justice or veracity and truthfullness. We need a blending of pathways to deal with these conflicts which often get converted into both terminable and interminable moral dilemmas. We need to blend the conflicting pathways.

The study of ethics itself is being hedged by questions of moral dilemmas and this has raised important issues about 'core values' and their relation to tradition and culture. Alasdair MacIntyre's <u>After Virtue</u>[22] express the deep worries regarding the fragmentation of values in our times. But, ethics itself is being torn by competing and conflicting positions like the Kantain and Utlitarian points of view. To heal the emerging threat of fragmentation we need the complementary role of a number of view points and new perspectives. An ethical perspective emerging on the basis of altruistic emotions as Lawrence Blum presents can cut across the sense of aridity and fragmentation besetting our value systems. This paper is charactered within a broad frame work which gives centrality to values and their linkage to emotions and human relationships.

In the discussion that follows, we are selecting a special issue which concerns the medical profession, this is the question of 'truth-telling' to patients regarding their real conditions and the ethical, psychological and philosophical perspectives to this problem.

The Ethics of Truth Telling

"A forty-six-year-old man, coming to a clinic for a routine check-up needed for insurance purposes, is diagnosed as having a form of cancer likely to cause him to die within six months. No known cure exists for it. Chemotherapy may prolong life by a few extra months, but will have side effects the physician does not think warrented in this case. In addition, he believes that such a therapy should be reserved for patients with a chance for recovery or remission. The patient has no symptoms giving him any reason to believe that he is not perfectly healthy. He expects to take a short vacation in a week"[23]

The physician has a number of alternative choices which involves the process of communicating information which is true:

(i) Ought he to tell the patient what he has found out or should it be concealed?

(ii) If he decides to reveal the diagnosis, should he delay doing so, atleast till he returns from the vacation?

(iii) If he does reveal the serious nature of the diagnosis, should he mention the possibility of chemotherapy, and his reasons for not recommending in this case?

(iv) Should he encourage every last effort to postpone death?

In this particular case, the doctor decided to inform the patient about the diagnosis right away but not the possibility of chemotherapy. Doctors face such issues in their routine work and the questions about what they hold, conceal, reveal or distort is a profoundly important matter to the paitent. Doctors manipulate information as a part of their therapeutic regimen and some think that the doctor has the right to manipulate the truth. The stress is on beneficence and not on veracity. The Hippocratic oath makes

no mention about truthfulness and even the Declaration of Geneva (1984) makes no mention of it. "The concern for curing and for supporting those who cannot be cured runs counter to the desire to be completely open"[24]. Physicians know the uncertainties of diagnosis, the pull of the "Self-fulfilling prophecy" and they dislike the bearers of being uncertain or bad news. "And last, but not least, sitting down to discuss an illness truthfully and sensitively may take much-needed time away from other patients".[25] Nurses, physicians, relatives of the sick function within this framework.

But yet problems arise as doctors do not work alone with patients, and as they have to consult a number of others. If they distort information or choose to lie, the choice may not be approved by others who participate in the care of the patient. Nurses for instance care for the patient almost twenty four hours and compared with the doctor's brief visit, they virtually live with the patient. "The doctor's choice to lie increasingly involves co-workers in acting a part they find neither humane nor wise. The fact that these problems have not been carefully thought through within the medical profession, nor seriously addressed in medical education, merely serves to intensify the conflicts"[26]. There are a small number of physicians who have brought up these problems for discussion, but their ideas have to yet get integrated into the mainstream of medical ethics, in an applied and practical way.

As Sissela Bok has clearly shown there have been three arguments which have been used to make the case for lying and these have been found defective : (i) truthfulness is impossible; (ii) patients do not need bad news; (iii) truthful informations harms them[27]. The first of these argements confuse "truth" and "truthfulness". The term truthfulness covers both reason and emotion. The term truthfulness refers to the avoidance of intentional manipulation of information. Some try to smudge the issue

by saying that the truth can never be known or communicated and this is to confuse truth and truthfulness in this context. It is the desire to be open with whatever information one has. Deception and truthfulness are the larger categories, truth and falsehood come within them. Thus, truthfulness brings us to the question of communication, not merely the neatly framed sentence and the proposition but also the sign, the gestures, the signals, facial expressions. In brief, communication involves both reason and emotion and all this covers the territory of deception and truthfulness. Once truth and truthfulness are confused, we leave room for occassional lying. It is a strategic move to discourage questions about truthfulness from carrying weight and thus leave the choice about what to say and how to say to the doctor. In medicine this strategy is made stronger by insisting that even if people understand what is spoken to them in ordinary situations, patients are not in a position to do so. Thus we embrace paternalism.

There is no conflict between the ethic of veracity and the ethic of care if the conflicts are openly handled than suppressed. A healing of the different pathways that values take is the best norm that can guide us, in our attempt to deal with a fragmented world.

There is also a broader philosophical point in becoming more open to the patient and, where possible, respecting autonomy. Apart from the ethics of the values, rights, care and veracity, there is the basic humanistic perspective which would pervade such inquiries : the important question is not merely whether life is saved or not in a quanitative way, but in more qualitative way, what kind of person leaves the world, a basic oriental concern and also shared by the more classical western world. As Elisabeth Kubler-Ross says today we are confronted by "a new but depersonalized science in the service of prolonging life rather that diminishing human suffering"[28]

"A look into the future shows us a society in which more and more people are 'kept alive' both with machines replacing vital organs and computers checking from time to time to see if some additional physiologic functionings have to be replaced by electronic equipment". In this manner, medical technology will develop and the need to emphasize that with all its technology medicine has to be a humanitarian concern will be very crucial. Thus the philosophy that the doctor is a healer rather than a mere mechanic the dominant image which can nourish a more holistic ethical orientation for our times. Bernie Siegel, discussing his experiences with cancer patientsin his Love, Medicine and Miracles[29], says that while seeing the suffering that one of the patients underwent, he was more than ever convinced that there is a need for compassion to balance medical heroism: "How can we say we are prolonging life when a person has become no more than a valve between the intravenous fluids going in and the urine coming out? All we are prolonging is dying"[30].

Now that we have outlined the ethical and philosophical perspectives concerning the question of truthfulness in the communication of information to the patient, we shall go into a more detailed study of the concept of communication which will bridge the problematic ethical issues in the doctor and the patient relationship.

The Communication Links Between Doctor and Patient

The question of truth-telling to patients and discussing death with patients need not be converted into an interminable dilemma and an insoluble moral issue but transformed into a problem of interpersonal communication within a hospital ward. "The solutions to the problem are practical ones: training of nurses and doctors in sensitive communication with the dying and the provision of adequate facilities and sufficient staff for the kind of service needed. To call these solutions 'practical' does not imply that

they are easy to put into effect. Within the competing priorities of medicine, care of the dying may not rank very high. It depends to a large extent on the way in which society which provides medical care understands the healh of individuals"[31]. Thus, if we wish to emphasise the role of the doctor as a healer rather than a mechanic-in addition to the initiative that the doctors take in the form of personal commitment and sensitivity - priorities in state medical care and social attitudes become equally important. Though what this paper examines and discusses will be more the conceptual framework within which we can generate these changing attitudes in the doctor-patient relation, the practical issues mentioned must not be forgotten.

Already in the growing literature on the subject some guidelines have appeared regarding the framework of therapeutic communication. In general, where possible it is wise to rule out the deliberate and persistent deception of patients. There is the classic case of a woman suffering from inoperable canmcer. She was told after an exploratory operation that her gall bladder had been removed. But she suspected this statement and persisted in her mistrust, a ward sister brought a bottle containing gall stones (not the patient's own). The sister followed by asking the patient the question, "Now are you satisfied?". Here is an instance where communication has been devalued[32]. Even if the reassurance worked, there was a break of the trust which patients place in hospital staff. Also, one day, a relative of the patient may himself become a patient. It must be emphasised that the lying that is done in a medical context with a good motive is different from the kind of deception, evasion and ambiguities found in the personal lives of people. But, experimental studies seem to show that truthfulness to patients is a good maxim for medical counselling, even in the case of death and dying.

Some research into this problem was done in a Swedish hospital with IOI patients who were suffering from inoperable cancer. The study compared the reactions of those who were told the diagnosis with those who were not and the findings are stated in this form:

"There are a small number of patients for whom telling the truth would be an act of needless cruelty. On the other hand, the large number of positive reactions shows that the impact need by no means be an overwhelming shock, and that it may even be of positive value to the patient during the further course of the disease"[33]. The authors of the study emphasise the value of personal counselling to the patients, Kubler-Ross in her studies felt that dying patients sense what is actually happening and openness is recommended. She makes a detailed study of the emotional context of denial, anger, depression of the patient and their possible replacement by hope and acceptance. The work Death and Dying graphically reveals that the patient gains if he or she is not isolated but invited to share the experiences with one who can listen or when the person is reluctant to talk, sit in silent communication. Specially in a world where advance technology can de-personalise the patient and convert the doctor into a mechanic and the great healing art of medicine into a mere technology, therapeutic communication generates an essentially humane approach to patients, and approach where reason and emotion interact. Communication refers to that which links human beings together at both non-verbal and verbal levels of interaction.

Communication enhances personhood and failure to communicate destroys personhood. Communication both bridges and maintains the distance between individuals. Communication creates new emotional bonds, showing controlled interaction with others[34].

Two areas of research have enriched the communication concept in clinical contexts.First the neo-Darwinian studies on facial expression and emotions by Ekman and Frierson and secondly the role of the mind and body in psycho-somatic medicine. Ekman and Frierson in their work. Unmasking the Face[35] say that both the physician and the nurse need understand the role of emotions by way of facial expression. Accurate interpretation of facial expressions often may give a key to understand the language of the face : "The physician and the nurse must understand the different ways people experience fear, for this is a common emotional reaction to the possibility of illness and treatment, and may heighten pain, prevent early detection of illness, interfere with treatment plans, etc"[36].

Understanding the types of fear, recognising sadness which can interfere with a patient's recovery, undestanding the inroads of anger which can have psychosomatic dimensions are helpful clues in the context of medical care, especially with the need to develop communication base. Emotions are primarily shown in the face and not in the body, the body instead shows how people are coping with emotion. There is no specific body movement pattern that always signals anger or fear, but there are facial patterns specific to certain basic emotions like, fear, disgust, anger, happiness and surprise.

Regarding the mind-body link, neglect of this fact by modern technological medicine has now been recognized: "The immune system, then,is controlled by the brain, either indirectly through hormones in the blood stream, or directly through the nerves and neurochemicals. One of the most widely accepted explanations of cancer, the "surveilance" theory, states that cancer cells are developing in our bodies all the time but are normally destroyed by white blood cells before they can develop into dangerous tumors. Cancer appears when the immune system becomes suppressed and can no longer deal with this

routine threat. It follows that whatever upsets brain's control of the immune system will foster malignancy"[37]. This disruption occurs due to the chronic stress syndrome. The mixture of hormones released by the adrenal glands as part of the fight-or-flight response suppresses the immune system. In the past, this was all right in dealing with occasional threats but the tensions of modern life are great and the hormones lower our resistance to disease. There is now experimental evidence that "passive emotions" like grief, feelings of failure and suppression of anger produce over secretion of the hormones, which suppress the immune system[38]. Though we do not know completely about the complex ways in which brain chemicals are related to emotions and thoughts, the central point is that our state of mind has an immediate and direct effect on the state of the body. It is by understanding this psychosomatic link that Bernie Siegel worked a technique of self-healing and personal change for some cancer patients, called Exceptional Cancer Patients. In this work Bernie Seigel most skilfully explores the link between mind and body.

The mind's ability to generate health and the development of the techniques of meditation for contacting the unconscious mind and the springs of emotions was a part of traditional eastern culture. It is only recently that the west has gone into this territory and understanding this territory gives a fascinating dimension for the process of communication between doctor and patient, as has been shown in the work of Siegel[39].

Bothe empirical and conceptual studies have shown clearly the psychosomatic structure of human emotions. In a recent seminar, we discussed the mind-body linkage and its relevance for psychosomatic medicine, using emotion studies as a basis for discussion.(40)

In our attempt to relate the relevance of understanding human emotions to medical concerns and medical ethics in particular, we have discussed the logic of emotion concepts, their relation to ethics and ethical perspectives, their place in the healing of conflicting pathways and their role in developing and ethics based on the respect for human persons and concluded with a study of emotions and the communication process and emotions and psychosomatic medicine. Understanding human emotions certainly adds a very important dimension for the development of medical care and a viable medical ethics.

Concluding Thoughts

The ethical perspective, "Respect for Persons" is not presented as the only viable ethical theory but rather as an added dimension which can avoid the deficiencies in Kantianism oriented towards moral rules and authority, utlilitarianism focussed on its attempt to base morality on happiness and conscience theories based on inner feelings. The ideal of respect for persons itself has problems. As mentioned earlier in this paper, treating others as persons is costly both in terms of time and money and other resources. Attempts to build medical care on norms of personalization can be a project that has complexicity and cost. It can cause uncertainty and delay in day to day decisions.

But, yet it provides a missing dimension in the ethics of medical care. Care and compassion and respect for persons need not be always be an expensive item, compared with the money thrown on the excesses of technology. Inspite of its uncertainty, lack of rigidity and openness are valuable aspects of this ethics generated by a respect for persons.

In terms of Kantianism, we see that this ethical viewpoint places no final authority on moral rules. Communication involves openness to change, lack of rigidity and a freshness of a response to context. In terms of Utilitarianism, value of benefit to society is not placed above the value of benefit to the individual, they are inter-related but a limit is defined. Finally, "this approach sees as the surest sign of trying to benefit the other a consistent attempt to open and maintain communication with him, even when personal being is only potentially present or has largely lapsed[11,41]. The notion of communication preserves an important value, the respect for persons. This paper is focussed on a conceptual stance which emphasises the respect for persons, the role of emotions and the value of inter-personal communication. It is also backed by some empirical studies which have been quoted in the preceding discussions. But, the value of the idea depends on practical issues, the possibility of training nurses and doctors who can engage in sensitive communication with the patients. The work of Elisabeth Kubler-Ross and Bernie Siegel clearly demonstrate that this concept has been implemented atleast in a piecemeal manner.

As an epilogue to conclude this paper, we have slected a paragraph from a patient's open letter to a physician :

"Teach me and my family about how and why my illness happened to me. Help me and my family to live <u>now</u>. Tell me about nutrition and my body's needs. Tell me how to handle the knowledge and how my mind and body can work together. Healing comes from within, but I want to combine my strength with yours. If you and I are a team, I will live a longer and better life"[42].

Notes

01. Eric J. Cassell, "Thinking about Death as a Wax Apple", The Hastings Center Report, Vol. 14, April, 1984, New York.

02. Jay F. Rosenberg, Thinking Clearly About Death, New Jersey, Prentice Hall, 1983 .

03. Eric J. Cassel, "Thinking about Death as a Wax Apple", The Hastings Center Report, Vol. 14, April, 1984, New York.

04. In psychology Schacter and Singer's psychological theory emphasises the role of cognition in emotional experience. In philosophy, Errol Bedford argues that emotions logically presuppose both evaluative and factual beliefs and that different types of emotions have a typical set of beliefs. See Stanley Schacter, "The Interaction of Cognitive and Physiological Determinants of Emotional State", Psychological Review 69, (1962), 379-99; Errol Bedford, "Emotions", Proceedings of the Aristotelian Society, Vol. 57, 1956-57.

05. See, Lawrence Blum, Friendship, Altruism and Morality, Rotledge & Kegan Paul, London, 1980.

06. Bernard Williams, "Morality and the Emotions", Problems of the Self, Cambridge University Press, London, 1973.

07. Ibid ..... p 207.

08. Lawrence Blum, Friendship, Altruism and Morality, Rotledge & Kegan Paul, London, 1980.

09. See Bernie Siegel, Love, Medicine and Miracles, Harper and Row, New York, 1986.

10. Ibid ..... p 4.

11. Bernard Williams, "Morality and Emotions", Problem of the Self, Cambridge University Press, London, 1973. p 221.

12. Ibid ..... p 222.

13. Lawrence Blum, Friendship, Altrusim and Morality, Rotledge & Kegan Paul, London, 1980.

14. Carol Gilligan, In a Different Voice, Harvard University Press, Cambridge, 1982.

15. Alastair Ampbell, Moral Dilemmas in Medicine, London, 1975.

16. Carol Gilligan, "The Coquistador and the Dark Continent : Reflections on the Psychology of Love", Deadlus, Summer, 1984, p 77.

17. Ibid .....

18. Ibid .....

19. Carol Gilligan, In a Different Voice, Harvard University Press, Cambridge, 1982.

20. Alastair Campbell, Moral Dilemmas in Medicine, London, 1975.

21. Lawrence Blum, Friendship, Altrusim and Morality, Rotledge & Kegan Paul, London, 1980.

22. Alasdair MacIntyre, After Virtue, Notre Dame, 1981.

23. See, Sissela Bok Lying, Vintage Books, Random House, New York, 1979, p 233.

24. Alastair Campbell, Moral Dilemmas in Medicine, London, 1975.

25. Ibid .....

26. Sissela Bok, Lying, Vintage Books, Random House, New York, 1979, p 238.

27. Ibid .....

28. Elisabeth Kubler-Ross, On Death and Dying, Macmillan, London, 1969, p 10.

29. Bernie Siegel, Love, Medicine and Miracles, Happer and Row, New York, 1986.

30. Ibid ..... p 17.

31. Alastair Campbell, Moral Dilemmas in Medicine, London, 1975, p 159.

32. Ibid ..... p 158.

33. Ibid ..... p 159.

34. Ibid ..... pp 136-137.

35. Paul Ekman and Wallace V. Fiersen, Unmasking the Face, Prentice Hall, New Jersey, 1975.

36. Ibid ..... p 3.

37. Bernie Siegel, Love , Medicine and Miracles, Happer and Row, New York, p 68.

38. Ibid .....

39. Ibid ..... p 147.

40. Padmasiri de Silva, "Body-Mind Problem and its Implications for Psychosomatic Medicine", Fulbright Summer Program for ISLE Professors, University of Peradeniya, July, 1987. Unpublished paper.

41. Alastair Campbell, Moral Dilemmas in Modern Medicine, London 1975, p 159.

42. Bernie Siegel, Love, Medicine and Miracles, Happer and Row, New York, p 128.

The ideas analytically presented in this paper are rooted in certain historical shifts regarding the ideal physician.

See, Eric J. Cassell, "The Changing Concept of the Ideal Physician", Deadalus, Summer, 1986, pp 185-208.
