A CARE-BASED MODEL OF THE PHYSICIAN-PATIENT RELATIONSHIP

By

JONATHAN M. BRESLIN, B.A., M.A.

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AUTHOR: Jonathan M. Breslin, B.A. (York University), M.A. (McMaster University)

SUPERVISOR: Professor E. (Boetzkes) Gedge

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ABSTRACT

The aim of this dissertation is to offer a new way of characterizing the ideal physician-patient relationship. Although several models of the physician-patient relationship have been put forth in the literature in recent years, they have all fallen short as ideal models of the relationship. One of the problems with many of the previous models is that they have tended to focus on finding an appropriate balance between physician paternalism and patient autonomy and, in doing so, have characterized the relationship as adversarial. It is simply counterproductive to characterize the relationship as one in which the physician is viewed as a threat to the rights and interests of the patient. The second problem with many of the models is that they focus too narrowly on decision making, ignoring other important aspects of the relationship. For instance, there is little if any discussion in the previous models of such important aspects of the physician-patient relationship as trust and communication. Nevertheless, I maintain that the models approach is the best approach to physician-patient ethics, and so I argue for a new model of the relationship – a model that incorporates the other important facets of the relationship, is widely applicable to different physician-patient relationships, and is more collaborative than adversarial in nature. My thesis is that 'care' serves as the ideal conceptual basis for a model of the physician-patient relationship. Thus, the main task of this dissertation is to philosophically examine the concept 'care', and to apply it to the physician-patient relationship in order to develop a care-based model of that relationship.

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Introduction

The discipline of health care ethics took shape during the 1960's as the issue of abortion came to the forefront of public consciousness. But the fact that the discipline of health care ethics did not exist prior to the middle part of the twentieth century does not mean that health care ethics issues did not exist prior to that time. In fact, some issues now classified as health care ethics issues[1] have been debated for centuries. Perhaps the oldest of these ethical issues is that of the physician-patient relationship, the history of which can be traced back to the writings of ancient Greek physicians and philosophers. The long history of the topic of the physician-patient relationship as an issue in health care ethics is no doubt a result of the fact that the kinds of questions that fall under its umbrella target the very heart of the profession of medicine. Such questions include: What role should the patient play in health care decision making? Is physician paternalism morally inappropriate? Is a physician ever justified in withholding information from or lying to a patient? What type of relationship should physicians have with their patients? These questions not only underlie many other issues, such as abortion and euthanasia, but it would be difficult to philosophically examine the profession of medicine without encountering many of them. Moreover, most physicians can enjoy a lengthy career in medicine without ever personally confronting issues like abortion or euthanasia, but a physician would not be able to practice very long before personally confronting some of the questions noted above.

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[1] I say "now classified as health care ethics issues" because prior to the mid-twentieth century the term 'discipline of health care ethics' did not exist, and so issues that are now referred to as health care ethics issues were once just considered medical issues.

The question that will serve as the focus of this dissertation will be the last of those listed above: What relationship should physicians have with their patients? Or, to put the question another way, What is the ideal model of the physician-patient relationship? I have chosen to focus on this question because the answer to it underlies the answers to many of the related questions in health care ethics. For example, determining whether physician paternalism is inappropriate or whether it is wrong for physicians to withhold information from patients will depend on what sort of relationship one thinks physicians should have with their patients. The answer I will defend is that the ideal model of the physician-patient relationship is one that is based on the concept of care.

One of the interesting things about the issue of the physician-patient relationship is that the answers to many of the questions listed above remained virtually unchanged for approximately 2500 years. From the time of the writings of Hippocrates in the fifth century B.C., right up until the latter part of the twentieth century, the prevailing belief was that the ideal or appropriate model of the physician-patient relationship was paternalistic – the view that physicians ought to treat their patients in the way a parent would treat a child. The justification for such a position was that the physician is the party in the relationship who possesses the knowledge and expertise required to heal the patient, and so the physician should have the authority to do what he believes is medically best for the patient. Based on this view of the relationship, Hippocrates and his followers (which included virtually everyone who had written on the topic up to the late 20th century) argued that physicians are justified in withholding information from and lying to patients as long as the physician believed it was in the patient's best medical interests to do so. The patient's role in medical decision-making was essentially to assent to whatever the physician proposed. According to Ludwig Edelstein, one of the foremost Hippocratic scholar, the Hippocratic ethic was a manifestation of the Greek philosophical-scientific school of thought called Pythagoreanism, which held that knowledge was too powerful and dangerous to be in the hands of ordinary lay people.[2]

As mentioned above, this view of the physician-patient relationship prevailed for almost 2500 years. In 1803 Thomas Percival wrote the first book on the ethics of medicine, in which he argued, following the Hippocratic ethic, that physicians know what is best for their patients and should act to promote their perception of patient welfare.[3] By 1957 the landscape had begun to change slightly, though the Hippocratic ethic still dominated; the American Medical Association's *Principles of Medical Ethics* maintained that although a physician generally should not break confidences, breaches of confidentiality are justified in three situations, one of which is to protect the individual patient.[4] The important thing, however, is that although the AMA recognized the importance of confidentiality, it still subscribed to the view that it is up to the physician to judge what is in the patient's best interests, and the physician's actions should be guided by this judgment. Philosophically, the continued support for the Hippocratic view was justified by the prioritization of the principle of beneficence – the idea that

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[2] Robert M. Veatch and Carol Mason Spicer, "Against Paternalism in the Patient-Physician Relationship," in *Principles of Health Care Ethics*, ed. Raanan Gillon (Chinchester: John Wiley and Sons, Ltd.,1994), 411.

[3] Ibid.

[4] James F. Childress, *Who Should Decide? Paternalism in Health Care* (New York: Oxford University Press, 1982), 41.

physicians ought to be guided by the obligation to provide benefits and balance benefits against harms. As long as the principle of beneficence dominated medical ethics, and as long as physicians possessed a knowledge base that far surpassed the average patient's level of medical knowledge, it was easy to defend the paternalistic view of the physician-patient relationship.

By the 1970's, however, the discipline of health care ethics was blossoming and the landscape of medical ethics began to change drastically. There were a number of factors that led to such a shift. The first factor was the civil rights movement and the birth of feminism in the 1960's, which together helped bring attention to the power imbalances that existed between the dominant and subordinate groups in society.[5] The movements aimed to put more power in the hands of disadvantaged, oppressed and vulnerable individuals, and encouraged people to question and challenge the existing establishment. In the medical context these movements contributed to the awareness of the power imbalance between both individual physicians and patients, as well as the institution of medicine and the general patient population.

The second factor, which is largely a result of the first, was the significant increase in the education level of the average patient due to the fact that women and minorities were, by the 1970's, attending colleges and universities in record numbers. Educational doors once closed to women and minorities opened up, and the feminist movement helped the average Western woman realize that she *could* do more than just keep house. The explosion in college and university enrolments, and the changing

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[5] Veatch and Spicer, 413.

demographic of those populations, meant that the knowledge gap between physician and patient was narrowing significantly. This narrowing in the knowledge gap has only been accelerated in the last fifteen years with the development of the Internet, which brought the field of medicine into the home of the average patient. Prior to the Internet information about medicine and health care was something to which only physicians and medical professionals had special access. Now, however, any person with a computer and an Internet connection can research whatever medical information he or she may want with incredible speed and accuracy. It is not uncommon today for patients to inquire with their physicians about clinical facts and experimental treatments they read about on the Internet. The bottom line is that in terms of medical knowledge and the authority that accompanies that knowledge, physicians may still have the upper hand (and always will) but the playing field is more level than it ever has been in the past.

The third factor that contributed to the shift in thinking about the physician-patient relationship was the significant advancements that were made in medical technology and treatments during the middle-to-latter part of the twentieth century. Improvements in the diagnosis and treatment of diseases such as cancer and AIDS, the invention of dialysis machines and respirators, and the developments in other medical fields like organ transplantation, to name just a few, have all had the positive effect of extending life and improving survival rates for chronic and terminal illnesses. Yet the flipside of this positive effect is that these advancements have also had the negative effect of prolonging suffering and the dying process in general. Medicine is considerably more complex now than it was even fifty years ago and, thus, so are the decisions people must make regarding their health care. Additionally, the social context of health care changed with the increase in technological complexity.[6] When medicine was simpler health care, and thus health care decisions, largely took place in the local doctor's office, and the doctor tended to be someone with whom the patient (or at least the patient's family) had a long-standing relationship. As medicine became more complex technologically, health care moved from the local doctor's office into clinics, hospitals, and nursing homes, which meant there would be less continuity of care.[7] As a result it can no longer be assumed that physicians and patients will always share the same values or goals with respect to medical care and the physician-patient interaction.

The result of these factors was a rallying cry in favor of patient autonomy – the idea that patients should have the freedom to determine the course of their own health care. Many physicians and ethicists began to realize that the principle of beneficence, which served for so long as the philosophical basis for the paternalistic view of the physician-patient relationship, may no longer be appropriate as the dominant principle of health care ethics. Patient values now had a role to play in health care decisions and so it could no longer be assumed that a physician could know what is in the patient's best interest; to ensure that the patient's values are given center stage, and to protect those values from paternalistic physicians, many argued that decision making control must be in the hands of the patient. Thus began the debate over the roles of physician and patient in medical decision-making, and over how that relationship in general should be characterized.

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[6] Veatch and Spicer, 413.

[7] Ibid.

The first landmark article on the topic of physician-patient relationship models was Robert Veatch's *Hastings Center Report* article in 1974.[8] Veatch offered four models of the physician patient relationship, centered largely around the balance between physician control and patient autonomy. Numerous authors followed Veatch's lead and offered discussions of physician-patient relationship models, including David Thomasma (1983)[9], William May (1983)[10], James Childress and Mark Siegler (1984)[11], Edmund Pellegrino and David Thomasma (1987)[12], and Linda and Ezekiel Emanuel (1992)[13].

Intermingled with these discussions of physician-patient relationship models have been numerous articles examining the more specific underlying issues surrounding the concept of patient autonomy: How should we understand the concept of patient autonomy? How autonomous should patients actually be? How do we find the appropriate balance between autonomy and paternalism (or autonomy and beneficence)? Some authors have argued that the traditional concept of patient autonomy is unrealistic

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[8] Robert M. Veatch, "Models for Ethical Medicine in a Revolutionary Age," *Hastings Center Report* 2, (1974): 5-7.

[9] David C. Thomasma, "Beyond Medical Paternalism and Patient Autonomy: A Model of Physician Conscience for the Physician-Patient Relationship," *Annals of Internal Medicine* 98 (1983): 243-248.

[10] William F. May, *The Physician's Covenant* (Philadelphia: The Westminster Press), 1983.

[11] James F. Childress and Mark Siegler, "Metaphors and Models of Doctor-Patient Relationships: Their Implications for Autonomy," *Theoretical Medicine* 5 (1984): 17-30.

[12] Edmund D. Pellegrino and David C. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (New York: Oxford University Press), 1987.

[13] Ezekiel J. Emanuel and Linda L. Emanuel, "Four Models of the Physician-Patient Relationship," *JAMA* 267 no.16 (1992): 2212-2226.

and undesirable for medical ethics[14]; others have argued for varying degrees of justified paternalism within the physician-patient relationship[15].

The result of decades of literature on the topic of the physician-patient relationship has been a seemingly never-ending tug-of-war between paternalism and autonomy, in which the relationship between physician and patient has become characterized as adversarial and antagonistic rather than collaborative. It is my view that this is an unfortunate consequence of the obsession with (and glorification of) the concept of patient autonomy and, thus, of the focus on trying to find a balance between patient autonomy and physician paternalism. I contend that the attempt to strike a balance between patient autonomy and physician paternalism is a lost cause as conflict and antagonism will be an inevitable result. A new concept is needed to serve as the basis for the physician-patient relationship, one that can emphasize the collaborative ideal of the relationship while capturing the important and valuable features of the concepts of autonomy, beneficence, and paternalism. I argue that 'care' is the appropriate concept, and so I propose a care-based model of the physician-patient relationship. I maintain that a care-based model of the physician-patient relationship will have normative force in that it will serve as an ideal for physicians to adopt with their patients, and will also have

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[14] Onora O'Neill, "Paternalism and Partial Autonomy," *Journal of Medical Ethics* 10 (1984): 173-178; James F. Childress, "The Place of Autonomy in Bioethics," *Hastings Center Report* 20 no.1 (1990): 12-17; George J. Agich, "Reassessing Autonomy in Long-Term Care," *Hastings Center Report* 20 no.6 (1990): 12-17.

[15] Childress, *Who Should Decide?*; Elliot Shinebourne and Andrew Bush, "For Paternalism in the Doctor-Patient Relationship," in Gillon, *Principles*; Julian Savulescu, "Rational Non-Interventional Paternalism: Why Doctors Ought to Make Judgments of What is Best for Their Patients," *Journal of Medical Ethics* 21 (1995): 327-331; Timothy E. Quill and Howard Brody, "Physician Recommendations and Patient Autonomy: Finding a Balance Between Physician Power and Patient Choice," *Annals of Internal Medicine* 125 no.9 (1996): 763-769.

descriptive force in the sense that it will realistically reflect the subtleties and nuances of actual physician-patient interactions. Models offered in the past have fallen short in at least one of the two areas above: they have either been unacceptable or undesirable as ideal models, or they have simply been unrealistic and/or unattainable.

The first chapter of my dissertation will review the history of the physician-patient relationship debate, focusing on the shortcomings of the various models described by previous authors. I will demonstrate how many of the models have been overly focused on the concept of autonomy, resulting in an antagonistic relationship between physician and patient. I will also show that while some authors have attempted to move beyond the traditional autonomy-paternalism paradigm and offer models that are more collaborative in nature, such as May's 'covenantal' model, they still fall short as ideal models in the ways described above. The first chapter will set the stage for my claim that a new kind of physician-patient relationship model is needed.

Chapter 2 will be devoted to the analysis and articulation of the concept of care that I will put forth. This chapter will thus be devoted to answering the seemingly basic question, What does it mean to care? The first task of the chapter will be to distinguish between the various usages of the word 'care' in order to extract the usage that is most appropriate for my purposes. I will distinguish between such usages as 'caring about', 'caring for', 'taking care of', and 'providing care'. What I will argue is that caring about something means that one takes an attitude of interest in or concern about that thing, and this attitude can take either a basic or deep form. The basic form of caring about is used when one simply has an interest in something, as in the statement "I care about whether it rains tomorrow." One cares about something in the deep sense when one is interested in or concerned about that thing to the extent that one feels a certain compulsion to act on behalf of that thing. It is this deep form of caring about that is usually implied when people say they care about their loved ones. In arguing that the ideal model of the physician-patient relationship is a care-based model, what I am claiming is that physicians should care about their patients in the deep sense.

After the above preliminaries are dealt with, I will then turn to the task of examining what it actually means to care about someone. I use the term 'examining' rather than 'defining' because the approach I will take to clarify the meaning of the concept 'care' will be in the tradition of the later Wittgenstein's "family resemblance" approach to clarifying the meaning of a concept – I will examine a variety of relationships that might be considered paradigm caring relationships in order to extract some of the important features of the care involved in those relationships, rather than trying to provide an ostensive definition of 'care'. I have opted for the Wittgenstinian approach because I believe that 'care' is a good example of a concept that illustrates Wittgenstein's argument that we can use and understand concepts without necessarily being able to provide an ostensive definition of the concepts we use. The second part of Chapter 2 will involve elaborating on Wittgenstein's argument and applying it to caring relationships in order to extract important features of those relationships that would be appropriate for use of the concept as a conceptual foundation for the physician-patient relationship.

Finally, Chapter 3 will involve applying the new understanding of the concept of care to the physician-patient relationship in order to show what a care-based model of that relationship would look like. I will discuss whether and how each of the caring features extracted from the paradigm relationships would apply to the physician-patient relationship, and, where appropriate, I will illustrate those features using case examples. It is my belief that my care-based model will account for the valuable features of autonomy, beneficence and paternalism, but will also inherently incorporate necessary limitations on behavior guided by those concepts. My argument is admittedly influenced by Aristotle's theory of virtue: if a physician develops a truly caring relationship with his or her patient, he or she will know when and to what extent respect for patient autonomy and paternalism are appropriate. In addition, my hope is that my model will be applicable to a wide range of physician-patient relationships, unlike many of the other models offered in the literature. I am not interested in developing a model of the physician-patient relationship that would only be applicable to, for example, the family practice scenario; rather I am interested in developing a model that can be applicable to a wide cross-section of physician-patient interactions.

Chapter 1: The History of the Debate

Clouser's Challenge and Aristotle's Influence

Before reviewing the history of the physician-patient relationship debate in more detail by critically examining models offered by previous authors, it is important to take a step back and briefly explain why a model of the physician-patient relationship is important. In an article[1] criticizing the models of Veatch and May (their models will be examined below), K. Danner Clouser questions the whole approach to developing models:

> What would really be helpful is to be told what would be immoral to do to a patient. It is wrong to deceive a patient. It is wrong to deprive a patient of freedom or opportunity...These can happen on any of the models; it is mistaken to believe that the 'right' model could prevent it.[2]

After demonstrating some of the weaknesses of the models by Veatch and May, Clouser concludes that the "models approach" is a lost cause because no model can possibly possess the prescriptive or normative force needed to guide physicians in their interactions with patients. Instead of asking physicians to adopt a certain type of relationship with their patients, and hoping that they do the right thing, it would simply be easier, according to Clouser, to give physicians a list of rules telling them what they should and should not do. So, what is the point of developing a model of the physician-patient relationship?

Though Clouser's challenge is aimed specifically at the models approach to physician-patient ethics, it is actually a manifestation of a much more significant and

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[1] K. Danner Clouser, "Veatch, May, and Models: A Critical Review and a New View," in Earl E. Shelp, ed. *The Clinical Encounter* (Dordrecht: D. Reidel Publishing Company), 1983.

[2] Ibid., 95.

longstanding debate in moral philosophy: the debate between normative action-guiding ethics and virtue ethics. Though I am not developing a virtue theory in this dissertation, I mentioned above that my approach (and, I believe, the models approach in general) is influenced by Aristotle's theory of virtue. According to Aristotle, the central question of moral philosophy was how to achieve the good life, which he defined as *eudaemonia* (well-being), the ultimate end for humans. Aristotle argued that the best way to achieve *eudaemonia* is to cultivate a set of virtues, or character traits, such as justice or temperance. One becomes virtuous when one learns to achieve the mean between the extremes of the emotions associated with particular character traits, as guided by *phronesis* (practical wisdom). For instance, the virtue of courage is the mean between rashness (deficient fear) and cowardice (excess fear). One has achieved the mean when one learns to exhibit the appropriate character trait "at the right times, about the right things, toward the right people, for the right end, and in the right way."[3] In other words, a person who exhibits the virtue of courage, for example, will know how fearless or fearful to be in any given situation and will act accordingly.

A virtue approach to ethics such as Aristotle's is different from a normative action-guiding approach to ethics, like Mill's utilitarianism or Kant's deontology. Normative action-guiding ethics tell us how we ought to act, or provide instructions on how to choose the morally right course of action. Mill's utilitarianism tells us that we should, all things considered, perform the action that will maximize overall happiness in a given situation. Kant's deontology tells us that we are obligated to act in accordance with the categorical

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[3] *Nichomachean Ethics* 1106b16-24.

imperative. The major difference between the action-guiding approach and the virtue approach is that the former tells us how we ought to act, while the latter tells us what kind of person we ought to be. Clouser clearly defends the former approach in that he thinks the best way to encourage physicians to act morally is to give them a list of (normative action-guiding) rules to observe.

The attempt to develop a model of the physician-patient relationship is unmistakably more closely related to a virtue approach than to a normative action-guiding approach. Rather than defending a list of rules for physicians to follow (e.g., do not lie to patients; do not treat patients without consent), the models approach attempts to influence the moral behavior of physicians by altering the *kind* of relationship physicians have with their patients. The models approach is not a direct virtue approach because it does not defend a list of character traits that physicians should cultivate in order to achieve a particular end; it is virtue-*influenced*, however, because it aims at altering the behavior of physicians that underlies particular actions rather than aiming directly at altering the actions themselves.

I believe the models approach is more fruitful than a "normative rules" approach for two reasons. First, no list of rules could possibly capture all of the actions that physicians should or should not perform. We could narrow the list down to the most important rules, but such a list will inevitably leave physicians without guidance in many situations. Moreover, there would have to be some account of how a physician should guide his or her actions in situations in which rules conflict with each other. A list of rules such as Clouser would defend paints an absurdly simplistic picture of physician-patient ethics.

The second reason why the models approach is more fruitful than the rules approach is that I think the right model of the physician-patient relationship, if adopted by physicians, would be more successful at encouraging moral behavior among physicians in their interactions with patients. Although Clouser is skeptical that a model could prevent immoral behavior, he is naïve to think that a list of rules will succeed in that goal. A paternalistic physician, for example, may still be inclined to treat a patient against his or her will regardless of what rules the physician was taught to obey. However, if physicians are trained from early in their education to cultivate a certain relationship with their patients, they will be more likely to act morally when the situation calls for it. This is exactly the type of argument available to the virtue theorist in response to what Solomon calls the "action-guiding objection"[4] to virtue theories. The objection is, quite simply, that because virtue theories focus on shaping the *character* of the agent, they cannot provide determinate guides for action. What this objection fails to recognize, however, is that virtue theories *are* action-guiding, they are just *indirectly* so. The ethical thrust of virtue theories is that if we become moral (virtuous) people, through education and practice, we *will* do the moral thing when situations arise. Similarly, if a physician learns to cultivate a certain type of relationship with his or her patients, that physician will behave morally in his or her interactions with his or her patients. My argument in this dissertation is that the appropriate type of relationship is a caring relationship. Therefore, in response to Clouser's

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[4] David Solomon, "Internal Objections to Virtue Ethics," in Peter A. French, Theodore E. Uehling, Jr. and Howard K. Wettstein, eds. *Midwest Studies in Philosophy Volume XIII Ethical Theory: Character and Virtue* (Notre Dame: University of Notre Dame Press, 1988), 432.

challenge, the point of a physician-patient relationship model is that it serves as a better foundation upon which to build physician-patient ethics than a list of rules.

The Previous Models

1. The Attempt to Strike a Balance Between Autonomy and Paternalism

1.1 Szasz and Hollender's three models (1956)

I mentioned above that Veatch's 1974 article was the first landmark article on models of the physician-patient relationship, but the first discussion of models actually appeared almost twenty years prior in an article by the psychiatrist Thomas Szasz and his colleague Marc Hollender.[5] In their article the authors outlined three main types of professional-patient relationships and how they applied to medicine. Although their models were not as complex and not as influential as Veatch's, their article is worth mentioning for a couple of reasons. First, the article was well ahead of its time in its recognition of the potential role that patient values have to play in medical decision-making. Their model of 'mutual participation', which they admitted was "essentially foreign to medicine," was the first mention in the literature of a model of the physician-patient relationship based on shared decision making between physician and patient. Second, they noted in their discussion of the 'activity-passivity' and 'guidance-cooperation' models, both paternalistic in nature, the potential for exploitation in any relationship between persons of unequal power (as in the case of physician and patient). This type of observation had not been made in previous defenses of the traditional

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[5] Thomas S. Szasz and Marc H. Hollender, "The Basic Models of the Doctor-Patient Relationship," *Archives of Internal Medicine* 97 (1956): 585-592.

paternalistic view of the physician-patient relationship, as the traditional view was based on the principle of beneficence. If physicians acted for the good of their patients, why would exploitation be an issue? The recognition by Szasz and Hollender of the significance of the power imbalance between physician and patient represented an early step in the direction of acknowledging the importance of patient autonomy.

1.2 Veatch's four models (1974)

The next article to appear on the topic of physician-patient relationship models was Robert Veatch's[6], which, although quite brief and purely descriptive in nature, would be influential for many years to follow. Veatch used the metaphors of *the priest*, *the contract*, *the colleague*, and *the engineer* to describe four types of relationships. In the 'priestly' model the physician acts as a priest – someone who is authoritative but (supposedly) altruistic and virtuous. The priestly model is actually the traditional paternalistic model in disguise, grounded in the principle of beneficence. The 'collegial' model is based on the idea that physician and patient are colleagues, working together to achieve the common goal of eliminating illness and preserving health. In the 'contractual' model the physician and patient are seen as equal parties entering into a contract for the purpose of eliminating illness and preserving health. Finally, in the 'engineering' model the physician is viewed as an applied scientist or technical expert, who is obligated to use his or her technical expertise to pursue the goal chosen by the patient.

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[6] Robert M. Veatch, "Models for Ethical Medicine in a Revolutionary Age," *Hastings Center Report* 2 (1974): 5-7.

Veatch's article is notable for several reasons. First, the models as described by Veatch clearly illustrate the shift in thinking about physician-patient ethics from a paternalistic to a more patient autonomy-based relationship. In Szasz and Hollender's article two of the three models were strongly paternalistic and the third was a model based on equal participation. In Veatch's article, however, only one of the four models was paternalistic, two were based on a collaborative relationship, and the fourth was a model characterized by full patient decision-making control. Thus, from Szasz and Hollender's to Veatch's discussions we see a shift from paternalism-dominated relationships to relationships that are much more patient autonomy-based.

The second thing that is notable about Veatch's discussion is the emergence of the first physician-patient relationship model based on patient autonomy and full patient control. In the engineering model it is the patient who decides what course of action to pursue and the physician is obligated to apply his medical expertise to achieve that goal. Szasz and Hollender's article took a significant step in the direction of patient autonomy with their model of mutual participation, and Veatch took it one step further with his engineering model.

Third, Veatch took the basic idea of a model of mutual participation offered by Szasz and Hollender and offered two examples of such a model, the collegial and contractual models. The positive aspect of these models is that they do represent a decent attempt to characterize the physician-patient relationship as collaborative rather than as a relationship purely of either physician or patient control.

Finally, with Veatch's article we see the completion of the autonomy-paternalism spectrum that would become the background against which many other models and discussions of models would be analyzed. In Szasz and Hollender's article we only had one half of the spectrum: strong physician paternalism, somewhat less strong physician paternalism, and equal decision-making control. In Veatch's article the spectrum has been completed with the priestly model at the paternalism end of the spectrum, the collegial and contractual models in the middle, and the engineering model at the patient autonomy end.

Although Veatch's collegial, contractual, and engineering models have been influential in terms of their contribution to the shift towards patient autonomy-centered physician-patient ethics, they have shortcomings that make them objectionable as ideal models for the physician-patient relationship.

To start with the engineering model, there are a number of reasons why such a model (or any model based on complete patient control) would be undesirable as an ideal model. One problem noted by Kluge is that to put full decision-making power in the hands of the patient would be to expose the patient to unnecessary risks since patients do not possess the medical knowledge and expertise that is integral to making important health care decisions.[7] Physicians are more than just technical experts who have the requisite skills for pursuing courses of action; they also have knowledge and experience that is vital to making *decisions* to pursue certain courses of action.

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[7] Eike-Henner Kluge, *Biomedical Ethics in a Canadian Context* (Scarborough: Prentice-Hall, Inc., 1992), 86.

The second problem with the engineering model, noted by Veatch himself, is that there is no room on such a model for the values of the physician – the patient chooses the course of action to pursue and the physician is obligated to apply his or her medical skills to achieve that goal. Thus, the physician is essentially a tool or employee of the patient since he or she is not free to object to a particular course of action chosen by the patient or to withdraw from the relationship if the physician's own values conflict with the chosen course of action. For example, Veatch states, a Catholic physician who believes abortion is murder should not be obligated to perform an abortion for a patient.[8] Since the physician is a moral agent, he or she must not be obligated to pursue courses of action to which he or she objects on moral grounds.

Third, the engineering model makes the mistaken assumption that the values that will come into play in making health care decisions are both well defined and known to the patient.[9] One problem with this assumption is that most people likely do not question or examine their values consciously until they find themselves in a situation that requires such introspection (e.g., when faced with a terminal illness). The engineering model assumes that patients come into the physician-patient relationship fully conscious of what their values are, and all they need is the facts and figures to decide what course of action will fulfill those values. The other problem with the assumption that values are well defined and known to the patient is that illness can interfere with one's thought processes to the

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[8] Veatch, "Models for Ethical Medicine," 5.

[9] Emanuel and Emanuel, 2221.

point that patients may express ambivalence or even contradictory values or preferences.[10] Both can make decisions extremely difficult if control over decision making lies entirely with the patient. It is exactly because values are often *not* well defined and known to the patient that there needs to be some room in the relationship for the physician to engage actively in the identification and clarification of patient values.

One final problem with the engineering model, which is related to the problem discussed above, is that the model is based on a very simplistic view of patient autonomy. The view of patient autonomy that underlies the engineering model is rooted in the Western liberal values of independence of thought and action – the patient is supposed to make his or her decision, free from physician influence, and the physician is obligated to pursue that course of action. This extreme view of patient autonomy was articulated and defended in response to the dominant paternalistic tradition in medicine: to protect patients from unwanted intrusion by powerful physicians, patients must be given full and independent control over medical decision making, "or else the bogeyman of paternalism will appear."[11] However, there are several things wrong with defending such an extreme individualistic notion of patient autonomy in medicine: 1) as noted above, illness can interfere with patients' thought processes, making it difficult for them to make rational and independent decisions; 2) *autonomy* is different from *liberty* (freedom of action) – since patients can be mistaken about their values, or can express conflicting values, autonomy should involve some degree of critical self-evaluation. Since illness and vulnerability can interfere with a

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[10] Childress, "The Place of Autonomy," 13.

[11] Agich, 14.

patient's reflective ability, physicians should at least help patients in this process of reflection; 3) again, as mentioned above, patients do not possess the knowledge and experience in medicine that is integral to making significant health care decisions – as long as patients are free to accept or reject them, patients need their physician's recommendations[12]; 4) many patients do not fit the paradigm of the independent decision-maker but rather prefer input (and even to be influenced) by others they trust[13]. Therefore, any model based on complete patient decision-making control, such as Veatch's engineering model, is undesirable as an ideal model of the physician-patient relationship.

The contractual and collegial models go a long way towards avoiding many of the problems with the engineering model discussed above since they propose a more collaborative view of the relationship between physician and patient. Nevertheless, each model has further problems that also make them undesirable as ideal models for the physician-patient relationship.

As described above the collegial model is based on the metaphor of the colleague. On this model the physician and patient are viewed as colleagues working together to achieve a common goal – specifically the goal of eliminating illness and preserving health.[14] The image is one of two scientists or medical researchers collaborating on a research project. There are two fairly obvious problems with using the metaphor of the

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[12] Quill and Brody, "Physician Recommendations and Patient Autonomy," 766.

[13] Anne Donchin, "Understanding Autonomy Relationally: Toward a Reconfiguration of Bioethical Principles," *Journal of Medicine and Philosophy* 26 no.4 (2001): 365-386; George J. Agich, *Autonomy and Long-Term Care* (New York: Oxford University Press, 1993), 3.

[14] Veatch, "Models for Ethical Medicine," 7.

colleague to describe the physician-patient relationship. The most obvious problem is that it is simply inaccurate to describe physicians and patients as colleagues. The metaphor of the colleague implies two people of equal standing who share the requisite knowledge for pursuing the common goal and are on an equal plane in terms of authority and control. This is obviously not the case with physician and patient; with the typical physician and typical patient there is a significant imbalance in knowledge and experience in health care, and the authority and power that comes with that knowledge and experience. No matter how much the physician informs the patient about his or her clinical situation, the patient will never know as much about health care as the physician; even patients who are themselves physicians will still often have to depend on the knowledge and expertise of the physician taking care of them.[15] Thus, a major problem with the collegial model is that it paints a highly unrealistic picture of the actual physician-patient dynamic.

One might respond to this criticism by pointing out that I have only described one particular type of collegial relationship, and that there are other types of collegial relationships that are not based on the parties sharing equal knowledge. Often colleagues who possess completely different knowledge sets will collaborate on a project, and their different knowledge sets will complement each other. For instance, an ethicist and a scientist might collaborate to write an academic paper on the ethics of stem cell research. Rather than share a body of knowledge, they bring together their different bodies of knowledge and each contributes something different to the project. However, this response

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[15] For example, a cardiologist who is seeing another cardiologist for heart problems *could* be seen as a colleague of his or her physician in that case; but if that cardiologist has to see an ophthalmologist for eye problems, he or she must depend on the knowledge of the ophthalmologist.

misses the point. Although the colleagues in such a case might not be equal in terms of sharing the same knowledge, they are equal in the sense that they are considered partners in the relationship and neither one has authority over the other. Colleagues are not true *colleagues* if one party has authority over the other (as in the case, for example, of an employer and employee working on a project together). Although physicians may not be legitimate authorities over patients in the way that employers are over employees, many patients are intimidated by physicians and regard them as authoritative. Thus, even though physicians and patients could be seen as bringing together different but complementary knowledge sets, they are not colleagues in the true sense of the word.

The other significant problem with the collegial model is that it assumes that the physician and patient necessarily share a common goal, specifically, the goal of eliminating illness and preserving health. Of course most patients will share this common goal with their physicians most of the time – when we are sick or injured, we want to be made better. However, it is simply not true that all patients will share a common goal with their physicians, let alone share the specific goal of eliminating illness and preserving health. There are a multitude of examples to illustrate this point: the example of a Jehovah's Witness who refuses a routine life-saving blood transfusion for religious reasons; the example of an ICU physician who believes resuscitation is inappropriate for her patient, even though the patient previously requested that everything be done; the example of the cancer patient who chooses palliative care rather the pursue another experimental treatment suggested by her physician. As a result of the factors discussed in the Introduction (the change in the social context of health care, the improvements in technology, and so on) it simply cannot be assumed that the physician and the patient will always share the common goal of eliminating illness and preserving health. As Veatch himself recognizes, "we have to admit that ethnic, class, economic, and value differences make the assumption of common interest which is necessary for the collegial model to function a mere pipedream."[16]

The contractual model, which is the model defended by Veatch, is similar to the collegial model in that it characterizes the physician-patient relationship as collaborative. Rather than view the relationship as one between two colleagues, however, the contractual model views the relationship as one between two parties who enter into a contract for the purpose of pursuing a certain goal. There are particular features of the contract metaphor that improve upon the colleague metaphor. First, there is no longer the *assumption* that the physician and patient will share a particular common goal; the metaphor of the contract implies that the physician and patient will negotiate early in the relationship what goal is to be pursued and set the terms of the "contract" around that goal. Second, the language of the contract implies that there are responsibilities and obligations for both parties, and the binding nature of a contract implies that there is protection for both parties, particularly the party on the weaker side of a knowledge/power imbalance. This is obviously important for the physician-patient relationship, as the typical patient will always be on the weaker side of that imbalance. Moreover, the contractual model improves upon the collegial model with the simple recognition that the two parties in the physician-patient relationship are not

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[16] Veatch, "Models for Ethical Medicine," 7.

typically of equal standing and the attempt to ameliorate this inequality (or at least compensate for it).

Although the contractual model does avoid some of the problems with the collegial model, there are nevertheless several problems that make it undesirable as an ideal model for the physician-patient relationship. First, even though the contractual model recognizes the possibility of a power imbalance and attempts to compensate for it by placing "legal" obligations on both parties, the inherent power imbalance between physician and patient still creates a problem for the contractual model. The problem is that a contract will only protect the vulnerable party in a relationship once the contract is enacted; but the power imbalance between the two parties will still have an impact on how the terms of the contract are initially determined. Protection for the vulnerable party during the term of the contract is meaningless if the vulnerable party was taken advantage of during the negotiation proceedings.[17] So viewing the physician-patient relationship as a contract between two parties will only overcome the problem of the power imbalance between physician and patient if the physician and patient are on equal footing when the terms of the contract are negotiated. But due to the ethnic, economic, class, educational, and gender differences that will often exist between them, patients are rarely if ever going to be on equal footing with their physicians when it is time to negotiate the terms of the "contract". Hence, it seems that the contractual model really does not overcome the problem of inequality that plagues the collegial model.

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[17] This point is applicable to virtually any professional relationship between an expert and a non-expert. Anytime there is an imbalance in knowledge or expertise between two parties in a professional relationship, there is potential for the non-expert to be taken advantage of during a contract negotiation.

One way of trying to overcome the problem described above would be to ensure that there is ample protection in the contract for the patient, as is done in other professional relationships. But the bigger problem with the model is that the language of contract – negotiation, legal protection, etc. – turns the physician-patient relationship into a cold legalistic negotiation between two parties, and ignores the human aspect of the relationship.[18] The metaphor of a contract is sufficient to describe the relationship one might have with one's lawyer or employer, but there is something very different about the relationship between physician and patient that makes the metaphor of a contract seem inappropriate. When we are sick or injured we are vulnerable and in need of compassion and concern, but describing the relationship between physician and patient as a contract ignores this human component of the relationship in favor of protecting the patient's rights.[19] Humanity and the recognition of the importance of patient values and interests are *both* important in the physician-patient relationship – one should not have to come at the expense of the other. Moreover, not only does the metaphor of a contract disregard the human aspect of the relationship, but it also succeeds in making the relationship adversarial

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[18] Kluge, 84.

[19] One might question at this point why the physician-patient relationship is different from other professional relationships – clients may need their lawyer's compassion and concern just like patients need their physician's compassion and concern. Although the physician-patient relationship does have much in common with other professional relationships, it is still different in significant ways. The kind of information we share with our physicians is often of a much more personal and sensitive nature than is shared in other professional relationships; we are physically vulnerable with our physicians because we are sick and in need of care; we expose ourselves to our physicians and give them persmission to explore our bodies, unlike in other professional relationships, which contributes to our vulnerability; and, given that the focus of the relationship is on one's health, there is more at stake in the physician-patient relationship than is often at stake in many other professional relationships. And because of these factors people *expect* a higher degree of humanity in their relationships with their physicians than they do with, say, their relationships with their lawyers or employers.

rather than truly collaborative. The need for a contract to protect the rights and interest of the patient implies that the physician is someone who is a threat to the patient and someone from whom the patient needs "legal" protection. It is difficult to see how trust and confidence are features of the contractual model, as Veatch claims they are, when the patient requires a metaphorical contract to protect him or herself from the interest-threatening physician.[20] Therefore, Veatch's contractual model is also not acceptable as an ideal model of the physician-patient relationship.

1.3 Emanuel and Emanuel's four types of models (1992)

Combining the approaches of Szasz and Hollender and Veatch, Linda and Ezekiel Emanuel developed four general types or classifications of models that can be clearly superimposed on an autonomy-paternalism spectrum. Their four types of models were the *paternalistic* model, the *deliberative* model, the *interpretive* model, and the *informative* model. The paternalistic model, as the name suggests, was simply the traditional paternalistic view of the relationship and akin to Veatch's priestly model. At the opposite end of the spectrum was the informative model, a model of full patient control and akin to Veatch's engineering model. Where Emanuel and Emanuel parted ways with Veatch was in their discussion of the models that fall in between the two extremes of the autonomy-paternalism spectrum. While Veatch offered two examples of models that could be placed

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[20] Veatch, "Models for Ethical Medicine," 7. According to Veatch, the "premise" of the contractual model is trust and confidence. I find this claim extremely odd since the notion of a contract would seem to imply a *lack* of trust – the reason we need contracts in professional relationships is precisely because we cannot trust people to do what they say. The contract protects us from people breaking their promises or going back on their word. This is why I say above that the metaphor of the contract makes the physician-patient relationship adversarial – because the implication of the metaphor is that the patient needs the contract because she cannot trust the physician to keep his word (or trust him to act in her best interests). Of course, since contracts are designed to protect both parties in the relationship, the metaphor also implies that the physician cannot trust the patient.

right in the middle of the spectrum, Emanuel and Emanuel proposed two models that are collaborative but fall more towards opposite ends of the spectrum: the deliberative model is a collaborative model in which the physician is justified in displaying a fair amount of authority and influence, while the interpretive model is a collaborative model in which the physician has some authority and influence but respect for patient autonomy is still the dominating principle.

Emanuel and Emanuel's interpretive and deliberative models improved upon Veatch's contractual and collegial models in two important ways. One improvement is that, since the models are more general types rather than specific examples of models, the main goal of the physician-patient relationship is construed much more generally on Emanuel and Emanuel's models than on Veatch's, making a specific or common interest no longer necessary. Recall that one of the problems with both the collegial and contractual models is that they relied on a specific shared goal between the physician and patient – the collegial model assumed that goal was to eliminate illness and preserve health and the contractual model required a particular goal to be "negotiated". The goal of the interpretive model is "to elucidate the patient's values...and to help the patient select the available medical interventions that realize these values"[21]; the goal of the deliberative model is described as helping the patient "determine and choose the best health-related values that can be realized in the clinical situation."[22] Neither model relies on the existence of a particular shared goal (such as eliminating illness and preserving health), nor requires

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[21] Emanuel and Emanuel, 40.

[22] Ibid.

the physician and patient to decide on a particular goal to pursue. Since the values of the patient are central to the goals of both models, the particular goals that will result from the interaction will depend upon the particular patient.

The other significant advantage of the interpretive and deliberative models over the collegial and contractual models is that the former more satisfactorily incorporate the reality of the power imbalance between physician and patient. One of the major problems with the collegial model was that it assumed that physician and patient are on an equal plane in knowledge and authority as colleagues are, which does not realistically reflect the typical physician-patient relationship. The contractual model tried to overcome this problem by using the notion of a legal contract to protect the rights of the vulnerable patient but neglected the fact that, due to the power imbalance between physician and patient, the patient is still vulnerable during the metaphorical negotiation process. Thus, the contractual model did recognize the reality of the power imbalance, but basing the relationship on the metaphor of the contract results in a relationship that also does not realistically reflect the typical physician-patient relationship. Neither the interpretive nor the deliberative model, however, depends on the equalization of power for the models to work. They both acknowledge that the power imbalance unavoidably exists and attempt to find a balance of physician influence and patient control that minimizes the impact of the imbalance.

The two features of the models discussed above do represent significant improvements over the models of Veatch. However, there are still problems with Emanuel and Emanuel's models that make them undesirable as ideal models.

The interpretive model attempted to find the right balance between physician influence and patient control by allowing the physician an active role in the decision making process but still placed the bulk of the decision making authority in the hands of the patient. The physician's role is to help the patient figure out what his or her values are and, once that has been achieved, to help the patient choose a course of action in line with those values. But the physician is expected to refrain from passing judgment on the patient's values and from directing the patient towards a particular treatment option. For example, in the case of a breast cancer patient trying to decide between radiation and chemotherapy or a mastectomy, the interpretive physician would engage the patient in conversation about her values (e.g., how important is it to her that she retain both breasts, and why) and then may say something along the following lines: "You seem to place a high degree of value on retaining both of your breasts because you will feel like an incomplete woman without them. Radiation and chemotherapy have lower success rates but will allow you to keep both your breasts, while mastectomy has a higher success rate but will force you to lose your breast. Based on what you have said, it sounds like radiation and chemotherapy are the best option for you. Is that what you would like to do?" This example exhibits the important features of the interpretive relationship: the physician helps the patient figure out his or her values, presents the information to the patient in terms of realizing those values, and then lets the patient make the final decision.

What is problematic about the interpretive relationship as described above is that when it comes right down to it, the interpretive relationship really does not advance much beyond the informative or engineering model. Though the physician has a role to play in the interpretive relationship, unlike the informative or engineering relationship, the role is still largely passive. The physician essentially acts as a therapist (or counselor, according to the authors), relegated to the role of "active listener" – someone whose job is to engage the patient in dialogue so that the patient can clarify his or her values. Beyond that the role of the physician is identical to the informative model – provide the patient with the necessary information and carry out the patient's decision. Unfortunately, the active listening role is not enough to overcome the problems with a full patient control model discussed above. There is still no room on the interpretive model for the physician's recommendations, apart from recommending what would be in line with the patient's values. In other words, the physician is still little more than a tool of the patient, which can not only expose the patient to unnecessary risk but can result in the physician being forced to participate in courses of action that she may find morally offensive.

Not only is there no room on the interpretive model for the physician's recommendations, but the passive role assigned to the physician also leaves no room for the physician to evaluate the patient's values.[23] For instance, suppose a physician becomes aware of the fact that his HIV positive patient is continuing to engage in unprotected sex without informing his partners of his HIV status. The physician questions the patient about his behavior, and the patient responds by saying, "Look, I really enjoy unprotected sex and I would like to enjoy what is left of my life as much as possible. If I tell people I have HIV they may make me wear a condom or not have sex with me at all. So I'm going to keep doing what I'm doing." On the interpretive model the bulk of the physician's job is done,

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[23] Emanuel and Emanuel, p. 45.

since he has engaged the patient in order to clarify the patient's values. At this point the interpretive physician must step back and allow the patient to pursue the course of action that will realize his values. But there seems to be something wrong with such a conclusion. Most would argue that in the above case the physician should, and may even be obligated to, challenge the patient regarding his values and try to convince him that if he is going to be sexually active, he really ought to wear a condom (or, at the very least, warn his partners). The patient's behavior is morally reprehensible because he is placing his own physical pleasure above the potential harm to which he is subjecting his sexual partners; and it seems reasonable to say that part of the physician's job should be to try to convince his patient of that. So while the interpretive model did assign a role to the physician in the relationship, it would seem that the role is not active enough.

The deliberative model attempted to overcome the above-mentioned problems with the interpretive model by moving more towards the paternalistic end of the spectrum and allowing more room for physician influence. Once the patient's values have been clarified, the deliberative physician is justified in trying to persuade the patient to adopt certain health-related values if the patient's values come into conflict with the values the physician believes the patient ought to pursue. In the breast cancer situation described above, the deliberative physician might say something like: "You seem to place a high degree of value on retaining both of your breasts because you will feel like an incomplete woman without them. Radiation and chemotherapy have lower success rates but will allow you to keep both your breasts, while mastectomy has a higher success rate but will force you to lose your breast. As your physician I must tell you that I think you are making a mistake in prioritizing your cosmetic desires over your life and health. What is the point of keeping both your breasts if it means you will probably die sooner? The decision is yours, of course, but I recommend that you choose the mastectomy because it has the chance of prolonging your life." Notice the difference between what the physician has said here and in the interpretive situation. In the latter case the interpretive physician simply recommended what would be in line with the patient's values and then gave the patient the choice; in the deliberative scenario the physician attempts to persuade the patient that the health-related value of prolonging life is more worthy than what the physician interprets as the cosmetic-related value of keeping both breasts, while still leaving the ultimate decision up to the patient.

The deliberative model does have several advantages over the interpretive model. One advantage, as noted by the authors, is that the deliberative model more closely embodies our ideal notion of autonomy by incorporating many of the factors that more autonomy-based models could not incorporate. The more active involvement of the physician helps to compensate for the fact that illness interferes with decision-making, that the patient does not possess the health care knowledge and experience possessed by the physician, and the insight that many patients do not fit the individualistic decision-making paradigm. Moreover, having the physician engage the patient in deliberation about what values he or she should pursue adds a component of critical self-reflection that was absent in the interpretive model.

Another advantage of the deliberative model is that it overcomes the deficiency in the interpretive model associated with the physician not having the freedom to evaluate and challenge the patient's values. To repeat what was said above, there seems to be something wrong with the conclusion that the interpretive physician should not try to encourage the HIV-positive patient to practice safe sex or to warn his prospective sexual partners. On the contrary, we seem to believe that physicians *should* promote health-related values.[24]

Although the deliberative model does improve upon the interpretive model, and may be the best of the models discussed thus far, there are a number of problems. First, though it seems intuitive that physicians should promote health-related values, one can question whether it is appropriate for physicians to promote health-related values as being more worthy than other values. Though they may be experts in health, physicians are not experts in axiology and are thus not an authority on how values should be ranked. Since value judgments are inherently subjective, one might argue, only the patient is in a position to judge which values are worth pursuing for him or her. For instance, the breast cancer case mentioned above involved a choice between the health-related value of prolonging life and the cosmetic-related value of preserving body image. What gives the physician the right to try to convince the patient that either of these values is any more worthy of pursuit than the other?

One may still maintain, however, that although physicians are not justified in prioritizing health-related values over other values in cases like the breast cancer case, there are still situations in which physicians are justified in judging a patient's preferences as misguided. That is, one might argue that value judgments are not purely subjective and

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[24] Ibid., 46.

that patients sometimes are simply *wrong* in their ranking of values.[25] On this view the physician would be justified in advocating for the "correct" ranking of values. This response gains support from a view of interests and preferences like Joel Feinberg's. According to Feinberg, having an interest in something means one has a stake in that thing – when one stands to gain or lose depending on the nature or condition of that thing.[26] Desires and goals that count as interests are of three types: (1) what Feinberg calls "welfare interests", which are the basic interests that are shared by all people and that are necessary for us to pursue our ulterior interests. Welfare interests include such things as health and reasonable length of life, the absence of absorbing pain and suffering, minimal intellectual acuity, and so on; (2) ulterior interests, or what Feinberg calls "focal aims", which are defined as interests in achieving a higher level of a particular element of welfare than is required to count as a welfare interest (e.g., the interest in developing and cultivating one's intellectual acuity beyond the minimal level); and (3) preferences that are means to achieving interests that fall into the first two categories.[27] How a particular person ranks his or her interests (i.e., whether physical health or length of life is more important than avoiding absorbing pain and suffering) will depend in part on that person's personal values.

Outside the realm of interests are what Feinberg calls "passing" wants or desires and are, by definition, preferences for things in which one does not have a stake, or preferences that are not means to achieving things in which one has a stake. These

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[25] Prof. Wil Waluchow, personal communication, March 21, 2003.

[26] Joel Feinberg, *The Moral Limits of the Criminal Law: Harm to Others* (New York: Oxford University Press, 1984), 33-34.

[27] Ibid., 56-57.

preferences would include such preferences as those for immediate physical or emotional gratification, like a sudden craving for an ice cream cone.[28] To tie this back in with the original argument, suppose, instead of an HIV-positive patient practicing unsafe sex, the patient was a young homosexual man who is putting himself at risk of contracting HIV because of his desire to practice unsafe sex. He knows he is risking his life doing so, but he tells the physician that he simply can't stand using condoms because they make sex less pleasurable. He would rather enjoy his life as much as he can, while he is alive, than live a life of playing it safe. One could argue based on this view of interests and preferences that the HIV patient is simply expressing a passing preference for physical pleasure that is outweighed by the risk of harm to himself. According to Feinberg, one is harmed only when one's *interests* are violated. Thus, one could say that since the above patient is putting his own life at risk in order to fulfill a passing preference, his physician is justified in advocating on behalf of his patient's health at the expense of his preference for physical plesaure. A similar conclusion could not be reached in the breast cancer case, however, because that case involves a conflict between the patient's *interests* – and perhaps even between two welfare interests. In such a case the physician is not justified in claiming that the patient's ranking of interests is wrong. This issue will be discussed in more detail in the next chapter.

Perhaps the most significant problem with the deliberative model is that granting physicians the freedom to persuade patients to adopt certain health-related values opens the door rather wide to the risk of unjustified paternalism. Emanuel and Emanuel were aware

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[28] Ibid., 43.

of this risk but failed to offer a satisfactory account of how the risk could be mitigated. They admitted that although in practice the deliberative physician could lapse into paternalism, "like the ideal teacher, the deliberative physician attempts to persuade the patient of the worthiness of certain values, not to impose those values paternalistically."[29] First, I think the authors failed to appreciate the extent of the risk of paternalism on their preferred deliberative model. Considering the power imbalance that exists between physician and patient, and the vulnerability that accompanies illness, the typical patient may not be able to resist the persuasive efforts of the physician in the way that people might be able to in other situations. Interestingly, Emanuel and Emanuel recognized this problem with the *interpretive* model:

> With limited interpretive talents and limited time, physicians may unwittingly impose their own values under the guise of articulating the patient's values. And patients, overwhelmed by their medical condition and uncertain of their own views, may too easily accept this imposition.[30]

Yet when they discussed the deliberative model, the authors downplayed the risk – which is especially interesting since the risk seems to be more pronounced on the deliberative model.

The second problem with their response to the paternalism risk is that they depend on a rather dubious distinction between persuasion and coercion. If someone is skilled enough at the art of persuasion, there really is little difference in effect between persuading someone to adopt certain values and imposing those values paternalistically. And the distinction becomes even less clear when it is a vulnerable patient being "persuaded" by a

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[29] Emanuel and Emanuel, 47.

[30] Ibid., 45.

powerful physician. Emanuel and Emanuel may be correct that the *ideal* deliberative physician might be able to tread the fine line between persuasion and coercion, but if unjustified paternalism is a real risk in the practical world, as even the authors themselves admit, then the deliberative model loses much of its force as an appropriate model for the physician-patient relationship. More will also be said about the issue of paternalism in the next chapter.

2. The Attempt to Break Free from the Autonomy-Paternalism Balance

2.1. May's covenantal model (1983)

Although the attempt to develop an appropriate model of the physician-patient relationship by trying to find the best position on the autonomy-paternalism spectrum has been a popular approach, it has not been the only approach. Some authors have tried to break free from the autonomy-paternalism dichotomy by developing models of the physician-patient relationship that do not represent a particular balance between patient autonomy and physician paternalism. One of the most well-known examples of such an approach was William May's covenantal model.[31]

In developing his model, May used the religious notion of covenant and applied it to the profession of medicine. Using the Exodus as the prime example of a covenant, May described a religious covenant as involving three elements.[32] The first element is the giving of a gift from one party to another, which, in the Exodus example, was God's deliverance of the Jews from slavery in Egypt. The second element is the making of a

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[31] May, *The Physician's Covenant.*

[32] Ibid., 108-109.

promise by the receivers based on the gift, which would be the vows made at Mount Sinai to live according to the commandments handed down by God. The final element is the acceptance by the receivers of the gift of a set of ritual and moral obligations by which the receivers of the gift will live. This last element would be the acceptance of the commandments themselves.

In applying this analysis of a religious covenant to the profession of medicine, May argued that physicians are the receivers of the gift and the public is the giver; the gift that the public gives to the physicians is the privilege to practice medicine. Physicians are indebted to the public for this privilege because of two factors. First, medical school is highly competitive and only a select group of people who apply will actually get to practice medicine. Second, physicians are continually indebted to the public because it is the public, when in need of medical care, that keeps physicians employed.[33] The physician makes a promise based on this gift to continue to provide care to patients who are in need, and accepts a set of obligations (e.g., a code of ethics) that will guide his or her practice.

What is attractive about May's covenantal model is that he attempted to develop an account of how ethical behavior could arise from *within* the physician, in much the same way as a virtue approach to physician-patient ethics. This point can be clarified by comparing the notion of a covenant to the similar notion of contract. According to May, the main difference between the contractual model and his covenantal model is that the contractual model reduces the obligations of the physician to "self-interested minimalism...Do no more for your patients than what the contract calls for: specified

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[33] Ibid., 114-115.

services for established fees."[34] On a contractual model, the obligations of the physician are limited to what is set out in the metaphorical contract – as long as the physician fulfills those obligations, she has exhausted her responsibility to the patient. On such a view the obligations and restraints on the physician's behavior are imposed externally, by the terms of the contract. On a covenantal model, however, the physician feels the internal motivation to act morally, and for the patient, because she feels indebted to the patient (as a member of the public) for the privilege to practice medicine.

In order for a model based on internal moral motivation to work in practice, what is needed is some account of how physicians would develop or cultivate the internal motivation. One problem with May's covenantal model is that it is unlikely that physicians would, on the whole, develop the feeling of indebtedness that serves as the foundation for the covenantal model. Such a feeling of indebtedness is not the kind of thing that could be *taught* to medical students. No matter how many times medical students could be told to feel privileged and to recognize that the public keeps them employed, it would not be enough to ensure that they would all truly feel that way; nor would it be enough to ensure that their feelings of indebtedness were strong enough to guide their behavior with patients. Without the indebtedness the covenantal model collapses.

One could respond that this criticism is not valid because as long as the feeling of indebtedness *could* be instilled in physicians-in-training, the model *could* work as an internal motivator.[35] Learning to feel indebted to the public for the privilege to practice

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[34] Ibid., 118.

[35] Prof. Elisabeth Boetzkes, personal communication, March 17, 2003.

medicine seems no more difficult than learning to be courageous or temperate on Aristotle's virtue theory. Nevertheless, there is a significant difference between May's view and a virtue approach like Aristotle's. On an Aristotelian view of virtue one is not *taught* to be courageous (although education does play an important role in Aristotle's theory), but rather one learns to be courageous ultimately through practice – one discovers through experience whether and how much fear is warranted in given situations until one develops the ability to act courageously in any situation. Thus, the internal motivation is developed internally and not imposed externally. But May's account of the covenant relies entirely on the internal motivation being imposed externally: medical school would teach medical students that they should feel indebted to the public until that belief (hopefully) becomes ingrained in their minds. There is no way for medical students or physicians-in-training to learn through experience to feel indebted to the public in the way that they could learn to be honest or courageous. A feeling of indebtedness is just not the type of thing that one can cultivate through experience. While this argument still does not establish that May's covenantal *could not* work in practice, it does support the claim that it would be extremely difficult to make it work.

Another problem with May's model is that the notion of a covenant creates the impression that physicians are essentially servants of the public. On the contractual model, obligations at least run both ways – both the physician and patient have obligations and responsibilities as set out in the contract. Moreover, the contract allows the physician to set limits on his obligations to the patient. But on the covenantal model the obligations only run from physician to patient, and there is no account of when (or whether) the physician is justified in limiting his responsibilities. The problem is not just that there are no limitations of physician obligation built in to the model, but that the very notion of a covenant seems to rule out such limitations. Servants typically don't have the authority to set limits on their obligations to their masters, and this is the impression of the physician-patient relationship created by the covenantal model.

Finally, a major weakness of the covenantal model is that apart from encouraging physicians to feel indebted to the public for the privilege to practice medicine, the model itself contains little in the way of direction to physicians about how to actually relate to the patient. What exactly is involved in being indebted to the patient? Does indebtedness require that the physician do whatever the patient requests? How does the covenantal model help with actual treatment decisions? Answers to questions like these were largely absent from May's account, and so it is unclear what a covenantal model of the physician-patient relationship would actually look like.

2.2. Pellegrino and Thomasma's beneficence-in-trust model (1987)

One final model worth discussing is the "beneficence-in-trust" model developed by Edmund Pellegrino and David Thomasma.[36] Pellegrino and Thomasma attempted to revive beneficence-based medicine while at the same time trying to free the principle of beneficence from the paternalistic baggage that historically accompanied the principle. Recall that the traditional paternalistic model of the physician-patient relationship was based on the principle of beneficence: do good for the patient, where good was interpreted as the patient's medical good as determined by the physician. In order to sever the link

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[36] Pellegrino and Thomasma, *For the Patient's Good.*

between beneficence and paternalism, the authors attempted to offer an account of the patient's good that did not run the risk of collapsing into physician paternalism.

To achieve this goal, the authors distinguished between four different kinds of human good, listed in order of importance: 1) the patient's ultimate good, which the authors defined as "the *telos* of human life as it is perceived by the patient, his or her view of the meaning and destiny of human existence;"[37] 2) the good of the patient as a human person, which is essentially the patient's capacity for autonomy; 3) the patient's best interest, i.e., the patient's subjective assessment of how treatment will affect quality of life; and 4) the patient's biomedical good.[38] Though more traditional paternalistic-oriented beneficence models may have recognized the existence of the other kinds of human good, the most significant difference between those models and Pellegrino and Thomasma's model is their ranking of biomedical good at the bottom of the list.

There are many attractive aspects of Pellegrino and Thomasma's model which make it, in my view, the most appealing of the models offered in the literature. One of these attractive features is that the authors recognized that, realistically, patient autonomy and *justified* physician paternalism are both integral to the ethical practice of medicine, and worked this insight into a principle of beneficence by defining the patient's good as including more than just medical good. Thus, the authors avoided many of the problems associated with Veatch's metaphors, and the other models discussed above, by going back to the basics and reinterpreting a principle that had dominated medical ethics in a different

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[37] Ibid., 81.

[38] Ibid.

form. In other words, rather than try to develop a model that would strike an appropriate balance between patient autonomy and physician paternalism, Pellegrino and Thomasma worked both concepts into a single, modernized principle of beneficence.

Another attractive feature of the beneficence-in-trust model is the recognition of the complexity of human good. The traditional beneficence-based model of the physician-patient relationship left itself open to the risk of unjustified paternalism because the patient's good was understood purely in terms of medical good. Pellegrino and Thomasma's model, however, divides the patient's good into four components, of which medical good is lowest on the hierarchy. Additionally, the other three goods (the ultimate good, the good as a human person, and the patient's best interests) are all to be judged *from the patient's point of view*. Thus, the patient's values are given central importance on the beneficence-in-trust model, where such values were largely ignored on the traditional beneficence-based model.

Although I mentioned above that the beneficence-in-trust model is the most attractive of the models discussed in the literature, there are a couple of problems with the account of the model given by the authors that really spoil the model's attractiveness. One problem is that they allow a theological source of morality to sneak into their discussion, which is problematic because it results in inconsistencies in their model. For instance, they defend the morality of a Jehovah's Witness' decision to refuse blood products because of a higher good, a spiritual destiny, which would be an instance of a patient's ultimate good ranked highest by Pellegrino and Thomasma. Yet just prior to that they claim that several other examples of refusal of life-saving treatment, such as penicillin for meningococcal meningitis or surgery for appendicitis, are examples of morally wrong treatment refusal. Why do they reject the morality of these refusals?

> When treatments are, without reservations, biologically good or beneficial, we would favor treatment as a moral obligation for both the patient and the physician. We may favor other goods when treatment is only marginally effective or beneficial.[39]

Thus, the authors seem to be saying that there are actually many situations in which an autonomous refusal of treatment would be considered morally wrong, and in which the physician might be justified in prioritizing the patient's medical good over his or her other goods. The problem lies in the fact that the way the authors characterize what they call the ultimate human good, and the fact that they rank the ultimate good highest on their list of human goods, seems to unfairly prioritize decisions based on religious beliefs over decisions based on non-religious beliefs. I say this because prioritizing the patient's ultimate good, interpreted as "the *telos* of human life as it is perceived by the patient, his or her view of the meaning and destiny of human existence,"[40] would give priority to decisions that are made in the context of beliefs about some ultimate end for humans. Although this ultimate end could be non-theological, typical examples of such an ultimate end are spiritual beliefs like the belief in heaven, reincarnation, nirvana, and so on. Even if beliefs in the ultimate human good were not restricted to theological or spiritual beliefs, why should decisions based on a perception of the ultimate human good be considered more worthy than decisions based on other good reasons?

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[39] Ibid., 47.

[40] Ibid., 81.

Consider the following example to illustrate this problem: Suppose an elderly patient had a gangrenous foot and amputation of the lower leg was the only way to stop the infection from spreading. He refuses the amputation, even though he is capable and well aware that he will die without the surgery, because he is a World War II veteran and refuses to voluntarily give up a limb when so many of his soldier friends had limbs blown off during the war. No matter what the consequence, he has vowed that out of respect to the memory of those lost in the war he will be buried whole. His refusal is not based on any conception of the meaning and destiny of human existence, and yet he is nonetheless providing a very good, intelligible reason for refusing treatment. Presumably Pellegrino and Thomasma would say that this is another example of an immoral treatment refusal, since the surgery is necessary and highly beneficial. So it seems that the patient's values, which are supposed to be the central feature of the beneficence-in-trust model, do not play as significant a role as it initially appeared.

A second problem with Pellegrino and Thomasma's model and, for that matter, with all of the models discussed in this chapter, is that they all seem to be missing the important humanistic component of the relationship. I made this point as a criticism of Veatch's contractual model, but it applies to all the models discussed. The models focus so much on balancing patient autonomy and physician paternalism that they ignore other important features of the relationship, such as physician-patient communication or, more generally, how physicians should behave toward patients. A physician could follow any one of the models discussed above and still not have a good relationship with her patients.

A model of the physician-patient relationship should focus on the relationship as a whole and not just on particular aspects of the relationship (such as decision making).

The discussion of Pellegrino and Thomasma's beneficence-in-trust model brings to a close this chapter on the history of the debate. What I have tried to accomplish in this chapter is to review a number of the popular and influential physician-patient relationship models that have been offered over the past few decades, and to show why they all fall short as the model that is most appropriate for the physician-patient relationship. In the next chapter I offer an analysis of the concept of care, which will serve as the foundation for a new model of the physician-patient relationship.

Chapter 2: An Analysis of the Concept 'Care'

'Care' is an everyday concept. By that I mean it is a concept that is commonly used by people during their everyday lives, in a variety of different circumstances and with a variety of different meanings. We hear people say, or have said ourselves, phrases like, "I care for you," "Take care of yourself," "I care about the environment," or "I don't care." What is interesting about the concept is that we all use it in our daily lives and yet few of us would probably be able to actually define 'care' if we were asked to do so. Like U.S. Supreme Court Justice Potter Stewart said about 'obscenity', we may not be able to define it, but we know it when we see it.[1] But what do we mean when we tell someone we care for him or her? How do the various usages of 'care' mentioned above differ in meaning from one another, if in fact they do differ? Is caring about the environment the same kind of caring as taking care of someone? What would be the appropriate usage of the concept for a care-based model of the physician-patient relationship? In the first part of this chapter I will attempt to sort out many of these issues.

Differentiating Among the Various Usages of the Concept

In the opening to this chapter I gave four examples of the usage of 'care' that we might hear in everyday language. What is probably obvious to the reader is that there is something different about the way 'care' tends to be used in the various contexts. That is, it seems that when we say something like, "I care about the environment," we do mean something quite different from when we say, "Take care

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[1] Jeffrey Olen and Vincent Barry, eds., *Applying Ethics*, 7th ed. (Belmont, CA: Wadsworth/Thomson Learning, 2002), 123.

of yourself." And the difference is still evident, though perhaps more subtle, between phrases like, "I care for you," and "I will take care of you." Though it may be less obvious, I will argue below that there is a difference between caring *about* something and caring *for* something, and that these differ further from *taking care of* something and *providing care to* something. They all, however, have a role to play in the physician-patient relationship. In what follows I will attempt to flesh out the distinctions between the various usages, but one thing that will become evident is that the distinctions are fuzzy at best.

The distinction between caring *about* and caring *for* is a distinction that has received some attention in the literature on care ethics. An initial observation about the two types of caring is that 'caring for' seems awkward in some contexts. For example, the phrase, "I care about the environment," seems perfectly acceptable, but it would strike us as odd to hear someone say, "I care *for* the environment." Why would that strike us as odd?

Tronto argues that the distinction between caring about and caring for lies in the type of object toward which one is caring. For Tronto, 'caring about' refers to less concrete objects; while 'caring for' is directed toward more particular objects, caring about is "characterized by a more general form of commitment."[2] Though Tronto is not clear about what she means by a "general form of commitment", there does appear to be something to the distinction she draws here. When we do use 'caring for', we tend to be referring to particular things (usually people): I care for my

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[2] Joan C. Tronto, "Women and Caring: What Can Feminists Learn About Morality from Caring?" in *Justice and Care: Essential Readings in Feminist Ethics*, ed. Virginia Held (Boulder, CO: Westview Press, Inc., 1995), 102-103.

wife; a mother cares for her children; a nurse cares for her patient; and people even care for their pets. We rarely hear people say that they care *for* more general things, such as groups of people (e.g., starving children in Africa) or 'things' (such as the environment). Similarly, we usually hear 'caring about' used in reference to these more general things: Joe cares about the environment; Bob doesn't care about the flood victims in Bangladesh; Sally doesn't care about the money.

However, the distinction does not work quite the way Tronto wants it to work because the two groups of objects are not mutually exclusive. That is, though 'caring for' is usually reserved for particular objects of care, 'caring about' is certainly not reserved only for more general commitments. Though it may be odd to say, "I care for the environment," there is nothing strange about saying, "I care about you." Moreover, there may be situations in which it may not be so odd to use 'caring for' in reference to a more general object. For example, I can say that I care about starving children in Mozambique because I do feel sympathy for them and wish they didn't have to suffer the way they do. But the aid worker who actually spends time in Mozambique helping to feed the children seems to be doing more than just caring about the starving children – we could say that she is actually caring *for* them. And the usage of that particular phrase would not seem inappropriate in the way that it would seem inappropriate if I were to say that I care for the children while I refrain from making any attempt to actually help them.

The above observations lead me to conclude that the distinction between 'caring about' and 'caring for' does not rest solely on the object of care but may have something to do with how the agent *reacts* to the object in need of care. More specifically, the distinction may depend on whether or not the agent takes active steps (or would take active steps) to help the object of care. Along these lines, van Hooft argues that 'caring about' "seems to attribute an interest and motivational orientation to an agent without making that attribution depend on the agent's typically behaving in certain ways."[3] What van Hooft is alluding to here is that the difference between the two types of caring amounts to the difference between an attitude that one takes toward something and action on behalf of that something. On this view caring about something means one takes a particular attitude toward that thing, but when one cares for something one is actually willing to perform certain actions or engage in certain behaviors for that thing. Thus, I may care about the starving children because I do take a particular attitudinal stance toward them, but the aid worker actually cares for them because she is also willing to take action to help them.

Although this approach to the distinction between caring about and caring for is on the right track, it also does not quite work. The problem is that although I may care about something even though I am not currently doing something for that thing, there seems to be something wrong with me saying that I care about it if I am not actually willing to act on its behalf. For instance, one could certainly challenge my claim that I care about the environment if I engage in behavior that is either indifferent to or is actually destructive of the environment. Thus, although caring

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[3] Stan van Hooft, *Caring: An Essay in the Philosophy of Ethics* (Niwot: University Press of Colorado, 1995), 32.

about something might not commit one to any particular actions, it seems as though caring about must have some implications for action.[4]

If we combine Tronto's argument about the target of care with van Hooft's distinction between attitude and action, we may get closer to a more accurate way of characterizing the distinction. Recall that while it seems strange to say that one cares for the environment or one cares for the homeless, it is also perfectly acceptable to say that one only cares about more particular targets of care. This is because there is something more *intimate* about the caring involved in caring for than that involved in caring about. This also explains why one could care for the homeless, while it is difficult to imagine how one could care for the environment. While caring about does have implications for action, it may be the case that the key to the distinction between caring for and caring about is that the action involved in caring for is of a more intimate or personal nature than in caring about. Along these lines, Jecker and Self state that while "caring about can occur at a distance from its object, caring for usually requires direct contact with the one who is cared for."[5] Hence, I could demonstrate that I care about the homeless by donating money to homeless charities (care from a distance), or I could care for them by volunteering in a homeless shelter, for example. But since the idea of having direct personal contact with the environment is a little odd, caring for the environment seems inappropriate. Thus, caring about is an attitude that carries implications for action that may be remote or

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[4] Prof. Elisabeth Boetzkes, email communication, December 18, 2002.

[5] Nancy S. Jecker and Donnie J. Self, "Separating Care and Cure: An Analysis of Historical and Contemporary Images of Nursing and Medicine," *Journal of Medicine and Philosophy* 16 (1991): 295.

impersonal, while caring for involves more personal, intimate action on behalf of the target of care.[6]

This gets us much closer to an acceptable way of characterizing the difference between caring about something and caring for something, but there is still one lingering question, the answer to which may help further clarify the distinctions. I said above that caring about is an attitude that carries with it certain implications for action, but what exactly is the caring attitude? In other words, what does it actually mean to care about something?

On a very basic level when one cares about something one is concerned about or interested in that thing, i.e., the attitude one takes toward the thing is that of concern or interest. When I say that I don't care about the Toronto Raptors, that is because I have absolutely no interest in the sport of basketball and so I am not at all concerned with the successes or failures of the Raptors. On the other hand, my friend cares very much about the Toronto Maple Leafs because he is a big fan of hockey and his hometown team – he is concerned with and interested in their success. Along the same lines, we care about our loved ones because we are concerned with their well-being.

One problem still remains: the concern or interest that one has in certain things may not necessarily imply a commitment to action, for a couple of reasons. First, it would seem that in some cases the depth or intensity of my caring attitude determines whether I am committed to action on behalf of something or someone. I

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[6] It may be worth noting that there is an altogether different usage of 'care for' that does not fit this picture. That usage is when people use 'care for' as a synonym for 'like', as in "I don't care for mushrooms."

may care about an old acquaintance in the sense that I am interested in keeping abreast of developments in his life, but such a weak caring attitude would not seem to commit me to action on his behalf.[7] On the other hand, I care about my daughter very deeply and this deep caring motivates me to act on her behalf. Hence, there seems to be a difference in the depth of the caring attitude one takes toward different things or people, and the depth of the caring attitude determines one's commitment to action on its behalf. Caring about something or someone in only the basic sense doesn't commit one to action, while caring in the deep sense does.

The second reason why the caring attitude might not commit one to action is that action on behalf of the other might be either impossible or inappropriate, depending on the particular context. For instance, if I were a farmer in an area currently experiencing a severe drought, and my livelihood depended on the weather, I might care very deeply about whether it will rain tomorrow or not. But in such a case it is impossible for me to take action because I cannot affect the weather. Or I can care very deeply about a friend in the sense that I have a deep concern for his well being, but action on his behalf might sometimes be inappropriate. If my friend were experiencing marital troubles, for example, it might not be appropriate for me to get involved on his behalf (or on behalf of their marriage).[8] On the other hand, there are certainly going to be many situations in which caring about my friend does commit

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[7] Since I prefer not to use the term 'weak' in this context I will henceforth refer to this kind of care as care in the basic sense.

[8] I thank Prof. Elisabeth Boetzkes for these examples and for helping me further refine this distinction.

me to action on his behalf, such as, for example, if my friend were abusing drugs or alcohol.

Thus, what distinguishes the different contexts of the caring attitude amounts to a combination of the depth of the caring attitude and the possibility and/or appropriateness of taking action. The caring attitude can take either a basic or deep form, and only caring in the deep sense seems to commit one to action. Moreover, the commitment to action that accompanies deep care is limited by the possibility and/or appropriateness of action in the particular situation. The result is four combinations of the components, depending on the situation: 1) basic care, which does not commit one to action; 2) deep care where action is impossible; 3) deep care where action is possible but inappropriate; and 4) deep care where action is both possible and appropriate. Furthermore, in situations that fall into the fourth category, the caring attitude commits one to action on behalf of the object of care because without the willingness to act one's caring attitude is open to question.[9] If I were to say that I cared deeply about someone and action was both possible and appropriate in the situation, and I chose not to act, I would be demonstrating that I don't really care about that person in the way I claim.[10]

The next task is to determine how 'caring for' and 'caring about' differ from the other common usages of 'care', such as 'to take care of' and 'to provide care'.

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[9] Of course one can only establish that one is truly willing to act if one actually does act; saying that I am willing to help if I never actually help is an empty promise. Hence, the simple *willingness* to act is not enough to establish that one cares – one must actually act.

[10] I should point out that throughout the remainder of this dissertation I will sometimes use 'care' as an adjective in describing someone, for example, as a "caring parent." I use the term in this sense to describe someone who takes a deep caring attitude toward things (i.e., a caring parent is one who cares about his or her children in the deep sense).

'Taking care of' is a very common phrase – we use it in statements such as, "I am taking care of my neighbour's cat while he is away." This usage of 'care' seems to imply a notion of responsibility – if I were to take care of my neighbour's cat while he was away, that would involve the responsibility to make sure the cat's needs are met. My neighbour would certainly blame me for failing to meet the cat's needs, e.g., if I forgot to feed it or didn't change the litter. In this context the caring attitude is actually irrelevant, or at least takes a back seat to the responsibility associated with the actions involved. I may not actually care *about* the cat (i.e., be concerned with the cat's well-being) but if I accept the job of taking care of the cat while my neighbour is away, I take on the responsibility of making sure the cat's needs are met. Thus, any concern I may have for the cat's well-being may be derived only from my desire to do the job properly.

This usage of 'care' is very similar to Hart's notion of role-responsibility. According to Hart, certain social roles carry with them certain responsibilities that are specific to that role. Responsibilities that are attached to social roles are what Hart called "role-responsibilities":

> Whenever a person occupies a distinctive place or office in a social organization, to which specific duties are attached to provide for the welfare of others or to advance in some specific way the aims or purposes of the organization, he is properly said to be responsible for the performance of these duties, or for doing what is necessary to fulfill them. Such duties are a person's responsibilities.[11]

When I agree to take care of my neighbour's cat while he is away, I essentially take on the role of "cat babysitter". Attached to that role would be the responsibilities

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[11] H.L.A. Hart, *Punishment and Responsibility: Essays in the Philosophy of Law* (Oxford: Oxford University Press, 1968), 212.

discussed above: feed the cat, change its litter, take it to the vet if it is sick, and so on. These responsibilities are only attached to the role of cat babysitter; my normal role of "neighbour" would not carry with it these responsibilities. The notion of role-responsibility also implies certain limits on one's responsibilities. For example, if I were to take care of my neighbour's children while he was away, I would be responsible for meeting *certain* needs (e.g., feed them, make sure they get to sleep at a reasonable time, and so on) but I would not be responsible for *all* of their needs (e.g., make sure they get a decent education and are emotionally stable).[12] These latter responsibilities would not be attached to the role of babysitter for the weekend.

The main difference between 'taking care of' and 'providing care' is that the latter does not carry with it the notion of responsibility that the former does. Providing care to someone (or providing someone with care) describes more generally the types of things that one might do in caring for someone (which may also be the same things that one might do in taking care of someone). The connection to 'caring for' implies that the things one does when one provides care to someone are more intimate or personal in nature. For example, a nurse on a geriatrics ward provides care to her patients when she helps them in and out of bed, bathes them, and talks with them. This intimate and personal nature of 'providing care' also explains why it makes little sense to talk about providing care to the environment or to one's favourite sports team, even though one can care *about* those things. Another reason why 'providing care' is inappropriate in such contexts may be that providing care to

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[12] Prof. Wil Waluchow, personal communication, March 21, 2003.

someone suggests that certain "caring tasks" have been *completed* (e.g., the geriatrics patient gets bathed or is helped out of bed and to the bathroom). That is, there is a need for care to be provided and the care is successfully provided. But since it is impossible to actually complete the care needed by the environment (i.e., to actually save the environment), it does not make sense to talk about providing care to the environment.[13]

So what is the relation between these various usages of care? To review what I have concluded above, to care about something means to take an attitude of interest in or concern toward that thing. This caring attitude can take either a basic or deep form, and care in the deep sense may or may not commit one to action on behalf of the target of care depending on whether action is possible and/or appropriate.[14] When one does act on behalf of the target of care, one can do so either remotely or intimately. For instance, I can demonstrate that I care about the homeless by donating money to a homeless shelter (remote) or by volunteering to help feed homeless people at a shelter (intimate). When one does things intimately or personally to demonstrate that one cares about something or someone, one is caring *for* that thing.

The relation between caring about and caring for, on the one hand, and taking care and providing care, on the other, amounts to the following. As I mentioned above, providing care encompasses the types of intimate and personal things that one

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[13] This additional reason was suggested to me by Prof. Elisabeth Boetzkes (personal communication, March 17, 2003).

[14] I have not attempted to offer an account of when caring action would be appropriate because I think the appropriateness will depend on the context of the particular relationship or situation. Thus, when I discuss care in the personal relationships later in this chapter, and in the physician-patient relationship in the next chapter, the notion of appropriate care will be somewhat clarified.

might do when caring for someone. These things may also be the same types of things that one does when one takes care of something, but taking care of is used in the context of role-responsibilities. One important thing to remember, however, is that there is no necessary connection between the caring attitude (caring about) and the things that one does when one provides care or takes care of something. That is, one can provide care for someone or take care of someone without actually caring *about* that person. Suppose Jill is a recent widow and Jack made a deathbed promise to her late husband, Jack's best friend, that he would take care of Jill for his friend once he died. Jack may not genuinely care about Jill at all (i.e., he may not be interested in or concerned about her) but is taking care of her simply out of a sense of duty to his friend. In the same way, one could take care of a pet for a friend while she is away on vacation, even though one may not really care about the pet at all. Or consider the example of the philanthropist who gives large sums of money to homeless charities. She may in fact care about the homeless, or she may simply want the public recognition of doing something significantly charitable. If one does care about the target of care, and the actions one performs on its behalf are of an intimate or personal nature, then one is caring *for* that thing.[15]

Applying this conclusion to the context of the physician-patient relationship, my argument in this dissertation is that physicians should care about their patients (in

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[15] One thing is still missing from the complete picture. Caring for involves intimate or personal actions performed on behalf of something that are grounded in a caring attitude. But what would we call actions performed out of a caring attitude that are more remote or impersonal in nature? One may recycle because one cares about the environment, but recycling doesn't fit the categories of caring for, providing care to, or taking care of the environment. Donating money to a charity may be grounded in a caring attitude but also does not fit the other categories. It may be that there is no usage of 'care' that fits these situations; rather, it may be more accurate to describe recycling or donating money as helping the environment or a particular cause.

the deep sense).[16] The reason I say care *about* and not care *for* is because the actions that physicians perform on behalf of their patients would more accurately be classified as taking care of patients rather than providing care to them. Since I have defined providing care as actions of an intimate and personal nature, such actions in the context of health care typically are part of the nurse's role and not the physician's (e.g., bathing the geriatrics patient). Moreover, the notion of role-responsibility fits well with the context of the physician-patient relationship because it is a professional relationship – physicians have certain responsibilities toward patients, *as physicians*, and these responsibilities are also limited by the social role. In arguing for a care-based model of the physician-patient relationship, I am arguing that in taking care of patients, physicians should also care about their patients. Also remember my Aristotelian influence: my hope is that if physicians learn to care about their patients, they will better be able to take care of them.

In arguing that physicians should care about their patients, I am allowing for the possibility that physicians can still be considered caring physicians even if they don't have contact with patients. For example, radiologists focus on studying X-rays and have little if any direct contact with patients. Yet they still perform actions on behalf of patients indirectly by examining the X-rays and trying to make an accurate diagnosis, even though the actions they perform on behalf of patients are of an even more remote and impersonal nature than physicians who have regular direct contact with patients. Thus we can still distinguish between caring radiologists and uncaring

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[16] From this point on I when I use 'care about' I will be using it in the deep sense delineated above, unless I specifically make reference to caring about in the basic sense.

radiologists by whether they care about the patients on behalf of whom they are acting.[17] Nevertheless, since the topic of this dissertation is on caring physician-patient relationships, I will only focus on physicians who actually have intimate and personal contact with patients.

What Does it Mean to Care?

Now that I have differentiated among various common usages of 'care', and have defended 'caring about' as the appropriate usage for a care-based model of the physician-patient relationship, the next task is to examine the concept itself to determine what it actually means to care about someone (i.e., what is involved in being deeply concerned or interested in someone). However, I will not attempt to offer a *definition* of 'care'; rather, I will analyze the concept by examining how caring actually manifests itself in several paradigmatic caring relationships, in order to extract the various features of caring that could be applied to the physician-patient relationship. Thus, I will be utilizing the approach to conceptual clarification popularized by Ludwig Wittgenstein.

The Wittgenstinian Approach to Conceptual Clarification

I mentioned in the Introduction that the approach I will take to the analysis of 'care' is in the tradition of the *later* Wittgenstein. This is because his views on conceptual analysis early in his career were markedly different from his views as they developed later in his career. Early in his career, Wittgenstein subscribed to the dominant *essentialist* view of conceptual analysis: the view that for any concept, there

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[17] Since they have no direct contact with patients it seems awkward to describe the work they do even as taking care of patients. The actions radiologists perform may fit into the same mysterious category that contains recycling or donating money to charity.

must be some common element in all cases in which we use that concept, something that defines all the cases of that thing as *that thing*.[18] In other words, there must be some element that determines the "essence" of that thing. For example, in order for us to say that a Buick station wagon and a Ferrari are both cars, there must be some particular element that defines what a car is and that allows us to say that those two rather different looking things are both cars. The defining element may be one property or, more likely, a set of properties, but the point is that on the essentialist picture *every* thing to which we attach the label 'car' must possess that property or set of properties in order to be correctly labeled 'car'. Once we have identified the defining property/properties, i.e., the essence of 'car', we can then provide a definition of 'car' in the form, "A car possesses properties *w*, *x*, *y*, and *z*." Moreover, on the essentialist view it is this definition that we have in mind when we actually use the concept in our language; in order for me to point to a Ferrari and claim, "That is a car," I must already know the definition of 'car' (i.e., that a car possesses properties *w*, *x*, *y*, and *z*).

In the *Philosophical Investigations*, Wittgenstein launched his attack on the dominant essentialist view by using 'game' as a counter-example. Since on the essentialist view we must know the definition of concepts we use, I must be able to articulate the definition of 'game' if I were to apply that concept to roulette or Monopoly -- and that definition will capture the essence of 'game'. However, Wittgenstein argued, when we think about all the different kinds of games, we must

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[18] William H. Brenner, *Wittgenstein's Philosophical Investigations* (Albany: State University of New York Press, 1999), 23.

realize that there are no essential properties common to every thing that we label 'game', but rather a set of properties, some combination of which is possessed by any particular game.

> Consider for example the proceedings that we call "games". I mean board-games, card-games, ball-games, Olympic games, and so on. What is common to them all?...For if you look at them you will not see something that is common to all, but similarities, relationships, and a whole series of them at that [*PI* 66].[19]

Instead of trying to identify the properties common to all games, which may be impossible to do, we could identify a set of properties, *v*, *w*, *x*, *y*, and *z*, that exist in different combinations in all games. So roulette may have two of the properties in common with Monopoly, but three of the properties in common with golf; and Monopoly may only have one of the properties in common with golf, but four of the properties in common with Trivial Pursuit. Thus, in order to correctly label something as a 'game', it must possess *some* of the cluster of game properties, not *all* of them.[20]

Wittgenstein likened the properties in such a cluster to the resemblances among members of a family: various members of a family will possess different characteristics in common with other members of the family, and the possession of *some* of those characteristics is what enables one to label them all as members of that family. For example, I have a different build or body shape from my sister, brother, and parents; my sister has a different eye color from me, my brother, and my parents; and my sister shares a temperament with my father, which differs from the

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[19] Ludwig Wittgenstein, *Philosophical Investigations*, trans. G.E.M. Anscombe (Oxford: Basil Blackwell, 1963).

[20] George Pitcher, *The Philosophy of Wittgenstein* (New Jersey: Prentice-Hall, Inc., 1964), 220.

temperament of me, my brother, and my mother. Yet we are all, unmistakably, members of the same family. So one important observation made by Wittgenstein was that there are some concepts that cannot be defined by the essentialist method. The other important observation he made was that we do not actually need an essentialist definition to understand and use concepts. Even though we may not be able to provide a definition of 'game', we still know how to use 'game' in our language -- and we know that poker is a game whereas eating ice cream is not.[21]

Before moving on, a couple of points of clarification may be needed. First, in arguing that there are no defining features common to all games, Wittgenstein was not arguing that there are no features *at all* common to all games. Such a statement would simply be false as all games could be described as activities, for example. What Wittgenstein argued was that there is no property common to all games that *determines* or *defines* them *as games*.[22] All games may have in common the property of being an activity, but there are also numerous other things also possessing that property that are not games (like eating ice cream). The second point of clarification is that Wittgeinstein does not need to be committed to the claim that some concepts, like 'game', *cannot* be defined in the essentialist sense, since the real thrust of his argument is the second of the two observations noted above: that we do not need an essentialist definition to understand and use concepts. It may in fact be the case that if someone were to try hard enough, she might be able to identify certain properties

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[21] Though, of course, eating ice cream could be turned into a game by adding some of the 'game' properties (whatever those may be).

[22] Bede Rundle, *Wittgenstein and Contemporary Philosophy of Language* (Oxford: Basil Blackwell, Ltd., 1990), 45.

that all games have in common and that define games as 'games'; but such a discovery would not weaken Wittgenstein's argument since his claim that we can understand and use 'game' without knowing such a definition would still stand.

Applying the "Family Resemblance" Argument to 'Care'

Wittgenstein's family resemblance argument is an appropriate starting point for analyzing the concept 'care' since, like 'game', it is a good example of a concept that we all understand and know how to use in our language without necessarily knowing the definition of the concept. Just as we are able to identify that Monopoly is a game and eating ice cream is not, we are also able to distinguish relationships that exhibit care from relationships that do not. Also, just as there are many examples of games, there are also many examples of caring relationships, and care can manifest itself in different ways within different relationships. The key to offering a Wittgenstinian analysis of the concept 'care', then, is to try to identify the cluster of "care properties". I will attempt to accomplish this by looking at a number of paradigmatic caring relationships in order to extract the features that would belong in the care cluster. The three main paradigmatic caring relationships I will examine are parenthood, friendship, and romantic partnership.[23]

1. Parenthood

When we think about what it means for a parent to care about her child, what sort of qualities or features come to mind? Perhaps the most obvious quality that

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[23] Although I am examining care as it is manifested in these relationships, I should emphasize that I am focusing on the caring attitude that one person in the relationship takes toward the other (e.g., what it means for a parent to care about his child), not on how caring occurs between the two parties. In other words, reciprocity is not important to my analysis of care since I am only concerned with physicians caring about patients, and not with patients caring about physicians.

comes to mind is that a parent who cares about his or her child is committed to the best interests of that child. Caring parents want their children to succeed, to be happy, to find fulfillment in life, to be healthy, and so on. In more common parlance, caring parents want the best for their children. It would be difficult to call a parent a caring parent if he or she did not want the best for his or her children. A parent who is not concerned with the health, happiness, and success of his or her children would hardly be a caring parent. But there is more to being a caring parent than just wanting the best for our children. Being committed to the best interests of one's children also implies that one is willing to do whatever one can do (or at least whatever is reasonable under the circumstances)[24] to help the child realize those best interests. Barbara Tarlow conducted a study of caring in different contexts by asking people how they would describe care in three different contexts: in the family, in school (with respect to the teacher-student relationship), and in volunteer agencies. Acting in the best interests of others was one of the most common caring concepts mentioned in the context of the family, and it was defined as "a process in which family members had been there to assist in the past, were now helping, and were expected to continue acting with beneficence to promote the health, well-being and happiness of

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[24] This qualification is directly related to the limits of possibility and appropriateness on the actions to which caring might commit one that I discussed earlier in this chapter. That is, a parent should not be blamed for being an uncaring parent if the appropriate action on behalf of the child is impossible or inappropriate given the circumstances. For example, if it is in the child's best interests to pursue a university education, the caring parent should take some steps to help the child pursue that interest (such as helping the child study or providing him or her with a tutor) but other actions (such as bribing or threatening the admissions committee of a university) would be considered inappropriate and, thus, beyond what is reasonable under the circumstances.

their family members."[25] Although this kind of commitment may exist between all members of a family, nowhere is it stronger and more apparent than in the commitment of a parent to his or her child.

The commitment to the best interests of one's child is not just a commitment to their current best interests but also to their future best interests. Not only do we want our children to be happy, healthy, and fulfilled now, but we also want them be happy, healthy, and fulfilled for the rest of their lives. Thus, being committed to the best interests of one's child means doing things for them now that will contribute to the realization of their best interests in the future. One way parents accomplish this, for example, is by providing their children with education. In addition to providing academic skills and knowledge through formal education, caring parents also make the effort to provide their children with other skills and the psychological grounding necessary for living a happy and fulfilling life. For instance, caring parents will make the effort to instill in their children a sense of self-worth, self-esteem, and self-confidence, and will try to foster decision-making and problem-solving skills, all of which will enable children to lead their own happy and fulfilled lives once they become independent from their parents. In other words, as many of the participants in Tarlow's study mentioned, being committed to the best interests of another person, particularly in parenthood, means *empowering* that person -- "doing something now that would foster the person's independence in the future."[26]

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[25] Barbara Tarlow, "Caring: A Negotiated Process that Varies," in *Caregiving*, ed. Suzanne Gordon, Patricia Benner, and Nel Noddings (Philadelphia: University of Pennsylvania Press, 1996), 68.

[26] Ibid., 69.

Being committed to the best interests of one's child requires that one try to provide the child with certain necessities of life, such as food, clothing, shelter, and, some would argue, education. It also requires trying to protect the child from harm and to promote the child's health. In other words, parents are committed to ensuring that the welfare interests of their children are fulfilled. However, recall from the Feinberg discussion in Chapter 1 that there is more to a person's best interests than just welfare interests; a person's interests also include ulterior interests and preferences that are a means to achieving welfare or ulterior interests. Unlike welfare interests, ulterior interests and preferences (as well as passing desires, which do not count as interests) are subjective and will vary from person to person, depending, in part, on a person's values. Being committed to a person's best interests means being committed not just to the person's welfare interests, but also to the other interests and preferences that are components of his or her best interests. Thus, an important component of the commitment to a child's best interests, and thus of being a caring parent, is the need to know and treat one's child as an individual. A parent cannot truly be committed to his child's best interests if he is not willing to learn what that particular child needs or wants.[27]

A common mistake parents make is trying to make their children conform to the parents' own conception of what they think *should* be in their children's best

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[27] It seems odd to talk about ulterior interests and preferences that are means to fulfilling other interests in the case of children because it may be the case that young children possess only welfare interests. For example, being committed to the best interests of an infant amounts to ensuring the infant's welfare interests are fulfilled. However, at some point during a typical child's process of maturation he or she will begin to develop ulterior interests and preferences, and so his or her best interests will expand to include those.

interests. Parents do this by pressuring their children to pursue certain career paths, to attend certain schools, by trying to influence the people with whom their children develop romantic relationships, and so on. In doing this parents fail to respect the individuality of their children and are only contributing to what *they* think will make the children happy and fulfilled. If a parent pushes her child to pursue something that she mistakenly thinks is in one of the child's ulterior interests, or that she thinks *should* be in one of the child's ulterior interests, then the result is that the parent is not actually committed to the best interests of her child.[28] If caring parents are committed to the best interests of their children, which include their more subjective ulterior interests and preferences that are means to interests, and a particular parent is not committed to these other interests, then that parent cannot be considered a caring parent.

Although being a caring parent includes being committed to helping one's child live a happy and fulfilled life, this does not simply reduce to an unlimited obligation to help the child fulfill whatever desires or interests he or she may have. This is especially evident in situations in which a child's welfare interests (i.e., health, safety, basic education) are at risk. If her teenage child wants to try skydiving, a caring parent does not just say, "Okay, if that is what will make you happy." On the

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[28] A couple of qualifications are needed here. First, parents can be genuinely mistaken about what is in a child's ulterior interests. In that case pushing the child to pursue a course of action in line with those interests is not uncaring. It is uncaring, however, when a parent tries to convince the child to adopt different interests altogether because the parent thinks certain ulterior interests are more worthy of pursuit. Thus, being committed to the best interests of one's child may be understood as acting on the basis of what one *reasonably believes* to be in the child's best interests. Second, as I will argue below, there are situations in which caring parents should push their children to pursue certain interests either because the child can be mistaken about what is really in her best interests or may be confusing what might be in her short-term interests with what is in her long-term interests. I thank Profs. Wil Waluchow and Karen Wendling for pointing out the necessity of these qualifications.

contrary, a caring parent will try to steer her child away from an activity that would put his or her welfare interests at risk. How she does this will depend on factors such as her child's age, and may range from refusing to give her child permission to skydive (for a young teenager) to trying to convince her child that the short-term thrill of skydiving is not worth the risk of death or serious injury (for a teenager over the age, say, of eighteen). Being committed to a child's best interests means a parent is willing to interfere when the child's welfare interests are at risk.

In addition to being willing to interfere to protect a child's welfare interests, a caring parent will also be willing to interfere at times to protect a child's ulterior interests. Caring parents will grant their children much more freedom with respect to their ulterior interests since, in most cases, they cannot possibly know better than the child what the child's ulterior interests are. However, there are times when this general rule does not hold, particularly with young or teenage children who have not yet discovered their own identities. Parents, by virtue of the fact that they are intimately involved in their childrens' lives from birth, are in the privileged position of knowing their children more intimately than anyone else, sometimes even more intimately than the children themselves. In the words of Joseph Kupfer,

> The parent witnesses the young child's coming-to-be. Consequently, he possesses intimate knowledge of the young child's development, including knowledge of the child before she knows herself. This gives the parent special access to the young child's personal identity.[29]

The implication of this is that there are times when the parent may actually have a better idea of what is in the child's ulterior interests than the child does because the

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[29] Joseph Kupfer, "Can Parents and Children be Friends?" *American Philosophical Quarterly* 27 no.1 (1990), 17.

parent actually knows the child better than the child knows herself. An example from my personal experience will illustrate this point nicely. I began my post-secondary education as an economics major, for a number of reasons: I had experienced moderate success in high-school economics; my older brother was in economics and finance and I liked the idea of following in his footsteps and "going into business"; and I really didn't know what else to study. My first year as an undergraduate student was far from successful, and I saw my grade-point average drop almost fifteen percent from my high-school graduating average. I remember one particular evening at the dinner table (I commuted to university from home) when my parents questioned whether economics was really what I should be studying and whether I should try to expand my interests and look for a different major. They were convinced that economics wasn't for me and that I would be much better off studying something different. I stubbornly refused to entertain their suggestion and tried to convince them that I really enjoyed studying economics; I just needed time to adjust to university life and I would be able to find success. A year later, after taking my first practical ethics course, I switched my major to philosophy, instantly finding academic success, and went on to pursue a Ph.D. in philosophy, specializing in health care ethics. I look back now and realize that my parents were exactly right – I am not mathematically inclined, and economics definitely was not for me. I was just a stubborn nineteen year-old who was afraid to admit I couldn't succeed at something. Even though I think I knew it all along, the point was that my parents knew me well enough to know that studying economics was not in my ulterior (and, thus, in my best) interests when I was unable to admit it to myself. My parents demonstrated that they were caring parents: they wanted me to find fulfillment and they knew that economics was not the means to that end – and they were willing to interfere when it looked like my behavior was putting that end in jeopardy.

The desire of a parent to interfere to protect a child's best interests can result in the parent becoming too involved and trying to exert too much control over his or her child's life. To protect against this a caring parent will balance this desire to interfere with two things. First, a caring parent will try to keep in mind that the main goal of parenthood is the empowerment aspect discussed above.[30] As Bernhardt explains, it is important for parents "to keep in mind the kind of individual the child is to be – an individual who is self-disciplined, capable of running his own life satisfactorily, capable of adjusting to the ever-changing world in which we shall live."[31] Interfering too much and exerting too much control over the child's life will thwart the process of empowerment.

The second thing caring parents can do to protect against becoming over-involved is to be patient and allow the child to develop at a pace that is appropriate to the particular child. Clearly, the importance of getting to know the child as an individual is necessary for allowing the child to develop at his or her own pace. Some children develop and mature quickly, while others need more time to discover their identities and to learn how to be independent. With respect to young children, a

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[30] According to Hoagland, the very *purpose* of parenting is to wean children of their dependency (Sarah Lucia Hoagland, "Some Thoughts About 'Caring'," in *Feminist Ethics*, ed. Claudia Card (Kansas: University Press of Kansas, 1991), 250.).

[31] Karl S. Bernhardt, ed., *Being a Parent* (Toronto: University of Toronto Press, 1970), 35.

mistake parents often make is expecting too much from their children too soon.[32] This often comes as a result of parents comparing their children to other children of the same age, and even comparing how their children are developing to the developmental pace of the average child as determined by the "experts". Parents may then worry that their child doesn't have the vocabulary that some other children have, or is not able to grasp mathematics as easily as his classmates, and will attempt to compensate for these "shortcomings" by pushing the child to learn more advanced vocabulary or to spend more time studying mathematics. The bottom line is that children are individuals and will not only possess different skill sets and aptitudes from each other, but will also grow and develop at different paces. In the same way that a caring parent will respect a child's individuality and make the attempt to know that child as an individual, a caring parent will also respect that a child needs time and freedom to grow at his or her own pace. As Mayeroff states in his analysis of caring, "To care for the other, I must see the other as it is and not as I would like it to be or feel it must be."[33]

As noted in the Tarlow quotation above, participants in her study mentioned the importance of permanence with respect to the commitment to a family member's best interests. Being committed to the best interests of one's child does not just mean that the caring parent is committed to those interests *now* but that she will continue to be committed to them in the future. This permanence in the caring parent's commitment to the child's best interests gives rise to another notable feature of the

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[32] Ibid., 34.

[33] Milton Mayeroff. *On Caring* (New York: Harper Collins Publishers, 1971), 25.

caring parent: the parent's dependability and reliability. In Tarlow's study, participants mentioned the concept of "being there" as an important feature of the caring person, which means that "the caring person would be present and prepared to help the person cared for in whatever way he or she could."[34] Whether the child is five years old or fifty years old, the caring parent will always be concerned about the child's best interests and will be willing (within limits) to help her child achieve those interests.[35] A parent who is inconsistent in this commitment and is sometimes "not there" for her child, is not truly committed to her child's best interests and can not be said to be a truly caring parent.

A further characteristic that is prevalent in caring parenthood is identification with the child's interests. This means that caring parents recognize that their children have their own interests and empathize with their children in their successes and failures in pursuit of those interests. A parent who knows his child has a certain interest, say to become a physician, but is uninterested or disinterested in whether or not his child succeeds in pursuing this interest, can not be said to really care about his child. A caring parent, on the other hand, will want his child to succeed in his goal, and will share in the child's pain of medical school rejection or elation at passing his medical school exams. When we care about others we cannot help but share in their

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[34] Tarlow, 61.

[35] The qualification "within limits" is important here. First, the dependability of the parent's commitment to the child's best interests is subject to the same limitations as discussed above with respect to the commitment. Second, there may be other acceptable limits on the parent's obligation to be there for his children. For instance, keeping in mind the importance of empowerment, a caring parent might cut off his irresponsible child financially to avoid fostering the child's continued dependence. Or a parent may not be able to help a child at a particular time because he is experiencing significant problems in his own life at the time (Prof. Karen Wendling, personal communication).

feelings brought on by their successes and failures. When we share in the feelings of our children, their interests become part of our interests; we have an interest in seeing our children succeed in the pursuit of their interests. However, our motivation for wanting them to fulfill their interests is simply because we care about them and not a selfish motivation to fulfill our own interests. As Marilyn Friedman explains,

> The flourishing of loved ones promotes my own well-being, yet my motivation to care for them does not require me to compute how their well-being will further my own interests; I am simply interested in them.[36]

Because of the particularly strong bond between parent and child, this identification can be extremely powerful and can actually lead to an enmeshing of the two separate lives of parent and child. Sometimes this can happen when parents lack interests of their own, when there is an opportunity for the child to pursue an interest that the parent once pursued (especially when the parent failed in the pursuit), or simply if the parent wants the child to follow in his or her footsteps. They latch on to the interests of their children and push them to pursue the interests more seriously than the children wish to pursue them. Some of these parents are said to be "living vicariously through their children" because they are, in effect, using their children to fulfill their own needs when they are unable to fulfill them for themselves. A current example of this behavior is parents who take their children's sporting events far too seriously. "Hockey dads," for example, have become a serious problem in Canada. They push their young sons into competitive hockey so that they can either relive success they once experienced, or live through that success for the first time. These

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[36] Marilyn Friedman, "The Social Self and the Partiality Debates," in *Feminist Ethics*, ed. Claudia Card (Kansas: University Press of Kansas, 1991), 165.

parents take the game so seriously that they scream at players who make mistakes (their own children and others on the same team), yell obscenities at the referees for making bad calls, and, in some cases, actually physically attack coaches, referees, and other hockey dads.[37] All of this happens in front of children who are as young as seven or eight years old. When parents become so enmeshed in their children's lives that they push their children to pursue interests that the children do not wish to pursue as seriously as the parent wants them to pursue the interests, the parents are no longer committed to the best interests of the children. Rather, they are motivated by the selfish desire to share in (and perhaps even *own*) the successes of their children.

Sometimes this enmeshing can occur unintentionally, simply because of the nature of the relationship of parent and child. As Peta Bowden explains in the context of mother and child, the daily activities of protecting and nurturing that are involved in motherhood can cause the boundaries between mother and child to dissolve.[38] Parents who care for their children are so involved in their children's lives from the very beginning, that sometimes they can forget that their children are individuals with their own interests. Val Plumwood refers to this kind of enmeshing as 'incorporation'. According to Plumwood, when one party in a relationship incorporates the other into his identity, as the enmeshed parent does, he denies the identity of the other. This incorporation can lead to "domination and

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[37] A perfect example is the recent case of the hockey dad convicted of manslaughter after beating a fellow hockey dad to death during an argument after a game.

[38] Peta Bowden, *Caring: Gender-Sensitive Ethics* (London: Routledge, 1997), 30.

instrumentalisation, the erasure of the other as an external limit on self."[39] In the parent-child relationship, this incorporation can lead to the kind of over-involvement in the child's life discussed above. Thus, the caring parent will identify with the interests of the child while at the same time recognizing the limits of that identification. "I experience what I care for…as an extension of myself and at the same time as something separate from me that I can respect in its own right."[40]

2. Friendship

Friendship is a valuable relationship for an examination of caring because, unlike the parent-child relationship, friendship is a relationship that is entirely chosen by the people involved. We cannot choose our parents (nor can we really choose our children, even though having a child is usually a choice), but we can certainly choose our friends. Of course friendship is based on feelings we have toward certain people, and we cannot really choose whom we like and whom we do not like; but it is up to us whether and how we act on those feelings.[41] The interesting thing about friendship for an analysis of caring is that caring seems to be a necessary feature of friendship – i.e., one could make the argument that one of the things that distinguishes a friend from an acquaintance or complete stranger is that friends care about each other in a way that acquaintances or strangers typically do not.[42] And while a parent is a parent

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[39] Val Plumwood, *Feminism and the Mastery of Nature* (London: Routledge, 1993), 157.

[40] Mayeroff, 7.

[41] Laurence Thomas. "Friendship," *Synthese* 72 (1987), 221.

[42] Some qualification of this statement might be needed. In denying that strangers typically care about each other I am not implying that strangers *could* not care about each other. If that were the case, physicians could not care about their patients. I am also not claiming that strangers *don't* care about each other. Many Christians, for example, live their lives according to the "love thy neighbour"

whether he cares about his children or not, a friend is not really a friend if he doesn't care about the people he calls his friends. Thus, relationships of choice, such as friendship, provide a valuable opportunity for examining what it means to care about someone.

One feature that friendship has in common with parenthood is the feature of dependability. However, the dependability of friendship is of a different kind than in parenthood. The dependability in parenthood arises from the dependence of the child on the parent early in life and from the commitment of the parent to the child's best interests. Children grow to expect that the commitment to their best interests will continue, and the caring parent is one who dependable in this manner. But in the case of friendship the early dependence and the commitment to the best interests that arises from that dependence does not exist. So what is the basis of the dependability of friends?

Although friends do not identify with each other's best interests in the way that parents identify with their children's best interests, there is a sense in which friends are committed to each other's best interests. We do want our friends to be happy and healthy, and it can be quite upsetting to us when our friends do not achieve these things. And although the commitment to help our friends achieve their goals may not be as strong as in the case of parenthood, we are willing to do things to help

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principle. *Typically*, however, strangers do not care about each other. Moreover, I recognize that people have friendships of different qualities, such as "best" friends, "good" friends, and just "friends". And these friendships may differ to a large extent in how much caring exists between the members. Nevertheless, I would say that friends of any quality, to qualify as friends, must care about each other to some extent. Therefore, I should specify that the type of friendship I am using for my analysis would probably resemble "best" friendship.

our friends that we wouldn't be willing to do for strangers. For instance, one friend might help get another a job interview with her employer; friends will help each other study for exams in school; friends will try to protect each other from engaging in risky behaviour; and friends will "be there" for each other in times of adversity. This commitment arises from the fact that the reason we choose to develop friendships with certain people is because we like those people and feel a certain affection for them. As we get to know them and spend time with them that affection grows and becomes a strong motivator to be there for our friends. Although the term affection is typically understood in terms of an emotion, such as fondness or love, Elizabeth Telfer defines the affection in friendship as "a desire for another's welfare and happiness *as a particular individual*."[43] She distinguishes this kind of affection from the motive of benevolence, which motivates us to seek the good of others in general as opposed to the good of others as individuals. What motivates us to help strangers is benevolence; what motivates us to be there for our friends is concern for that particular person's welfare or happiness.

The dependability of friends thus arises from the strength of the affection and fondness friends feel for each other. Perhaps this is one way of understanding the difference between people we consider our "best" or "close" friends and people we simply consider our "friends". Though we may expect the latter to be there for us to some extent, we expect much more from our best or close friends; and this may have something to do with the fact that the affection and feeling of fondness is much

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[43] Elizabeth Telfer, "Friendship," in *Other Selves: Philosophers on Friendship*, ed. Michael Pakaluk (Indianapolis: Hackett Publishing Company, Inc., 1996), 251.

stronger between best friends than it is between friends. Someone whom I consider just a friend would not disappoint me nearly as much if he were inconsistent in his commitment to be there for me as my best or close friend would if he were inconsistent in the same way. I would be disappointed because the lack of commitment would indicate to me that my friend's affection and fondness for me is not as strong as I had thought it was. In the words of Ralph Waldo Emerson,

> The end of friendship…is for aid and comfort through all the relations and passages of life and death. It is fit for serene days and graceful gifts and country rambles, but also for rough roads and hard fare, shipwreck, poverty and persecution.[44]

Therefore, since the friendship that I am using for this analysis resembles best friendship, dependability can be considered an important feature of such a relationship.

Before moving to the next caring feature of friendship, it may be appropriate to say another word about the motivation of friendship. As I noted in the discussion of parenthood, caring parents are committed to the best interests of their children and identify with their children's interests not out of a selfish desire to further their own interests but simply because caring parents care about their children. When one's child is in need of help, for example, the caring parent does not stop to consider whether she herself will benefit from providing assistance, or whether the pros outweigh the cons for herself; on the contrary, the caring parent helps her child *simply because that person is her child and is in need of help.* This same selfless motivation also exists in the case of friendship. Friends do not help each other because they will

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[44] Ralph Waldo Emerson, "Friendship," in Pakaluk, 227.

benefit themselves from helping or out of some ulterior motive other than that a friend is in need. "Friendship involves a substantial concern for the good of the friend for his own sake, and a disposition to act to foster that good, simply because the other is one's friend."[45]

This motivation to be there for one's friend simply because the other is one's friend gives rise to another caring feature of friendship: loyalty. The affection and fondness that serve as the basis for friendship results in a special bond that develops between friends. The affection and fondness we feel for our friends are unique in that they are feelings we have for only a very limited number of people. The feelings we have toward our friends stand apart from the feelings we have toward all others as being of a very unique kind. This is especially true in friendships that have a long history. A bond builds between friends that results in friends seeing each other as more important than most other people in their lives. Friends are willing to do things for each other that they would not be willing to do for many other people. This special bond gives rise to a strong feeling of loyalty toward one's friends. We feel that we owe our friends certain things, such as support, that we do not owe to other people. We feel a sense of duty to stand by our friends and support them because they are special to us. In many ways this loyalty is similar to the dependability discussed above, but it takes on a slightly different connotation. Loyalty implies more than just being dependable; it implies that one is committed to making that relationship a priority over others (e.g., over acquaintances or "lesser" friends), and

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[45] Lawrence A. Blum, *Friendship, Altruism and Morality* (London: Routledge & Keegan Paul Ltd., 1980), 43.

that one would stand by that person in cases of conflict with other people. This kind of loyalty may not play a significant role in simple friendships, but it certainly plays a role in best or close friendships. We expect our best friends to choose us over others when a choice must be made because they are our best friends.

A third caring feature of friendship is that friends are honest and sincere with each other. One thing that is particularly hurtful and can be particularly damaging to a friendship is when one friend has been deceitful or has lied to another friend. It can also be hurtful when one friend is not open with the other and refrains from sharing personal information with the other that the friend shares with other people. We expect our friends to be honest, sincere and open with us because openness and honesty seem to reflect the quality of the friendship and the strength of the friendship bond. When we have a strong friendship with another person, we feel comfortable being open and honest with that person. We feel free to share personal information with that person that we may not share with anybody else. "A friend is a person with whom I may be sincere. Before him I may think aloud."[46] One of the reasons we feel that we can be open and honest with friends is because we feel confident that they will be open and honest in return. When we are in need of advice, for instance, we take comfort in the fact that our friends will be honest and sincere in their advice.

I mentioned above that it can be hurtful to us when our friends are untruthful with us or when they are not open and sincere with us. What can be even more hurtful and damaging to a friendship is when one is open and sincere with a friend

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[46] Emerson, 225.

regarding personal information, and that friend fails to respect one's privacy by revealing that personal information to others. The bond that enables us to feel comfortable revealing personal and private information to our friends also generates the expectation that we can trust our friends to keep such information private. In fact, the extent of the trust we have in our friends will determine both the quantity and quality of the personal information we choose to reveal to them. Since we don't have a strong bond with acquaintances, we may not feel comfortable revealing very personal information to such people and so we will place limits on our openness with them. But the strong bond we have with best friends allows us to trust them more than we would trust acquaintances, and so we will be more open with them than with acquaintances.

Laurence Thomas argues that the bond of mutual trust is one of the salient features of friendship.[47] The mutuality of the trust is grounded in the fact that the connection between trust and openness works both ways. I said above that the level of trust will determine how open we are willing to be with our friends. Yet what contributes to the *mutuality* of trust between friends is that one's willingness to be open with one's friend will also contribute to the trust one's friend has that one will maintain his or her confidentiality. So the trust that I have in my friend to maintain my confidentiality will determine how much and what personal information I am willing to reveal to him; and my willingness to reveal such personal information to him will contribute to his willingness to trust me with his personal information. The

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[47] Thomas, 217.

reason it works this way is because my willingness to be open with my friend says something about my feelings regarding the bond that we have as friends. As Thomas explains,

> [T]he extent to which a person is willing to reveal to us private information about himself which he is not willing to reveal to most others is the most significant measure we can have of a person's willingness to trust us, where the trust in question implies considerably more than that the person takes us to be of unquestionable moral character.[48]

Thus, the openness and sincerity that is important to friendships is directly connected to the trust that friends have in one another, and the relationship between the openness and the trust runs both ways. If a friend violates my confidentiality and breaks the mutual bond of trust, it sends a very powerful negative message about the strength and quality of our friendship.

There is one final caring feature of friendship that differs markedly from the parent-child relationship. As I discussed above, because parents are responsible for the well-being of their children early in life, until the children are able to live independently, parents have a certain amount of justified authority over their children.[49] Parents and children are not equal in terms of autonomy because they *cannot* be; the dependence of children on their parents makes equality impossible. In the case of friendship, however, the two parties are typically on equal footing with respect to authority and autonomy. Neither party in a friendship is under the authority of the other as children are under the authority of their parents. This

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[48] Ibid., 224.

[49] Ibid., 222.

equality in authority is, according to Thomas, another one of the salient features of friendship.[50]

According to Joseph Kupfer, equality in autonomy is a *necessary* feature of what he calls "ideal friendship". Inequality in autonomy will foster inequality and dependence, with one friend relying on and depending disproportionately on the other.[51] Over time the dependence of one friend on the other might put a strain on the friendship, eventually resulting in one of two consequences: either the more autonomous friend will diminish her commitment to the friendship, or she will try to help the dependent friend become more independent and autonomous. Additionally, the more autonomous friend could try to take advantage of the dependent friend by exerting authority and control over her. This kind of behavior is often seen in young children, when one friend acts "bossy" toward the other. Such behavior inevitably results in the more dependent friend eventually expressing displeasure with the behavior of the other, and often results in the disintegration of the friendship. In any case, Kupfer may be correct that equality in autonomy and authority is a necessary feature of friendship.

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[50] Thomas, 217.

[51] Joseph Kupfer, *Autonomy and Social Interaction* (Albany: State University of New York Press, 1990), 100.

3. Romantic Partnership[52]

The relationship between romantic partners has much in common in terms of caring features with both parenthood and friendship, particularly the latter. Because romantic partnerships often begin in the same way that friendships begin, they typically grow out of affection and a developed bond like friendships do. However, they are based on emotions of a much more intense nature than friendships, and so are more akin to parenthood in that respect. Thus, when one thinks about the caring features of romantic partnership, one will conclude that it shares many of the same caring features with friendship and parenthood: dependability, identification with the other's interests, commitment to the best interests of the other, loyalty, honesty, and equality in autonomy and authority (at least in the case of modern Western partnerships).

For instance, one feature that romantic partnership shares with parenthood but not with friendship is the feature of identification with the other's interests. Because romantic partnerships are based on a deep affection and love for another person, and because the lives of romantic partners are intertwined with each other to a greater extent than any other relationship, romantic partners who care about each other cannot help but identify with each other's interests. When we love someone in this way and share a life with that person, "the other's well-being and suffering is

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[52] I am using the term "romantic partnership" as a neutral term that encompasses any committed relationship based on romantic love, such as the typical heterosexual marriage. Of course this will also encompass other relationships that don't fit into the narrow category of marriage, such as common-law relationships and homosexual committed relationships.

experienced as constitutive of our own well-being and suffering."[53] However, one difference between the identification in romantic partnership and parenthood is that the intertwining of the lives of romantic partners makes the boundary between healthy involvement and over-involvement significantly more blurry.

One caring feature that romantic partnership shares with friendship but perhaps plays a more prominent role in the latter than it does in the former is that of the equality in autonomy and authority. However, the feature takes on a slightly different meaning in the context of romantic partnership than in friendship. As mentioned above, Kupfer argues that equality in authority and autonomy is a necessary feature of ideal friendship, implying that friends could not be best friends or could not remain best friends if one is less autonomous or under the authority of the other. But it would be difficult to make the same claim with respect to romantic partnership. Many romantic partnerships involve one partner being more or less autonomous than the other, and sometimes it is this fact that makes many such relationships successful. Sometimes people are actually romantically drawn to people who are their opposite in this area: people who don't like making important decisions are often drawn to people who tend to take control in such areas, and vice versa. And it is precisely this imbalance that makes many of these relationships successful.[54]

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[53] Kupfer, "Can Parents and Children," 21.

[54] One could argue that the same could be said of friendship: inequality could make a friendship successful in the same way that it could make a romantic partnership successful. Typically, though, I think that equality in autonomy and authority plays a more prominent role in ideal friendship than it does in romantic partnership. Nevertheless, I concede that the contrast between the two relationships on this point may not be so stark.

How the importance of equality in autonomy and authority manifests itself in caring romantic partnerships is in the partners treating one another with equal respect. Unequal relationships like the one described above can still be caring partnerships as long as each partner treats the other as deserving of equal respect as a person.[55] For instance, even though a woman with limited autonomy may not be comfortable making major financial decisions and would rather leave these decisions to her husband, he can still treat her with equal respect by keeping her informed of the decisions he makes and being open with her when she makes inquiries into their financial situation. On the other hand, if the husband refuses to keep her informed and disregards her requests for information, or complains about his useless slave-of-a-wife to his friends, he is not treating her with the respect she deserves as a person. Treating one another with equal respect is an important component of a caring romantic relationship.

There is one final caring feature of romantic partnership that has not been discussed thus far, though it could also be considered a caring feature of parenthood. This feature is selflessness, and it is connected to the commitment to the other's best interests. Although friends are committed to one another's best interests to a certain extent, the selflessness that caring parents and romantic partners exhibit does not exist to the same extent in the typical case of friendship. This is likely because the bond between friends and the emotions involved are not of the same magnitude and intensity as in parenthood and romantic partnership. Thus, friends usually are not

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[55] This point could apply to the other relationships as well, though it would manifest itself quite differently in the case of parenthood.

dedicated to the other's best interests in the way that caring parents are dedicated to their children and romantic partners are dedicated to each other. Friends typically are not as committed to helping each other, and are more likely to withdraw their support or assistance when it conflicts with their own best interests, than are parents or romantic partners. Romantic partners, on the other hand, because they care about each other so deeply, are more dedicated to one another and are more willing to make sacrifices to help one another achieve their interests. Although the loyalty in friendship means that friends are more likely to make each other a priority over other people, they are more likely to make *themselves* the priority in the relationship.[56] In the case of romantic partnership, however, partners will tend to make *the other person* the priority in the relationship.

To conclude, the aim of this chapter was to provide an analysis of the concept 'care' based on a Wittgenstinian "family resemblance" approach to conceptual analysis. I began the chapter by differentiating among various usages of 'care', and I argued that physicians should care about their patients. After briefly summarizing Wittgenstein's family resemblance argument, I proceeded to apply the family resemblance approach to the concept 'care' by examining three paradigm caring relationships in the attempt to extract a cluster of caring properties. These properties represent various caring features that exist in different combinations, and even manifest themselves differently, in the three paradigm relationships. My examination

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[56] There are, of course, exceptions to such an analysis of friendship. For example, war buddies who are willing to sacrifice themselves to protect one another would be an ultimate example of selflessness (Prof. Wil Waluchow, personal communication). This is why I used the word "typical" earlier in this paragraph – *typically*, friends are not this committed to one another.

of the paradigm relationships of caring parenthood, friendship, and romantic partnership revealed the following cluster of caring properties: commitment to the best interests of the other; treating the other as an individual; identification with the other's interests; dependability; loyalty; selflessness; honesty/sincerity/openness; mutual trust; equality in autonomy and authority; and treating the other with equal respect as a person. In the next chapter I will discuss which of these caring properties are appropriate for the physician-patient relationship, and how the properties manifest themselves in that relationship. It may be the case that some of the properties listed above are not appropriate for the physician-patient relationship, which would be entirely consistent with the family-resemblance approach. Just as some of the properties exist in one or two of the paradigm relationships, but not in all three, there may be some properties that are also not appropriate to the physician-patient relationship.

Chapter 3: Care in the Physician-Patient Relationship

The goal of this chapter will be to develop my care-based model of the physician-patient relationship by applying each of the caring properties uncovered in the previous chapter to the physician-patient relationship. I will discuss each caring property in turn, focusing on whether that particular property is appropriate for the physician-patient relationship and, if it is appropriate, how it might manifest itself in the relationship. While some of the properties will transfer directly from the paradigm relationships to the physician-patient relationship, others will likely have to be reinterpreted to be more fitting for such a different kind of relationship. The major difference between the physician-patient relationship and the paradigm relationships is that the latter are social or personal relationships that are not structured around professional roles, while professional relationships like the former are structured around such roles. This means that the emotion and affection that give rise to some of the caring properties, such as selflessness, in the paradigm relationships will not exist in the physician-patient relationship, and so those properties will either not be appropriate or will reveal themselves differently in the physician-patient relationship.

Commitment to the best interests of the other

It goes without saying that the relationship between physicians and patients should be guided to some extent by physicians' commitment to the best interests of their patients. This commitment is expressed in the principle of beneficence, which is typically interpreted as an obligation "to help others further their important and legitimate interests by preventing and removing harms," as well as "to weigh and balance possible goods against the possible harms of an action."[1] As noted in my Introduction, the principle of beneficence has a long history in medicine, tracing back to the Hippocratic era, and was considered the dominant principle (along with the related principle of non-maleficence) in medical ethics until only recently. However, the rather uncontroversial claim that physicians should be committed to the best interests of their patients raises further controversial questions: What exactly is meant by 'best interests' (i.e., which interests should physicians be committed to helping the patient realize), and *how* committed should physicians be to their patient's best interests? Referring back to the discussion of parenthood will help us come to a better understanding of the physician's commitment to the patient's best interests, including answers to these two questions.

In the case of parenthood the commitment of the parent to the child's best interests arises from the caring parent's desire to see his child live a happy, healthy, and fulfilled life. The same could be said of physicians with respect to their patients. In much the same way that parents want their children to be happy and healthy, physicians desire the same for their patients. The difference is that because physicians are not emotionally attached to their patients in the way that parents are to their children, and because their interactions with their patients are constrained by the professional nature of the relationship between physician and patient, the desire on the part of physicians for their patients' health and happiness will be more limited. For example, we wouldn't expect our physicians to care about whether or not we get

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[1] Tom L. Beauchamp, "The 'Four-principles' Approach," in Gillon, *Principles*, 14-15.

the job or the promotion we were hoping for because it is typically not part of the physician's job as a physician to be concerned with such aspects of our lives.[2] However, physicians do want their patients to be healthy, and health is certainly a major factor in one's ability to live a happy and fulfilled life. For patients who cannot be made healthy (e.g., the terminally ill), physicians still want their patients to be as comfortable and happy as they can be during their remaining time.

Even if physicians are concerned with the happiness of their patients in a general sense, the constraints of their professional roles as physicians will mean that what they can do for patients to achieve that happiness will be limited. It is perfectly conceivable that a family physician who has developed a friendship with a longstanding patient might actually be concerned with other aspects of the patient's happiness, such as his career or his home life. But while a parent, friend, or romantic partner might be able to help the patient fulfill his interest (such as getting the job he really wants), helping a patient in this way falls outside the bounds of the physician-patient relationship. Patients do not see their physicians for help securing employment, they see their physicians for *health-related* issues. Thus, the commitment on the part of the physician to the patient's best interests will be of a more restricted nature. In this respect, of the relationships discussed in the previous chapter, the physician's commitment to the patient's best interests may more closely

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[2] I say "*typically* not part of the physician's job" because there are situations in which such concerns will be related to the patient's health and, thus, part of the physician's area of concern. For example, a physician might be concerned with her patient's high blood pressure or sleep problems, which may be due to stress related to wider aspects of the patient's life (Prof. Wil Waluchow, personal communication).

resemble the commitment to the best interests of the other in friendship: physicians want their patients to be healthy and happy, but are more limited in what they are able, and willing, to do to help their patients achieve this.

In the discussion of parenthood I noted that caring parents are not just committed to their childrens' current best interests but also to their future best interests. Hence, one of the goals (if not the main goal) of parenthood is empowerment – to provide the child with the psychological, emotional, and intellectual skills necessary to live as an independent adult in the future. In other words, one of the goals of parenthood is to raise children to be autonomous adults. In this respect, parenthood also has much in common with the physician-patient relationship, though the empowerment manifests itself quite differently. Parents empower their children by providing them with education, teaching them problem-solving skills, and instilling in them a sense of self-confidence and self-worth. These specific methods of empowerment lie outside the bounds of the physician-patient relationship, but physicians nonetheless are committed to the empowerment of their patients in the sense of at least trying to restore the autonomy that is diminished due to illness. Eric Cassell was one of the first to stress the importance of this commitment to empowerment, arguing in a 1977 article that the function of medicine is actually to preserve the autonomy of the patient and to restore his or her independence.[3] Examples of this type of empowerment would be an intervention

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[3] Eric J. Cassell, "The Function of Medicine," *Hastings Center Report* 7 (1977): 16-19.

designed to restore a patient's cognitive deficit (e.g., treating a high fever that is the cause of a patient's delirium) or surgery to restore a patient's mobility.

There is another sense in which empowerment plays an important role in the physician-patient relationship. The empowerment described above relates to the physician helping the patient overcome the impact of illness and trying to restore the patient to his or her previous level of independence. But the autonomy of patients is also vulnerable within the physician-patient relationship, due to the impact of illness and the power imbalance between many physicians and patients. Feminist ethicist Sue Sherwin is particularly concerned with the need to empower vulnerable populations in the health care setting. According to Sherwin, physicians are obligated to be particularly sensitive to the needs of patients who are members of populations that, due to social circumstances, have traditionally been less than "fully" autonomous because such patients need help developing the capacity to make important health care decisions.[4] Empowerment in this sense might involve giving an elderly patient extra time and enabling her to consult with family members before making a treatment decision. However it manifests itself, empowerment enables patients to pursue their interests.

That physicians want their patients to be healthy implies that they are committed at least to the patient's welfare interests. All things being equal, health is something that is valued by all people and, since physicians are health "experts", it is

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[4] Susan Sherwin, "A Relational Approach to Autonomy in Health Care," in *Readings in Health Care Ethics*, ed. Elisabeth Boetzkes and Wilfrid J. Waluchow (Peterborough: Broadview Press, Ltd.), 2000.

uncontroversial to claim that physicians are, and should be, committed to the health of their patients. But in my discussion of parenthood I also noted that caring parents are committed to more than just their childrens' welfare interests; because they want their children to live happy and fulfilled lives, caring parents are also committed (within the limits discussed) to helping their children achieve their ulterior interests. Friends and romantic partners are also committed to one another's ulterior interests to a certain extent. Given that physicians should be committed to the health of their patients, can it be argued that physicians should also be committed to the ulterior interests of their patients? Or should the physician's commitment to his patient's best interests be limited to the patient's welfare interests? I think physicians should be committed to their patient's ulterior interests, within limits, and the extent to which physicians should be committed to these interests will depend in part on the type of medicine practiced by the physician.

As I noted in the Introduction, medicine throughout most of its history was dominated by the principle of beneficence, interpreted narrowly as the obligation to promote the patient's best *medical* interests. Until the twentieth century this position went unchallenged because there was no reason to challenge it. Patients want to be healthy and until the twentieth century medicine remained simple enough that there were not many significant decisions to be made. Few treatments were available for diseases and ailments, and so there was little that physicians could actually do to heal patients or prolong life. But in the early-mid twentieth century the landscape of medicine started to change, for the reasons outlined in the Introduction: medicine became more technological, the patient demographic started to change, the social setting of medicine changed from the doctor's office to the institution, and so on. This meant that there were decisions to be made, surrounding such issues as pursuing risky and experimental treatments for diseases, life support, kidney dialysis and organ transplantation, and even blood transfusions. These kinds of decisions are necessarily value-laden, making patient values an unavoidable part of the medical landscape.

Since a person's ulterior interests are based to a significant extent on that person's values, the question of whether physicians should be committed to their patient's ulterior interests boils down to whether, and to what extent, physicians should help patients pursue their values in the health care setting. As long as those values relate to health care decisions, I think most physicians, *to a certain extent*, must be committed to helping their patients realize their personal values. Not to do so would be to fail to respect the patient's right to make an autonomous decision regarding his or her health care, even if that decision is a bad one from the physician's point of view. The example of a Jehovah's Witness who refuses a life-saving blood transfusion is a prime example of such a decision. For people who do not share the religious beliefs of the Jehovah's Witness, refusing a simple live-saving blood transfusion when the alternative is certain death might seem irrational. This can be an especially difficult decision to accept for physicians, who are trained to think of their primary role as healers. If physicians were only obligated to be committed to their patients' welfare interests, one would have to conclude that a physician faced with a Jehovah's Witness' refusal of a blood transfusion would be justified, if not obligated, to administer the blood transfusion against the patient's will. However, the right of a Jehovah's Witness to refuse life-saving blood transfusions is protected by law and is considered a paradigm example of the obligation of physicians to pursue more than just the patient's health or physical well-being. More generally, the right to refuse medical treatment was established in the United States almost ninety years ago in the *Schloendorff* case.[5]

The justification for such a right is the value of autonomy or self-determination: every competent adult should have control over what happens to his or her body, and forcing treatment on a competent patient against his or her will fails to respect this right to self-determination. Although traditionally the role of the physician was defined strictly in terms of cure and restoration of the patient's physical well-being, it is generally agreed now that cure and restoration of physical health is only one part of the physician's role – relief of suffering and improving quality of life are also considered important roles of the physician. For instance, George Agich defines the primary goal of the physician-patient relationship as "to improve the well-being of the suffering individual,"[6] where "well-being" means more than just *physical* well-being.

The extent to which physicians should be committed to their patient's ulterior interests depends in part on the kind of medicine being practiced by the physician.

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[5] In *Schloendorff* the patient, Mary Schloendorff, agreed to an examination of a fibroid tumor and explicitly stated that she did not want the tumor removed. While under anesthetic the doctors removed the tumor contrary to her wishes, and she developed post-surgical complications.

[6] George J. Agich, "Scope of the Therapeutic Relationship," in *The Clinical Encounter*, ed. Earl E. Shelp (Dordrecht: D. Reidel Publishing Company, 1983), 236.

An example of a context in which patient values play a significant (if not dominant) role in treatment decisions would be oncology, particularly in cases where the patient's cancer is terminal. A storyline on the popular medical show *E.R.* illustrated this kind of situation perfectly. One of the characters, himself a physician, had found out that a brain tumor he recently had removed in an experimental surgical procedure had recurred and was now inoperable and untreatable. The character was faced with a grim choice: without chemotherapy he would have at most a few months to live, while if he chose to undergo intensive chemotherapy (accepting the side effects that go along with such a treatment), he would be able to extend his life but only by a few more months at most. He initially chose to undergo chemotherapy, but then withdrew from the treatment after deciding that he would rather have three months of freedom than six months of hospital admissions and chemotherapy treatments. From a traditional strictly medical point of view, the best decision is obvious, as it would seem to be in the Jehovah's Witness case – treatment with extended life is better than no treatment and an earlier death. Yet this kind of decision must be made based on the values of the particular patient. An elderly widow without close family relationships might choose a different course of action, as might a *different* man in the same position as the television character. Thus, the values and ulterior interests of patients should play a prominent role in the relationship between patient and oncologist.

Another example of a physician-patient relationship at the same end of the spectrum would be the relationship between patient and palliative care physician.

Palliative care, by its definition, is centered on relieving the pain and suffering of patients dying from terminal illnesses or incurable chronic illnesses. In this context, where cure and restoration of health is no longer possible, physicians must be committed to helping the patient realize their ulterior interests as they relate to treatment decisions. A common example of a treatment decision in palliative care is whether or not to take high dosages of medication to control pain, which will also have the effect of diminishing the patient's cognitive status. The choice for these patients is between maintaining their cognitive faculties (so they can make decisions, interact with family, and so on) and dealing with the terrible pain caused by their condition, on the one hand, and getting relief from their constant pain but sacrificing the benefits of cognitive awareness, on the other hand. In this type of scenario, unlike the oncologist case above, there is not even a best choice from a medical point of view – the basis for a decision can *only* be the patient's personal values.

At the other end of the spectrum are going to be medical specialties in which patient values will not play as prominent a role. Surgery might be an example of such a specialty. At first glance, it would seem that there is no role for the patient's values in surgery – the surgeon performs procedures to which the patient has already consented (except in emergency cases), and so there would be no role for the patient's values during the surgery. The patient's values would come into play during the consent process, when the patient must decide whether or not to consent to the surgery; but in most cases consent would be obtained by the physician most responsible for the patient's care, not the surgeon. Even in surgery, however, patient values will have a role to play. The *Schloendorff* case, which established the right to patient self-determination, is a perfect example. In that case the surgeon went ahead and removed the tumor after the patient had explicitly stated that she did not want the tumor removed and had consented only to exploratory surgery. If there were no role for patient values in the operating room, and surgeons were only concerned with the patient's welfare interests, then the surgeon in *Schloendorff* could not be blamed for his actions.[7]

There is another issue that has arisen in recent years in the context of surgery that shows that even surgeons need to be concerned about their patient's values. The issue is the status of do-not-resuscitate orders (DNRs) in the operating room. This issue has arisen because DNRs (either in the form of advance directives or orders written while the patient is hospitalized) have become fairly commonplace in health care institutions. Some patients with DNRs may develop problems while in hospital that require surgery. Since there is a certain amount of risk associated with anesthetic and surgical procedures in general, risk which is amplified in patients who suffer from an underlying illness, there is always the possibility that the patient may arrest or develop respiratory depression during the procedure and require resuscitation. The issue is what should be done with the patient's existing DNR: should DNRs always be reviewed prior to surgery? Or should they be either unilaterally upheld or temporarily suspended?

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[7] A similar situation, suggested to me by Prof. Wil Waluchow, would be if a surgeon made an unexpected discovery during a surgical procedure and felt confident, based perhaps on previously expressed wishes, that the patient would want certain steps taken with respect to the discovery. In such a case the surgeon would be basing his or her decision on the patient's values.

Many surgeons and anesthesiologists argue that DNRs should be unilaterally suspended for surgical procedures based on the view that in order for them to perform their jobs to the best of their abilities, they must necessarily expose patients to a significant degree of risk, and they do not want to be responsible for letting a patient die on the operating table if he or she arrests. On the other side of the argument are those who argue that the patient's right to make autonomous decisions regarding his or her health care does not stop at the operating room door, and respect for the patient's wishes requires that the status of the DNR *at least* be reviewed with the patient prior to surgery. Making a unilateral decision to suspend a patient's DNR prior to surgery fails to respect the patient's wishes, for reasons none other than that surgeons and anesthesiologists do not want to be responsible for the death of the patient. This represents a scenario in which even surgeons should be committed to the ulterior interests of their patients.

Given that physicians should be committed, at least to some extent, to their patient's welfare *and* ulterior interests, the question that remains to be answered is how physicians should balance the commitment to both the patient's welfare and ulterior interests when the two sets of interests come into conflict. It is relatively easy to answer this question in situations like the palliative care case described above, when the patient's welfare interests can no longer be realized. But there are a multitude of situations in which there will be a clear conflict between the patient's ulterior interests and his or her physical well-being, such as the Jehovah's Witness case. How should a physician determine which commitment takes precedence in a given situation?

As discussed in Chapter 1, Pellegrino and Thomasma attempted to answer this question by ranking what they consider to be the four components of patient good in a hierarchy. Most important is the patient's ultimate good (e.g., to secure a place in heaven), followed by the patient's good as a human person (the patient's autonomy), followed next by the patient's subjective good (his or her assessment of the quality of life that might be produced by the intervention), and finally the patient's biomedical good. Thus, according to Pellegrino and Thomasma's ranking, the patient's capacity for autonomy, personal values, and subjective assessment of the proposed intervention at the particular point in time, *always* take precedence over the patient's biomedical good. Aside from the problems already discussed in Chapter 1, a significant problem with any attempt to rank components of patient good in this way is that it treats all situations according to the same universal rule ("always make biomedical good the lowest priority") and thus ignores the features of the particular relationship between physician and patient (e.g., oncologist or surgeon) as well as other contextual features (e.g., the patient's diagnosis/prognosis; what the proposed intervention is; and so on).

Although it is outside the scope of this dissertation to provide a full account of how physicians should balance competing interests, Dan Brock[8] has made an attempt

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[8] Dan W. Brock, "The Ideal of Shared Decision Making Between Physicians and Patients," *Kennedy Institute of Ethics Journal* (March 1991): 28-47.

that serves as a good starting point. Rather than ranking competing values in a hierarchy, Brock places the different values along a spectrum. At one end of the spectrum are the patient's welfare interests (incorporating more than just biomedical good), what he calls a person's primary functional capacities: biologic functions (e.g., organs that function well); physical functions (e.g., mobility); mental functions (e.g., intellectual and emotional capacities); and social functions (e.g., the ability to communicate).[9] According to Brock, these primary functional capacities are needed for a person to achieve the objective ideal of self-determination or autonomy. Toward the middle of the spectrum are what Brock calls agent-specific functions, "which are necessary for a person to pursue successfully the particular purposes and life plan he or she has chosen."[10] For example, an agent-specific function might be the capacity for highly abstract reasoning for someone pursuing higher mathematics, or extremely steady hands for a surgeon. Even further along towards the agent-relative end of the spectrum are "the particular desires pursued by particular persons on particular occasions in their valued aims and activities."[11] An example of a decision based on such agent-relative values would be a young woman who chooses to terminate an unplanned pregnancy because it would interfere with her goal of completing her law degree. Brock then concludes,

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[9] Ibid., 38. The similarities between Brock's list of primary functional capacities and Feinberg's list of welfare interests are quite apparent, though Feinberg's list is a little longer because it includes more than just functions or capacities.

[10] Ibid. Again, this is very similar to Feinberg's ulterior interests but is much more limited due to the focus only on functions or capacities.

[11] Ibid. These more agent-relative desires parallel the preferences that are means to achieving other interests in Feinberg's account.

> The more the patient's values and choices in shared decision making appear to be in conflict with his or her objective good, that is, ideals and functions at the objective end of the continuum, the stronger the case for the physician being an advocate for those ideals and functions and seeking to insure that the patient's values and choices do not, in fact, conflict with them.[12]

In maintaining that physicians are justified in advocating for the ideals and functions at the objective end of the spectrum, Brock is not saying that physicians "should ride roughshod over a patient's values and choices if they appear to be in conflict with his or her objective good."[13] To say so would be to revert back to the old paternalistic way of thinking, based on the limited understanding of patient well-being. What he is saying is that because all patients, as human beings, value the primary functional capacities, it is safe for physicians to assume that, all things being equal, patients want those functional capacities preserved as much as possible. Since the values at the subjective end of the spectrum are *subjective*, it is less appropriate for physicians to try to advocate for such agent-specific functions and values. So rather than prioritize medical beneficence and open the door to physicians "riding roughshod" over patient values, or prioritize patient autonomy and subscribe to the view that patient values are incorrigible, Brock has introduced a view that allows physicians to promote the patient's medical good while at the same time respecting the patient's autonomy. Unfortunately it is not too clear in Brock's analysis whether, or when, physicians are justified in overriding patient wishes, beyond the obvious cases of incapable patients and requests that would require the physician to violate the law.

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[12] Ibid., 39.

[13] Ibid.

Although Brock's continuum does serve as a good starting point for an analysis of how physicians should balance competing commitments, it is only a starting point because it is incomplete by itself. The problem with Brock's continuum is that, in the end, it doesn't constitute much of an improvement over traditional Hippocratic paternalism in which the patient's biomedical good was always given priority over the patient's other interests. If physicians are more justified in advocating on behalf of their patients' welfare interests because they are more likely to be confident in their knowledge of what is in their patients' welfare interests than in their ulterior interests, the end result is that welfare interests will always get the benefit of physician advocacy over ulterior interests.

That a patient's decision conflicts with his or her welfare interests should not itself give the physician reason to advocate on behalf of those welfare interests. Rather, it should put the onus on the physician to investigate into the patient's decision to find out what the reasons are behind that decision. The justification for physician advocacy on behalf of the patient's welfare interests should depend on the acceptability of the reasons for the decision and not on where the interests that are being "sacrificed" fall on the continuum. Acceptability will take into account a number of factors: the patient's capacity or competency; the autonomy of the patient in making the decision (i.e., whether the patient is being manipulated or coerced); and whether the reasons for the decision are *good* reasons. Although what counts as a good reason would have to be spelled out more fully, one requirement for a reason to be a good reason is that it be rational, i.e., that the patient is not trying to achieve something that is impossible (e.g., requesting a brain transplant to treat a brain tumor). Another requirement might be that the reason(s) must arise from ulterior interests and not merely from a "passing desire" -- it might be considered acceptable for a patient to sacrifice a welfare interest to achieve an ulterior interest, but not to achieve something that would be considered a passing desire.

The issue of how physicians should balance their commitments to their patients' various interests brings us directly to the second question I asked at the beginning of this section: *How* committed should physicians be to either the patient's welfare or ulterior interests? In other words, are physicians justified in acting paternalistically in their commitment to the patient's welfare or ulterior interests? How far should physicians go in advocating for the patient's welfare interests? And are physicians ever justified in paternalistically advocating for a patient's agent-relative functions or ulterior interests? Below I will argue that there are situations in which physicians are justified in paternalistically overriding a patient's wishes to protect the patient's welfare interests (aside from the obvious case of emergencies), and there are also situations in which it is morally appropriate for a physician to act paternalistically in advocating for a patient's ulterior interests. Notice that there is a subtle but important difference between these two claims: paternalistically *overriding a patient's wishes* versus *acting paternalistically* toward patients. The difference between these two claims will be explained below.

Typical definitions of 'paternalism' in the literature have tended to focus rather narrowly on successful interferences with a person's autonomy for what the actor takes to be the other person's benefit. Dworkin initially defined paternalism as, "the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, needs, interests or values of the person being coerced."[14] Pointing out that confining paternalism to interference with liberty of *action* is too limited, Allen Buchanan expanded Dworkin's original definition to include interference with a person's freedom of information, "or the deliberate dissemination of misinformation."[15] Dworkin later modified his views on paternalism, based on the comments of critics like Buchanan, to essentially boil down to the interference with a person's autonomy (for the person's benefit).[16] Robert Veatch and Carol Spicer adopted a similar definition in arguing against paternalism: "Paternalism refers to behavior that attempts to interfere with the autonomy of an individual without his/her consent (explicit or presumed) for the express purpose of benefiting that individual."[17]

However, Paul Hershey[18] noted that even a broad definition that focuses on interference with autonomy fails to capture various kinds of paternalism. Consider Hershey's example of the aunt who decides she would like to help her college student

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[14] Gerald Dworkin, "Paternalism," in *Philosophy of Law*, ed. Joel Feinberg and Hyman Gross (Belmont: Wadsworth Publishing Co., 1991), 230.

[15] Allen Buchanan, "Medical Paternalism," *Philosophy and Public Affairs* 7 no.4 (1978): 372.

[16] Gerald Dworkin, "Paternalism: Some Second Thoughts," in *Paternalism*, ed. Rolf Sartorius (Minneapolis: University of Minnesota Press, 1983), 107.

[17] Veatch and Spicer, "Against Paternalism," 409.

[18] Paul Turner Hershey, "A Definition for Paternalism," *Journal of Medicine and Philosophy* 10 (1985): 171-182.

nephew by depositing money into his bank account without his knowledge. Such an action does not interfere with the nephew's autonomy in any way, and yet it seems to be a paternalistic action. Thus, Hershey proposes the following definition of paternalism:

> An action, *x*, initiated by *A* (an individual or group) with regard to *B* (another individual or group) is paternalistic if and only if: (I) *x* is primarily intended by *A* to benefit *B*, (II) *B*'s consent or dissent is not a relevant consideration for *A*.[19]

One thing the above definitions all have in common is that they interpret paternalism as referring solely to concrete actions (or omissions) or events. The references to interference in Dworkin's, Buchanan's, and Veatch and Spicer's definitions imply that someone is *doing something* that will either be successful or unsuccessful in the goal of interfering with someone else's autonomy. Though Hershey's definition avoids reference to interference, so that it can accommodate such examples as the money-depositing aunt, it still refers explicitly to *actions* as being paternalistic. The paradigm examples of paternalism in medicine follow this way of thinking: administering treatment against a patient's wishes; lying to or withholding information from a patient; withholding treatment considered inappropriate; and so on. All of these examples refer to specific events that can be identified as paternalistic actions.

The problem with defining paternalism solely in terms of actions or specific events is that a person can act *paternalistically*, in the sense of acting or behaving in a paternalistic manner, without performing a *specific* paternalistic action. Recall the

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[19] Ibid., 180.

example in my discussion of parenthood of the teenager who wants to go skydiving. Suppose written parental consent were required from skydiving companies for any person below the age of majority. If the parent forbade his fourteen year-old son from going skydiving by refusing to sign the consent form, he would be performing a paternalistic action. Such an action would be easily accommodated by the above definitions of paternalism. However, if the teenager were of legal age and did not actually need parental consent, the parent technically could not override the teenager's wish to goskydiving. Instead, the caring parent expresses his displeasure with the idea of his son going skydiving and tries to convince the teenager that it is not a risk worth taking. Nevertheless, the parent realizes that in the end the decision is up to his son and so he is both respecting his son's autonomy and considering his son's consent or dissent. The parent's behavior would therefore not be considered paternalistic by any of the above definitions, and yet he does seem to be acting paternalistically. This type of scenario can easily be transferred to the context of medicine. A physician who respects her patient's autonomy but nonetheless tries to convince her patient that one treatment option is better than the other seems to act paternalistically even though she is not, according to standard definitions like the ones above, performing a paternalistic action. It is helpful to make the comparison between medical paternalism and parenthood since, after all, the term 'paternalism' literally means, "acting in a way like that of a father toward his children."[20]

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[20] *The Compact Oxford English Dictionary*, quoted in Nancy S. Jecker. "Is Refusal of Futile Treatment Unjustified Paternalism?" *Journal of Clinical Ethics* 6 no.2 (1995): 133.

Unfortunately, there is no room here to search for a full definition, or to perform a Wittgenstinian analysis, of the concept 'paternalism'. For the purposes of my dissertation we can accept a definition like Hershey's to account for paternalistic actions while adding the caveat that a physician can act in a paternalistic manner (i.e., in the way of a father, or parent, toward his or her children) even if she doesn't perform a specific action that would fall under Hershey's definition. For the remainder of my discussion, the term 'paternalism' will be understood to encompass both paternalistic actions (the type covered by Hershey's definition) and acting paternalistically (in the sense of acting in a paternalistic manner). The two questions that remain to be answered are: Is physician paternalism justified to protect the patient's welfare interests? And is physician paternalism justified to protect the patient's ulterior interests? I will argue that there are situations in which paternalism is justified in both cases, although it is easier to justify in the case of welfare interests.

The most apparent examples of paternalism in medicine are cases of overriding a patient's wishes or treating a patient without his or her consent. Thus, one way to establish that there are situations in which paternalism is justified in the case of a patient's welfare interests is to uncover a case of overriding a patient's wishes or treating a patient without consent that is morally justified. However, it is important to keep in mind that many typical cases of overriding a patient's wishes or treating a patient without consent would not actually be considered paternalism according to a definition like Hershey's. For example, refusing a patient's request to keep his recently diagnosed HIV-positive status from his wife is not paternalistic because it would not be done for the patient's benefit; rather, it would be done to benefit the wife and protect her from harm.

The one obvious case of justified paternalism is the case of treating a patient without consent in an emergency situation when the patient is unconscious or incapable for some other reason. In such cases physicians are justified in protecting the patient's welfare interests and treating the patient without consent, provided that waiting for the patient to regain consciousness or taking the time to find a substitute decision maker would increase the risk to the patient of serious harm or death. However, emergency scenarios are considered special circumstances and are uninteresting for an analysis of justified paternalism.

A good example of justified paternalism to protect a patient's welfare interests would be a physician's refusal of a patient's request for an unnecessary antibiotic.[21] For example, strep throat, a condition caused by various strains of the streptococcus bacteria, results in a sore throat, fever, and swollen tonsils and lymph nodes. Strep throat is easily and most quickly treated with antibiotics. Although it can in some cases lead to serious complications, strep throat will go away in three to seven days with or without treatment.[22] In most cases, the symptoms of strep throat can be relieved to some degree with nonprescription medications. Given the growing concern about antibiotic resistance in humans, physicians have good reason to be more selective in prescribing antibiotics to their patients. If a patient has a

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[21] I thank Prof. Karen Wendling for this example.

[22] *MSN Health Medical Encyclopedia.* <http://content.health.msn.com/content/healthwise/59/14676.htm>

particularly mild case of strep throat and is demanding antibiotics, the physician might be justified in refusing the request and instead recommending rest and nonprescription medication to relieve symptoms. In such a case the physician would be acting to protect the welfare interests of the patient, since in the long term antibiotic resistance could have much more significant health implications for the patient than strep throat in the short term.

As I have argued above, the commitment to the patient's best interests is not limited to the patient's welfare interests. But if physicians should also, to some extent, be committed to the patient's ulterior interests, would paternalism be appropriate to protect those interests? Childress refers to this kind of paternalism as "soft" paternalism – paternalism based on the patient's values.[23] Soft paternalistic actions, like the antibiotic case above, are difficult to defend in the case of ulterior interests (or Brock's agent-relative functions) because it cannot be assumed, as it can with welfare interests, that a particular patient will possess certain ulterior interests. The problem with paternalistic actions in the case of ulterior interests is that the physician, in the words of Veatch and Spicer, "would have to be able to make a legitimate claim that he or she was in a good position (perhaps the best position) to know what was in the interests of the patient. We believe that the physician is never in the best position."[24]

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[23] Childress, *Who Should Decide?*, 18.

[24] Veatch and Spicer, 416.

Paternalistic actions to protect a patient's values may be more difficult to defend morally but there may nonetheless be situations in which such paternalism would be justified. Consider as an example the following case:

> The patient, Mrs. Fong, is an 85-year-old, widowed woman suffering from end-stage renal disease. She is Chinese and does not speak English. She has been living with her son's family for the past few years. Although she could not verbally communicate with the nephrology staff, it had become clear that Mrs. Fong was growing increasingly frustrated with dialysis and expressed this to her son. Not wanting to see his mother suffer, her son, along with her daughter visiting from China, approached her physician of two years, Dr. Tina, about withdrawing her from dialysis. Dr. Tina informed them that although she could not be certain, Mrs. Fong would likely die within several weeks once withdrawn from dialysis. Dr. Tina felt confident that Mrs. Fong's children were in fact supporting her wishes, and so she supported their plan to take Mrs. Fong home to die comfortably. Five months later Mrs. Fong's children returned to the hospital with her, telling the staff that they can no longer cope with her care – she has lingered much longer than expected and she is suffering more now than before. They told Dr. Tina that she wants to go back on dialysis. However, Mrs. Fong resisted any attempts to start a line for dialysis, and even resisted attempts to run simple blood tests. Her capacity was questionable. Mrs. Fong's son claimed that she began to change her mind after being brought home, but Dr. Tina replied that in her actions she was clearly stating that she does not want dialysis. Her son responded that she was not thinking clearly because of the disease and the medication and was adamant that he knows what she wants. Dr. Tina said that she is not prepared to restrain his mother to insert a line for dialysis, particularly since she is very frail and any attempt to restrain her might harm her. Dr. Tina reminded Mrs. Fong's children that both they and the health care team have the same goal in mind – to do what is best for their mother. "You mother has been consistent in her treatment refusal," she told them calmly. "I've known her for two years now and it seems clear to me that she doesn't want any more dialysis. And I think you know that too." Recognizing the son's inability to cope, Dr. Tina assured him that his mother can stay in the hospital and they would do whatever they could to keep her comfortable. After a long silence, Mrs. Fong's daughter, who had remained quiet, turned to her brother and said, "Just stop, we're going to be hurting her with more dialysis." He eventually agreed, and they continued to visit her in the hospital until she died three weeks later.

What complicates this case somewhat is that because the patient does not speak English, the physician must deal directly with her substitute decision makers in making the treatment decision. Nevertheless, the involvement of substitute decision makers does not render the label of paternalism inappropriate. The moral foundation of the concept of substitute decision-making is respect for patient autonomy, not the principle of beneficence; the rationale for substitute decision-making is to extend the patient's control over her health care beyond the point at which she becomes incapable of expressing her own wishes.[25] Treating an incapable patient (or a patient who is unable to communicate) through her substitute decision maker is not circumventing the patient's consent or right to autonomy; on the contrary, it is respecting the patient's autonomy indirectly, through the substitute decision maker. Therefore, overriding the wishes of a substitute decision maker for the patient's benefit would qualify as paternalism just as if the patient had expressed the wish herself.

In the case of Mrs. Fong the physician performed a paternalistic action (refusing to put the patient back on dialysis) not to protect the patient's health or physical well-being but to protect her ulterior interest in pursuing quality of life over extended life. Although the physician was concerned about the harm that Mrs. Fong might have suffered in being restrained, her refusal was ultimately based on the fact that she felt confident that placing the patient back on dialysis was not in line with the patient's values. Even though the patient could not communicate with her verbally, the physician had known the patient for two years and, given that the patient was an end-stage renal patient who was initially on dialysis, likely had fairly regular contact with her and her family. She initially supported the family's decision to withdraw the patient from dialysis because she felt, based on her knowledge of the patient and the patient's non-verbal communication, that the decision was made by the patient. Although the son claimed that his mother changed her mind originally, and

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[25] Neil M. Lazar, et al., "Bioethics for Clinicians: 5. Substitute Decision-Making," *CMAJ* 155 (1996): 1436.

questioned her capacity, her physical refusal of treatment five months later represented to the physician a wish not to have dialysis that was consistent with her earlier wishes. She also recognized that the son's desire to put her back on dialysis was likely based more on his inability to cope with her care at home and his discomfort with watching her linger and suffer. Thus, the physician was justified in paternalistically overriding the wishes of the patient's children in order to protect the patient's ulterior interests.

There is still one problem with the above case as an example of soft paternalism. Although overriding the wishes of a substitute decision maker is technically equivalent to overriding the wishes of the patient, this is not exactly true when the wishes of the substitute decision maker conflict with the known wishes of the patient. In the case of Mrs. Fong the physician is not actually overriding the *patient's* wishes through her children, but is actually overriding her children's wishes because they are not in line with what she believes are the patient's wishes. Thus, it is the substitute decision makers that are the targets of the paternalistic action, not the patient. The problem is that because of the inherent subjectivity of personal values, it would be extremely difficult to imagine a case in which a soft paternalistic action would be justified. The following, however, might be a better example of justified soft paternalism[26]:

> Mike is a 34 year-old man in the early stages of AIDS who comes into the hospital and is diagnosed with *pneumocystis*. In discussing the plan of treatment with Mike and his partner, the attending physician suggests that they think about what steps Mike might want taken if his condition deteriorates significantly. Although he is not able to give detailed instructions,

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[26] This example was also suggested to me by Prof. Karen Wendling.

> Mike does tell the physician that he does not want to be put on any life-support machines. During treatment for the infection, however, Mike has an unexpected allergic reaction to the antibiotic, and starts experiencing respiratory distress. In order to stabilize his condition Mike will require temporary use of a ventilator. Recognizing the need for a decision, and since Mike's partner is not readily available, the physician decides to override Mike's express wishes and put him on a ventilator, believing that Mike's wishes not to have life-support machines were applicable only to irreversible conditions. Since Mike wanted treatment for the *pneumocystis*, and temporary use of the ventilator might allow him to live many more good years, the physician feels that she is justified in overriding his expressed wishes in this situation.

In this case the physician has paternalistically overridden the patient's expressed wishes because, based on what she knows about the patient, she believes that acting contrary to the patient's expressed wishes would actually be more in line with the patient's ulterior interests. Although his wishes are vague and he has not expressed clear reasons for his wishes, Mike's desire not to be put on life-support reflects his ulterior interests (however those specific interests might be characterized). Mike may have expressed the wish not to be put on life-support, but the physician is confident that if Mike had accounted for this type of unforeseen situation he would have opted for the temporary use of the ventilator. Thus, the physician justifiably engages in paternalism to protect the patient's ulterior interests.

Even if a case could not be made for a physician justifiably overriding a patient's wishes or treating him without consent to protect his ulterior interests, physicians are justified in acting *paternalistically* to protect such values. Recall that the distinction between paternalistic actions and acting paternalistically is based on my claim that physicians do not have to override a patient's wishes or lie to a patient to be paternalistic in their interactions with patients. A physician can still act in a paternalistic manner while respecting the patient's autonomy or right to consent. I noted in my discussion of previous models in Chapter 1 that one of the major shortcomings of any model based on unbridled patient autonomy is that such models mistakenly view the patient as a fully independent, rational decision-maker who only needs the facts from the physician to make medical decisions. These models ignore the reality that most patients need more than just facts, and that physicians do have a level of expertise that is vital to making major health care decisions. Even Emanuel and Emanuel's interpretive model fell short in not allowing the physician to take enough of an active role in the decision-making process. As Quill and Brody note, "physicians fail to use their power appropriately when they withhold their guidance."[27] Some patients need more than just facts or value clarification; they need their physicians to give them guidance and direction, whether they explicitly request it or not.

Giving advice or guidance is not in itself paternalistic. Sometimes, however, physicians may need to take it one step further and try to persuade or convince their patients to choose a particular course of action. An obvious example would be an overweight patient with hypertension who would rather not give up smoking and drinking. Such patients are pursuing courses of action that are putting their own welfare interests at risk, and so the physician is justified in advocating on behalf of those interests. The question at hand, however, is whether physicians are justified in this kind of paternalistic behavior to protect their patients' ulterior interests.

The criticisms of full patient autonomy that lend support to physician paternalism to protect the patient's welfare interests also support paternalistic

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[27] Quill and Brody, 764.

behavior on the part of physicians to protect the patient's ulterior interests. The detrimental effect that illness (and institutionalization, for patients in hospitals and nursing homes) can have on a patient's decision-making capacity will affect the patient's ability to make decisions in accord with her ulterior interests as well as her welfare interests. The decisions of patients can be affected by internal influences (such as fear, anxiety, confusion, and extreme emotion, as well as pain and the impact of medication on the patient's cognitive abilities), and external influences (such as pressure or manipulation from family members).[28] All of these factors can impact the patient's ability to make a decision that is consistent with his personal values. When a physician suspects that any of the above influences are affecting the patient's decision in this way she is justified in doing what she can to encourage the patient to make a decision that is more in line with his personal values, while still respecting the patient's autonomy.

One way a physician can do this is by actively trying to persuade the patient that one option is more appropriate for him based on his values. This approach is suitable for situations in which it is clear to the physician that the patient is making a decision that is in conflict with the patient's values as the physician understands them. Consider the following case:

> Susan is a 73-year-old woman who suffers from end-stage chronic obstructive pulmonary disease and has been on Dr. Jones' chronic care ward for the past seven months. Susan has always been a vibrant and social woman who loves visitors, and she gets plenty of them – her children, grandchildren, close friends, and acquaintances from her church. Even other patients on the ward enjoy stopping by her room for visits. On numerous occasions the nursing staff has had to remind her to use her oxygen since she seems to forget about it when

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[28] Edward Etchells, et al., "Bioethics for Clinicians: 4. Voluntariness," *CMAJ* 155 no.8 (1996): 1085.

> she has visitors and ultimately gets short of breath. One day Dr. Jones spoke to Susan about the importance of her oxygen and suggested that maybe she reduce the number of visitors she has so she can get proper rest. "Don't be silly, doctor," she replied. "Spending time with family and friends is all I have to get me through this. If I can't have visitors, or I have a stupid oxygen mask stuck to my face while they are here, then I might as well give up. I'd rather die talking with people I love than live alone in this room." Based on her experiences with Susan, and what she has learned about her from Susan's family, Dr. Jones was not the least bit surprised at Susan's response. Susan's condition continued to deteriorate and two weeks later Dr. Jones decided to speak to Susan about intubation, even though she knew what Susan's response would be. "Absolutely not," Susan said. "If I don't want an oxygen mask stuck on my face I certainly don't want a tube stuck down my throat. I don't want anything interfering with my ability to talk to my family before I die." Now, one week later, Susan seems to have changed her mind. "Doctor," she said to Dr. Jones, "I was talking with my family and they seem to think I should have the intubation. Maybe I should have it. What do you think?"

Based on her relationship with the patient and everything she had learned about her, the physician in this case knew what the patient's reaction would be to the intubation option when she first discussed it with her. The patient was clearly a very social woman who made her ability to communicate and interact with family and friends a very high priority. She even stated that she would rather die sooner while able to communicate than live longer without that ability. All of a sudden the patient seems to be changing her mind based on a discussion she had with her family. When a patient changes his or her mind like this, the physician is certainly justified in at least exploring the change of mind with the patient. In this case, though, more than just exploration may be needed. Although it is possible that the patient has had a genuine change of mind, the values she has expressed and her behavior in the past indicate that intubation would not be in her best interests. The uncertainty with which she is questioning her original decision, and her request for the physician's opinion, seem also to lend support to the possibility that the patient is being pressured by her family into accepting an intervention that would not respect her values. Thus, the physician is justified in countering the pressure from the family by saying something like, "Susan, I'm surprised to hear you say that. Based on our conversations in the past and everything I know about you, I really don't think intubation is the best thing for you. It would eliminate all possibility of verbal communication and you have told me on more than one occasion that communication is the most important thing for you. Of course I will support your wishes, but you need to ask yourself what you really want." Such a response would be paternalistic in nature because it involves pressure on the part of the physician to pursue one course of action over another, but in the end it still respects the patient's autonomy. This would parallel the parent's attempt to talk his eighteen year-old son out of skydiving even though, in the end, it is the son's choice. The important thing, however, is that the physician's bias toward on option is based on what the physician knows to be in the patient's best interests, taking into account both the patient's welfare and ulterior interests.

Treating the other as an individual

In order for soft paternalism to be justified and to be effective in protecting the patient's ulterior interests, it is obviously necessary for the physician to know the patient as an individual. In fact, even for soft paternalism to be *possible* the physician must know the patient as an individual so that he or she can actually know what would be in the patient's ulterior interests. Because western medicine has become very specialized and much health care takes place in the institutional setting where the average patient will be cared for by numerous physicians (including residents and clerks, in a teaching hospital), it can be a challenge for physicians to really know patients in this way. However, I would disagree with Veatch and Spicer that physicians are *never* in a good (or the best) position to know what is in the interests of the patient. In relationships of long-term care, such as chronic care, palliative care, and family medicine, for example, physicians can get to know their patients very well, especially since illness (particularly at the end of life) can cause patients to share intimate and personal details with their physicians that they do not share with others. Moreover, serious illness often causes people to examine their values and wishes for the first time in their lives, and physicians may be party to this examination. Sometimes families are not close with each other and really do not know each other very well. Also, although family members will on the whole want the best for their loved ones, there are situations where family members can be driven by other motives. For instance, an adult child who has been taking care of her elderly mother may want the physician to "do everything" because she depends on her mother's pension money. Or a child who genuinely cares for his elderly mother may want the physician to do everything because he can't stand the thought of losing his mother. In some cases physicians *will* be in a good, perhaps even the best, position to know what is in their patient's best interests.

That physicians in long-term specialties may have the opportunity to get to know their patients because of the length of the relationship does not mean that physicians who *do not* have long-term relationships cannot also get to know their patients as individuals. In order to ensure that patient care is guided by the values of the patient, all physicians must attempt to get to know their patients to the extent that this is possible given the constraints of the relationship. For example, a physician might make it a policy when he meets a patient for the first time to try to learn something about the patient by saying something as simple as, "Tell me a little bit about yourself." Getting to know a patient does not require that the physician sit down with the patient for hours on end, or even that she asks the patient explicit questions like, "What do you value in life?" One can learn an incredible amount about someone in one short conversation if one asks the right questions and picks up on the cues. This can even be accomplished in the context of the intensive care unit, where physician-patient relationships are very short-term and patients are often unconscious. ICU physicians can attempt to learn about their patients by having brief but meaningful conversations with family members, starting with, "Tell me a little bit about your mother." Given the right opportunity and circumstances, most people will not hesitate to open up about themselves or their loved ones.

Of course the less confident physicians are that they know their patients as individuals, the less they would be justified in acting to protect their patient's ulterior interests paternalistically. Palliative care and family physicians, for instance, who tend to have longer-term relationships with their patients and have more opportunity to get to know their patients, may thus be *more* justified than ICU physicians in advocating on behalf of their patient's ulterior interests because they may be more confident that they do know what is in their patients' best interests. But any physician, in principle, *could* be justified in paternalistically advocating on behalf of a patient's ulterior interests.

Physicians can make the same mistakes with their patients in terms of treating the other as an individual that parents make with their children. With respect to the parent's commitment to his children's best interests, I noted that parents can make two mistakes: 1) parents may try to make their children conform to their own conception of what is in their children's best interests (deliberately or unconsciously); and 2) parents may compare their children to other children (or compare their own children to one another) and expect them to fit a certain "mold." Both of these mistakes result in the parent failing to treat the child as an individual – the child is either treated as having the same interests as the parent or the same interests as other children. Physicians can make the same mistakes in the health care context: they can either transfer their own values on to the patient or try to make the patient conform to their own conception of what is valuable, and they can treat the patient as a generic patient who has the same interests as all other patients.

If a physician allows her own values to determine how she takes care of her patient, the result can be a blatant example of unjustified paternalism – the physician would be imposing her own conception of what is in her best interests on her patient. However, this does not mean that the physician is deliberately trying to make the patient conform to her own conception of what is valuable; physicians who do let their values affect their decisions will likely do so unconsciously. For example, a physician may decide that resuscitation is inappropriate for a particular patient because the physician doesn't consider it a benefit to be permanently attached to a ventilator. Or a physician may decide to withhold certain information, or frame the information a certain way, because she thinks surgery in this particular case is the only rational choice. Julian Savulescu, in his defense of physician paternalism, argues that the traditional paternalists went wrong not in forming judgments about what is best for their patients, but by "*compelling* patients to live according to their, the doctor's, evaluations of what is best."[29] Thus, physicians must remind themselves that their patients will have values different from theirs and that being committed to their patients' best interests means maintaining the focus on the values of the patient and not allowing their own personal values to determine the care they provide to their patients.

The other mistake physicians can make is by treating all patients the same, as though every patient has the same interests. This can also result in blatant unjustified paternalism, or what Childress refers to as "hard" paternalism – imposing values "that are alien to the patient, even though they may be commonly accepted by the society or by the so-called 'reasonable person'."[30] For instance, a physician may be inclined to think a patient is incapable because he is refusing an intervention that patients always accept. Thirty years ago it would have been common for physicians to force blood transfusions on Jehovah's Witness patients because no rational patient would refuse a simple life-saving blood transfusion. Other more subtle ways physicians can

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[29] Savulescu, 78.

[30] Childress, *Who Should Decide?*, 18.

treat patients as generic patients is by focusing too much on abstract statistics and survival rates in their discussions with patients, which treats the patient as a category or classification of patient rather than an individual. Elizabeth Latimer, a Canadian family and palliative care physician, argued that in the case of resuscitation discussions, since "numbers from survival curves are not applicable with any degree of accuracy to individual patients and create enormous distress they should not be used."[31] Therefore, just as physicians must remind themselves that their patients will value things differently than they will, they must also remind themselves that patients will value things differently from other patients.

One final word about the commitment to the patient's best interests needs to be said. It is important to stress that physicians do not have an absolute obligation to do what they can to help their patients fulfill their interests. One of the other major problems with physician-patient relationship models based largely on patient autonomy is that they ignore the fact that the physician is a moral agent who should have some freedom to determine what she is willing to do and what she is not willing to do for a patient. Being committed to the best interests of the patient does not necessarily mean the physician must always help the patient fulfill those interests. It is generally accepted in western medical ethics that physicians are not obligated to participate in the health care of patients when doing so would constitute a serious conflict with their personal conscience or the values of their institution: "Health care

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[31] Elizabeth Latimer, "The Decision not to Resuscitate: Talking with Patients and Families," *CMAJ* 140 (1989): 134.

providers should not be expected or required to participate in procedures that are contrary to their professional judgment or personal moral values or mission of their facility or agency."[32] If carrying out the wishes of a patient would constitute a serious conflict with the physician's own values or moral conscience, that physician must not be obligated to participate in that course of action. However, since the patient does have the right to make choices consistent with her own personal values (as long as those choices are not in violation of the law), the physician is obligated to provide the patient with the opportunity to carry out her wishes without the physician's direct involvement. For example, though a Catholic physician can refuse to perform an abortion for a patient, he should refer the patient to another physician who could help her carry out that wish – not to do so would amount to patient abandonment (which will be discussed below). This requirement ensures that patients retain autonomy over their health care while also ensuring that physicians retain their personal and professional integrity.

Identification with the interests of the other

The strength of the emotions that caring parents feel for children, and that romantic partners feel for each other, leads to the identification with the interests of the other in those relationships. Caring parents are so committed to the best interests of their children that the interests of their children actually become part of the interests of the parent. Watching a child or partner fall seriously ill, or experience

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[32] "Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care" [policy], 3. This policy can be found at <www.cma.ca>.

failure, can be just as difficult as experiencing those things for oneself. Should physicians identify with their patients' interests in this way?

Whether physicians should or should not identify with the interests of their patients might be a moot issue because it is unlikely that physicians even *could* identify with the interests of their patients. The identification of interests from parent to child and between romantic partners develops out of the strong emotional bond between the two people in the relationship. This is why friends will not usually identify with one another's interests in the way parents or romantic partners will – the emotional connection is typically not as strong between friends. Thus, although friends will want the best for each other, they will not be as deeply affected by one another's successes and failures. For instance, Kupfer describes how parents take pride in their children while friends, who may be glad for each other and find pleasure in each other's successes, don't really take *pride* in each other's achievements.[33] If friends do not identify with one another's interests to anywhere near the same degree that parents and romantic partners do, because the emotional connection between them is not as strong, it is highly unlikely that a physician would ever *be able* to identify with the interests of her patients.

If identification with the interests of the other is grounded in the emotional connection one feels for the other, the question then is: *If* they could, *should* physicians develop this emotional attachment so that they could identify with their patients' interests? The answer to this question must be 'no', for the consequences of

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[33] Kupfer, "Can Parents and Children," 21.

such an emotional attachment between physician and patient could be disastrous in terms of the care that physicians would be able to provide for their patients. One consequence that may result from an emotional attachment between physician and patient is that physicians may be reluctant to do things that are necessary but may hurt the patient. For example, if a physician were so attached to a patient that he identified with the patient's interests, he may be more reluctant to share bad news with the patient regarding his diagnosis, just as family members often want bad news withheld from their loved ones because they fear the psychological and emotional impact on the person they love. Similarly, the physician may have a harder time withdrawing or withholding treatment when it is indicated for (or requested by) a patient.[34] In other words, if physicians were emotionally attached to their patients (even if not in a romantic way), there might be a significant increase in the risk of unjustified physician paternalism.

A more important reason why physicians should not become emotionally attached to their patients is that it would be too psychologically and emotionally trying for a physician to have such an attachment to all her patients.[35] It would be too difficult for physicians to deal with the suffering and illness of their patients if they were attached to their patients in the way that they are attached to friends and loved ones. Emotional attachments to patients would only exacerbate physician burnout.

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[34] Howard Curzer, "Is Care a Virtue for Health Care Professionals?" *Journal of Medicine and Philosophy* 18 (1993): 56.

[35] Prof. Elisabeth Boetzkes, personal communication, March 17, 2003.

On a more general note, an emotional attachment could negatively affect the physician's ability to be objective when the job requires it.

> Loss of objectivity decreases the accuracy of diagnosis, the correctness of treatment decisions, the success rate of procedures, etc...Emotional ties to patients tend to compromise the objectivity of professionals.[36]

It is for exactly these reasons that it is considered inappropriate for physicians to treat family members.[37] Therefore, the identification with the other's interests that exists in parenthood and romantic partnership is not appropriate for the physician-patient relationship.

I argued above that physicians must make the attempt to find out what their patients' interests are in order to be properly committed to their best interests, but I believe there is a middle ground between knowing what a patient's interests are and identifying with those interests that would help physicians in their commitment to their patients' best interests. A physician can know what a patient's interests are in the abstract without really *knowing* the patient as a person. For example, I could tell a physician that I would rather die than be permanently hooked up to machines, but if the physician doesn't make the attempt to put that statement into context and understand what it means to me, he will not truly be able to understand me as an individual. In a paper well ahead of its time, Herman Blumgart argued for what he called "compassionate detachment," in which the physician "enters into the feelings

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[36] Curzer, 59-60.

[37] For example, the *Code of Ethics* of the Canadian Medical Association instructs physicians to "limit treatment of yourself or members of your immediate family to minor or emergency services and only when another physician is not readily available." <www.cma.ca>.

of one's patient without losing an awareness of one's own separateness."[38] The idea behind this concept of compassionate detachment is to *appreciate* the patient's feelings and desires, as opposed to just knowing what they are in the abstract or fully identifying with them. This concept of appreciation plays an important role in the doctrine of informed consent. For instance, Ontario's Health Care Consent Act states that patients must be "able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."[39] Appreciation is different from understanding in that appreciation "grasps more than just the medical details of the illness, options, risks, and treatment...the patient must appreciate the implications of the medical information for his or her life."[40] To appreciate the patient's feelings and desires means the physician must be able to grasp what they mean to the particular patient, and the implications of decisions for that patient's life. Compassionate detachment is thus a midway point between knowing the patient in the abstract and being emotionally attached to him. Therefore, although it is inappropriate for physicians to *identify* with their patients' interests, they should try to *appreciate* them.

Dependability

One caring feature that ran through all three relationships discussed in the previous chapter was the feature of dependability: the expectation that the other will *continue* to "be there" for us in the future. Parents, friends, or romantic partners who

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[38] Herman L. Blumgart, "Caring for the Patient," *New England Journal of Medicine* 270 no.9 (1964): 451.

[39] *HCCA* (1996), s. 4. (1).

[40] James F. Drane, "The Many Faces of Competency," *Hastings Center Report* (April 1985): 20.

are not dependable send the message that they are not truly committed to our best interests and, thus, do not truly care about us. Hence, dependability is an important feature of caring relationships.

If dependability is an important feature of caring relationships, one would expect it to play a significant role in discussions of the physician-patient relationship. Yet most discussions of the physician-patient relationship, including the models discussed in Chapter 1, focus only on the relationship as it manifests itself in the present context and disregard the importance of continuity in the relationship. Even discussions that focus on professional virtues, such as that of Michael Bayles[41] or Edmund Pellegrino,[42] fail to make mention of dependability or any similar virtue. However, the concept of dependability does appear in some medical ethics codes under the guise of the importance of continuity of care. For example, the Council on Ethical and Judicial Affairs of the American Medical Association defines the fifth right of the patient as

> [T]he right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.[43]

Along similar lines, the CMA's *Code of Ethics* states,

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[41] Michael D. Bayles, *Professional Ethics*, 2nd ed. (Belmont: Wadsworth Publishing Company), 1989.

[42] Edmund D. Pellegrino, "Toward a Virtue-Based Normative Ethics for the Health Professions," *Kennedy Institute of Ethics Journal* 5 no.3 (1995): 253-277.

[43] American Medical Association, Council on Ethical and Judicial Affairs, "Fundamental Elements of the Patient-Physician Relationship," (1994) in *Contemporary Issues in Bioethics*, 5th ed., Tom L. Beauchamp and LeRoy Walters, eds. (Belmont: Wadsworth Publishing Company, 1999), 40-41.

> Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given adequate notice that you intend to terminate the relationship.[44]

Continuity of care is one way of thinking about the feature of dependability in the physician-patient relationship. Patients need to know that as long as they are in the hospital, or as long as they are part of their family physician's practice, for example, their physician will continue to be committed to their best interests. This is why it is important to talk about the physician-patient *relationship* and not just about physician-patient *interactions*. The term 'interaction' indicates that the care a physician offers a patient is an isolated event, where in reality interactions between physicians and patients are often just parts of an ongoing relationship (even if it is a very brief relationship). Even physicians who practice acute-care medicine and may only have one-time interactions with particular patients are still in ongoing relationships with the general patient population. Not only do patients need to feel that they can depend on their physicians, but they also need to be able to depend on the profession as a whole. If patients are not able to depend on their physicians to continue to be committed to their best interests, they will always fear abandonment by their physicians (or by physicians in general).

Timothy Quill and Christine Cassel[45] consider it to be so important that physicians be dependable in the sense of always being there for their patients that they defend nonabandonment as a central obligation of physicians. According to

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[44] Canadian Medical Association, *Code of Ethics*. <www.cma.ca>.

[45] Timothy E. Quill and Christine K. Cassel, "Nonabandonment: A Central Obligation for Physicians," *Annals of Internal Medicine* 122 no.5 (1995): 368-374.

Quill and Cassel, it has become especially important for physicians to remain committed to the care of their patients in modern health care because of the prevalence of chronic illness today. Since people suffer and live with diseases and conditions for much longer periods of time than they did even thirty years ago, patients will tend to have longer-term relationships with physicians today than they used to. The obligation of nonabandonment "acknowledges and reinforces the centrality of an ongoing personal commitment to caring and problem solving between physician and patient."[46]

Depending on the particular relationship between the patient and the physician, the obligation of nonabandonment may require more than simple continuity of care as described in the AMA statement above, which only requires physicians to continue to provide treatment as long as it is medically indicated. For physicians in longer-term specialties, such as family medicine, oncology, or palliative care, nonabandonment may require that the physician continue to be there for their patients even when they are no longer under the physician's direct care or when treatment options have been exhausted. This could involve taking an active role in the patient's comfort care at the end of life, helping the patient explore options for care at the end of life (e.g., treatment withdrawal, sedation, artificial nutrition and hydration, and so on), helping to advocate on behalf of the patient when the patient is under the care of another physician, or taking some time to visit the patient at home if

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[46] Ibid., 368.

the patient is receiving home care. "The promise to face the future together is a central obligation of the physician-patient relationship."[47]

Again, it is important to stress that there are limits to such an obligation. Arguing for physician dependability in the form of an obligation of nonabandonment does not mean the physician must continue to participate in the care of the patient no matter what. When attending to the needs or interests of the patient would require the physician to violate his or her own personal or professional values, the physician is justified in refusing to participate in the fulfillment of those interests or needs. However, nonabandonment does require that the physician make every effort to understand the specific needs of the patient and to work with the patient to find a course of action that would require neither party to sacrifice his or her values, as opposed to simply refusing to acquiesce to the patient's request and withdrawing from the patient's care. If dependability is understood in terms of continuity of care and nonabandonment, then physician dependability is certainly an appropriate and important feature of the physician-patient relationship.

Loyalty

One property of a caring relationship that is particularly prominent in both friendship and romantic partnership is that of loyalty, understood essentially as making one's relationship with another person and the interests of that person a priority over one's relationship with other people. Being loyal to one's friend means considering one's obligations to that friend to be more important than obligations one

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[47] Ibid., 370.

might have to other people (e.g., lesser friends or strangers). It would mean that when the interests of one's friend come into conflict with the interests of another person, one will be more inclined to protect or further the interests of one's friend at the expense of the other person. In the context of romantic partnership loyalty takes on a slightly different connotation but the point is still the same: one considers one's obligations to one's partner as more important than one's obligations to other people. If loyalty is understood as prioritizing one's obligations to the person with whom one has a particular relationship over one's obligations to other people, then I would maintain that physicians should be loyal to their patients.

It should be made clear that in advocating for physician loyalty to their patients I am not arguing that physicians should be more partial to some of their patients over other patients who are also under their care. With respect to all those who are under the care of a physician, the physician should remain impartial and not prioritize the interests of one patient over another. To do so would be to play favourites when all are equally entitled to the physician's care. What I am arguing, however, is that physician loyalty means physicians should prioritize the interests of their patients over the interests of patients who are not theirs (or over future patients who are not yet in need of care). For example, if two patients are competing for one spot on a transplant list, the physicians of both patients should advocate for their own patients to be given priority.[48]

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[48] On the face of it this claim would seem to conflict with another principle accepted as important in medicine, the principle of justice. However, I think the principle of justice in medicine is much more important at the macro level than at the micro level. What I mean by this is that the other principles (beneficence, non-maleficence, and respect for patient autonomy, on the Four-Principles view) should

The prima facie obligation for a physician to be loyal to her patients is derived from her commitment to their best interests. A physician cannot be truly committed to her patients' best interests if she is regularly willing to sacrifice their interests to the interests of others who are not under her care. Being committed to the best interests of patients means not just making their *best interests* a priority but also making *their* best interests a priority. In his discussion of professional ethics, Michael Bayles argues that loyalty is one of the "virtues" of the professional, and that such loyalty can conflict with both the professional's self-interest and the interest of third parties.[49] In order for a physician to remain loyal to his patients, he must be willing to prioritize the interests of his patients over his own interests as well as the interests of patients not under his care.

To maintain that physicians should consider the interests of all those in need of care equally would be to place an undue burden on physicians. In taking care of all patients, present and future, the care of physicians would be spread so thinly that they would end up, in effect, taking care of nobody. The point of allowing physicians to limit the sizes of their practices and of only requiring hospital physicians to be responsible for a limited number of patients is so that they can focus their care and

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take priority over justice in treatment decisions made by physicians in particular cases, as long as those decisions are made within a system that prioritizes the principle of justice. This would allow physicians to be loyal to *their* patients while ensuring that all patients are taken care of. In the transplant list example, it is appropriate for physicians to advocate for their own patients as long as the criteria used to place patients on the list and, ultimately, to select patients from the list is just.

[49] Bayles, 88.

successfully take care of some people. This does not amount to the abandonment of patients because they will be taken care of by other physicians.[50]

The more common cases of the interests of a patient coming into conflict with third parties involve situations where the patient's interests conflict with the interests of those who are not, or not *yet*, patients. Consider the following case:

> Jim is a 57-year-old man who is referred to by the emergency room staff as a "frequent flyer." Five months ago he suffered a severe heart attack after climbing the stairs to his third-floor apartment. Luckily one of his neighbors had heard a commotion and called an ambulance after finding Jim lying in the hallway. Jim is single and has no contact with any relatives. He is slightly mentally challenged but is able to live independently, has a job at a warehouse, and is perfectly capable to make medical decisions. After surviving his heart attack he became extremely paranoid about dying from a second heart attack and didn't want to leave the hospital. The staff assured him that he was well enough to be discharged home and talked with him at length about symptoms and warning signs of heart trouble. He finally calmed after he was told that he could always come back to the hospital if he was worried about his heart. Since his discharge five months ago he has returned to the emergency room seven times concerned about his heart. Every time he demands to be checked out, and every time his workup shows that he is in good health. The staff is frustrated that he takes up their valuable time with false alarms and try to talk to him after each visit, but it fails to accomplish anything. Jim inevitably returns within a few weeks claiming that he is having a heart attack.

In a case like this the conflict is between the interests of the patient and the interest of others who may need care and might not get it because the patient is utilizing valuable resources. The staff must either give the patient priority over the interests of others and "treat" him when he appears, or they must give priority to others who might need the resources and refuse to take care of him. However, turning the patient away in a case like this would be morally inappropriate. As soon as the patient enters the emergency room, he expresses a need for care, which creates an obligation on the part of the staff to take care of him. Even if the patient is not in need of *treatment*, as in the case above, he still needs care in the sense that he is

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[50] As long as the system itself is just so as to ensure that all patients are taken care of.

suffering fear and anxiety surrounding his health. And, of course, it is always a possibility that his symptoms are real and he will be in need of treatment. As soon as Jim enters the emergency room he enters into a relationship with the staff and the physician who will examine him. To turn him away in order to conserve resources would be to prioritize the interests of a hypothetical patient who does not yet need care over a patient who exists and is currently in need of care. To turn him away would also send the message that the staff doesn't care about him. A patient who is "there" and in need of medical attention should always take priority over an unidentifiable patient who *might* need care at some point in the future.

There are, however, limits to a physician's loyalty to her patients. Loyalty does not mean the physician must *always* prioritize the interests of her patients over others, in the same way that loyalty in friendship does not mean one should always prioritize the interests of one's friend over the interests of others. There may be situations, for instance, where one might have obligations to others that are considered to outweigh one's obligations to one's friend. In the context of medicine, the limits on the obligation to maintain patient confidentiality are examples of the limits on a physician's loyalty to his patients. The *Tarasoff*[51] case in the United States established the legal duty on the part of therapists to protect third parties whose well-being is threatened by their clients, and this reasoning has been extrapolated to the context of the physician-patient relationship. In 1997 the College of Physicians

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[51] In *Tarasoff*, a university student killed his ex-girlfriend two months after expressing the desire to kill her in a session with a campus psychologist. The psychologist called the campus police, who detained the patient but released him when he appeared rational and assured the police he would not harm his ex-girlfriend.

and Surgeons of Ontario accepted the recommendations of an expert panel representing provincial and national medical organizations on the issue of a duty to warn. The panel recommended that physicians have a duty to warn the police, and perhaps the target of the threat, if a patient threatens serious harm to a person (or group of people) and it is more likely than not that the threat will be carried out.[52] So while there are reasonable limits to physician loyalty, physicians should in general be loyal to their patients.

Selflessness

Another feature that was discussed in the context of romantic partnership, though it is also especially evident in parenthood, is selflessness: making the interests of the other in the relationship a priority over one's own interests. Selflessness is slightly different from loyalty, in the way I described that concept, in that loyalty involves making the other a priority over third parties. In the case of selflessness, one makes the other a priority over oneself. Mayeroff, in his analysis of caring, used this exact term, 'selflessness': "In caring, the other is primary; the growth of the other is the center of my attention...[t]here is a selflessness in caring."[53] In the context of caring in nursing, Gastmans describes a fundamental characteristic of the caring attitude as, "a shift [that] takes place from interest in one's life situation to the

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[52] Irwin Kleinman, et al., "Bioethics for Clinicians: 8. Confidentiality," *CMAJ* 156 (1997): 523. This limit on confidentiality is another example of a limit on the more general commitment to the patient's best interests.

[53] Mayeroff, 39.

situation of the other, the one in need of care."[54] Yet the selflessness that exists in romantic partnership and parenthood is more than just a shift in focus or attention from oneself to the other; selflessness also speaks to the *motivation* of the caring person, the motivation being to make the interests of the other a priority over one's own interests. This means that when parents care about their children, or romantic partners care about each other, they prioritize the interest of the other for *the other's* benefit, and not out of an egoistic desire to further their own interests.[55]

I noted above that Bayles described the professional's self-interest as a threat to the professional's loyalty to the client, but the physician's self-interest more appropriately falls under my discussion of selflessness rather than loyalty. In the context of the physician-patient relationship it is certainly important that the physician act selflessly. This means that the physician should, all things being equal, place the interests of the patient above her own. The reason I say "all things being equal" is that there are limits to the requirement to act selflessly, just as there are limits to the selflessness that exists in personal relationships. Allowing one's child to go hungry because one would rather gamble at the racetrack than put food on the table is morally blameworthy selfishness; but not buying one's child a new car for her sixteenth birthday because one is saving for renovations to the house is not morally

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[54] Chris Gastmans, "Care as a Moral Attitude in Nursing," *Nursing Ethics* 6 no.3 (1999): 216.

[55] This seems to give rise to an interesting philosophical problem: If I identify with some of my wife's interests so that those interests actually become part of my interests, then making her interests a priority over mine would seem to actually further my own interests in the process. Thus, am I not acting selfishly rather than selflessly? The answer is that what would determine whether my behavior is selfless or selfish is my *motivation.* If my motivation is to further her interests for *my* sake, then my behavior is selfish. But if my motivation is to further her interests for *her* sake, even though my interests might be furthered in the process, then my behavior is selfless.

blameworthy selfishness. In the context of personal relationships selfishness is morally blameworthy when it is displayed too often, or involves sacrificing significant or important interests of the other in favor of less significant interests of one's own.[56] The same standard could be applied to physicians: physicians should, *on the whole*, be selfless toward their patients, and should not be willing to sacrifice significant interests of their patients to achieve less significant interests of their own.

The problem with applying selflessness to the physician-patient relationship is that physicians typically will have a number of different reasons for making decisions in taking care of patients, and for becoming physicians in the first place. Although many people become physicians because they want to help others, there are other factors that come into play: money, prestige, admiration of the public, and so on. It is simply unrealistic to assume that physicians are motivated *only* by the desire to help others. And it may also be the case that a physician is motivated only by those selfish desires. Consider the following example[57]: Joe wanted to become a physician for the prestige and gratitude of the public. He is strongly committed to developing caring relationships with his patients (by cultivating the qualities outlined in this chapter) *because* he wants to gain a reputation among his colleagues and the patient public of being a caring physician. So while Joe is strongly committed to his patients' best

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[56] Where these lines are drawn (e.g., what counts as "too often") will depend on the particular relationship. For instance, parents might be expected to be selfless more often and sacrifice more significant interests for their children than friends are expected to do for each other.

[57] I thank Prof. Wil Waluchow for this example.

interests, for example, his motivation in doing so is self-interested. The question is, should he be considered a caring physician?

On the one hand it shouldn't matter what his motivation is as long as he continues to act in the appropriate way. On the other hand Joe's motivation speaks to his attitude; and if his motivation is selfish then his attitude is also selfish. The problem is that what defines behaviour or actions as selfless depends on the motivation of the actor – one cannot act selflessly for selfish reasons. The same action would be labeled either selfless or selfish depending on whether one's motivation is self-interested or other-interested. It is for this reason that I think the answer to the above questions must be "no" – Joe should not be considered a caring physician if his motivation is selfish. Recall that the proper attitude is what defines caring: one cares about someone when one takes an attitude of concern toward that person. Selflessness is one way of demonstrating that one cares about someone. But if one is selfishly motivated, i.e., if one is acting to further the other's interests in order to further one's own interests, then one's attitude is not really one of concern for the other.

Does this mean that physicians cannot be caring physicians if they are also interested in money, prestige, or admiration of the public? No, because the fact that a physician has these other interests does not necessarily speak to the physician's motivation. The important thing is that when it comes to actually taking care of the patient, the physician's motivation should be selfless, that is, the physician's motivation should be to promote the interests of her patient, and the other interests should only be secondary.

When a physician allows her own interests to motivate her care of her patient, the result is a conflict of interest. Conflicts of interest are problematic because they can interfere with the physician's commitment to the patient's best interests, and thus can degrade the dependability of the physician as well as the trust the patient has in the physician (the feature of trust will be discussed below).[58] Patients cannot be confident that their physicians are committed to their best interests if there is concern that the physician might be motivated by other factors. For example, suppose a representative of "Bob's Discount Eye Clinic", a new clinic offering laser vision correction, approached a prominent local opthalmologist and offered the opthalmologist $500 for every patient the opthalmologist referred to the clinic for laser surgery. Up to this point the physician has been sending his patients to "The Eye Place" for the procedure because they are the best clinic in his professional judgment. Although he has never heard of this new clinic before and is not familiar with the surgeon they have hired to do the procedures, he doesn't know if he can refuse such a lucrative deal. All he has to do is tell his patients that a new and better clinic has opened, and he can make a fair amount of extra money.

If the opthalmologist were to accept the offer, his actions would be morally inappropriate. What should determine his referral policy for laser eye surgery, or for

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[58] Trudo Lemmens and Peter A. Singer, "Bioethics for Clinicians: 17. Conflict of Interest in Research, Education, and Patient Care," *CMAJ* 159 (1998): 961.

any other health matter, is what in his professional judgment would be in the patient's best interests. If The Eye Place is the best clinic offering laser eye surgery, then that is where he should send his patients. In accepting the deal with Bob's Discount Eye Clinic, the opthalmologist would be placing his own financial interests ahead of his patient's best interests. The physician, then, cannot be said to care about his patients. Thus, it is vital that physicians are selfless in their relationships with patients. According to Pellegrino, "effacement of self-interest" is one of the essential virtues of the health care professional,

> since without it the patient can become merely a means to advance the physician's power, prestige, profit, or pleasure...the need for effacement of self-interest is urgent if the patient is to be protected against exploitation.[59]

I mentioned above that physicians should, *on the whole*, be selfless with patients and should not be willing to sacrifice significant interests of their patients to pursue less significant interests of their own. The limits on physician selflessness are important to protect physicians from self-sacrifice and burnout. For instance, if a family physician were to postpone a week's worth of patient appointments to take a much-needed vacation, that would in itself not be morally blameworthy. But if a physician made a *regular habit* of canceling or postponing appointments to golf with friends, that might be morally blameworthy. Another situation in which a physician might be justified in basing a decision on pursuing his own interests would be if the patient's best interests did not support one course of action over another, i.e., if the patient's best interests could be equally served by pursuing either one of two courses

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[59] Pellegrino, "Toward a Virtue-Based Normative Ethics," 269.

of action. Suppose, for example[60], that there are two possible treatment options for a condition and neither one is clearly more advantageous than the other in terms of the patient's best interests – they may have similar risks and side effects, similar success rates, comparable levels of invasiveness, and so on. Suppose further that the physician is the principal investigator in a study to determine the effectiveness of one of the treatment options. In such a case the physician's decision to recommend one treatment option over another may be based entirely on selfish interests, but as long as he is not willing to sacrifice the patient's best interests to pursue his own, he is not acting selfishly; the only reason for deciding based on his own interests is that the patient's best interests do not support one course of action over the other.

Honesty/Sincerity/Openness

I noted in my discussion of friendship that we expect our friends to be honest and sincere with us; that is, we expect that our friends will not deliberately deceive us, and we expect that they will be genuine in their interactions with us. A related concept is that of openness – we expect not only that our friends will be honest and sincere but that they will also be willing to share their thoughts, experiences, and feelings with us. Of course we also expect our romantic partners and our parents to be honest and sincere with us, but dishonesty and insincerity can be particularly damaging to a friendship. And many people are more open with their friends than with anybody else, and are even willing to share personal information with a best friend that they are not willing to share with a romantic partner. The main reason

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[60] I thank Prof. Wil Waluchow for this example.

why honesty, sincerity and openness are so important in caring relationships like friendship is that the extent of their prevalence in the relationship says something about the strength of the bond and the level of respect between the two parties in the relationship. A friend who is dishonest with me shows a lack of respect for me as a friend; and a friend who is not open with me sends the message that he does not consider our friendship strong enough to share personal information, and/or that he does not trust me with that information.

The topic of honesty has received a fair amount of attention within discussions of the physician-patient relationship. It usually arises in the context of debates about issues like truth-telling and disclosure of medical error. However, there are a number of different ways that honesty and the related concepts of sincerity and openness can manifest themselves within the physician-patient relationship. In his discussion of the essential virtues of the health care professional, Pellegrino focuses specifically on *intellectual* honesty: "acknowledging when one does not know something and being humble enough to admit ignorance."[61] If a physician is intellectually dishonest in this way, she is directly deceiving the patient by presenting herself as something she is not and possibly even giving the patient false information. Admitting ignorance can be difficult for a physician because she may worry that the patient will think she is a bad physician for not knowing something. But intellectual honesty is important in the physician-patient relationship for a number of reasons: in providing the patient with possibly false information, a physician violates the patient's autonomy by interfering

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[61] Pellegrino, "Toward a Virtue-Based Normative Ethics," 269.

with the patient's ability to make an informed decision; intellectual dishonesty can lead to an inaccurate diagnosis or prognosis, or a missed diagnosis, which can have harmful consequences for the patient; and intellectual dishonesty can have a disastrous impact on the patient's trust in the physician and the patient's opinion of the dependability of the physician. One medical specialty for which intellectual honesty is particularly important is family medicine because it is vital for family physicians to be able to admit the limits of their medical knowledge and to refer patients to specialists when it is appropriate.

Another example of dishonesty in medicine is the provision of unnecessary tests or procedures.[62] Financial gain is the most obvious reason why a physician would deliberately perform an unnecessary test or procedure, and so it is also an example of a physician being selfish rather than selfless. Providing unnecessary tests or procedures is dishonest because the patient is made to believe that the test or procedure is necessary, and so it amounts to the deliberate deception of the patient. A physician is not committed to the patient's best interests if the physician is willing to convince the patient to undergo tests or procedures that are unnecessary.

The context in which physician honesty is most often discussed is that of truth-telling – whether physicians are ever justified in lying to patients regarding their diagnoses or prognoses. This kind of dishonesty was justified under traditional Hippocratic medicine by reference to the dominant principles of beneficence and non-maleficence. If in the physician's judgment honesty regarding a patient's diagnosis

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[62] Bayles, 81.

or prognosis might result in harm to the patient, then the physician was considered justified in lying to the patient. Now that respect for patient autonomy is considered as important, if not more important, than the other principles, it is generally argued that physicians are rarely if ever justified in lying to a patient because such dishonesty shows blatant disrespect for patient autonomy. As in the case of intellectual dishonesty, a patient cannot make informed decisions about his health care if he is lied to by the physician. Lying to a patient can also have harmful consequences for the patient: she might fail to obtain medical attention or pursue treatment options, and she may make significant life decisions (such as reproductive decisions) that she might not make if she were aware of her condition.[63] And, of course, lying can have a significant impact on the trust the patient has in the physician. In the same way that I would be less likely to trust a friend who lied to me, I would be reluctant to trust a physician who did the same.

Honesty covers not only directly lying to a patient but also withholding information from the patient that is relevant to the patient's decision-making. Disclosure is important for a variety of reasons. Failure to disclose pertinent information can interfere with the patient's right to make autonomous health care decisions just as lying can do so. And, of course, failure to disclose can also have the same potential harmful consequences that lying can have. Another concern is that even when patients are not explicitly given information, they can pick up on non-verbal cues like eye contact and facial expressions, and can learn about their

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[63] Philip C. Hebert, et al., "Bioethics for Clinicians: 7. Truth Telling," *CMAJ* 156 no.2 (1997): 226.

conditions from other sources. Premi reported that one study found that a sample of cancer patients actually knew more about their disease than a sample of cardiac patients, even though the cancer patients were actually told less.[64] It is certainly better for the patient to get information directly from the physician than to be left to pick it up from other sources. Since information is necessary for making informed decisions, disclosure is one of the essential components of informed consent.[65] According to the *Health Care Consent Act* of Ontario, the pertinent information to which patients are entitled includes the nature of the treatment, the expected benefits and risks of the treatment, the material side effects of the treatment, alternative courses of action, and the likely consequences of not having the treatment.[66]

However, the obligation to disclose pertinent information to the patient does not mean the physician is obligated to *force* information on the patient. Although most patients do request full disclosure when it comes to their diagnoses, prognoses, and treatment options, this is not true for all patients. Some patients would rather not know what their diagnosis is, and/or some might not want to know specifics about their prognoses. For instance, a patient may want to be told she has terminal cancer but does not want to know how long the doctor thinks she has to live. A recent study showed that although 97% of patients interviewed would want to be told if they have a life-threatening illness, only 72% stated that they would want to be told all the

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[64] J.N. Premi, "Communicating Bad News to Patients," *Canadian Family Physician* 27 (1981): 838.

[65] Edward Etchells, et al., "Bioethics for Clinicians: 1. Consent," *CMAJ* 155 (1996): 178.

[66] *HCCA* (1996), s. 11 (3).

details. Moreover, the study found a correlation between the amount of information desired and both age and education level -- only 61% of patients over 60 years of age wanted all the details, compared to a range of 73-82% for those under 60; and the higher the education level of the patients, the more details they wished to be told.[67] Other studies have also found a difference in cultural attitudes regarding disclosure. For instance, one study found that Korean-born patients preferred to be given less information than US-born patients.[68]

In the same way that respect for patient autonomy demands disclosure when patients request information, respect for patient autonomy also demands that physicians respect a patient's decision to refuse information. Thus it is important for physicians to find out from the patient what the patient's "policy" is on disclosure. Does the patient want to be told everything? Under what circumstances might the patient *not* want to know certain information? *What* information, if any, would the patient not want to know? Discussing these issues with the patient (which is, itself, a reflection of the physician's openness) will help the physician determine what her approach to disclosure will be with a particular patient. One approach to finding out the patient's disclosure policy might be what Freedman calls "offering truth," in which the patient is offered the opportunity to learn the truth, at whatever level of

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[67] Robert J. Sullivan, et al., "Truth-telling and Patient Diagnoses," *Journal of Medical Ethics* 27 (2001): 192-197.

[68] Hebert, et al., "Truth Telling," 227.

detail the patient desires.[69] An alternative to asking the patient directly what and how much information he or she wants is to start the discussion with the patient in very general or vague terms and become more specific as the patient asks for more information.[70] As Freedman notes a patient's knowledge of his diagnosis and prognosis is not all-or-nothing; it exists along a continuum and patients will fall somewhere between the extremes of theoretical "absolute ignorance" and unattainable "total enlightenment."[71]

A slightly more controversial issue related to disclosure that would fall under the realm of openness is the disclosure of medical error. It is a particularly sensitive topic for physicians for two reasons: First, just as it can be emotionally and psychologically difficult for physicians to admit ignorance on a particular topic, it can be even more difficult for a physician to admit that he has made a mistake – especially when that mistake has or could have harmful consequences for the patient. Second, many physicians are reluctant to disclose medical error out of fear of retaliation, such as professional sanction or lawsuits from the patient or patient's family.[72]

However, there are a number of factors that support a moral obligation to disclose medical error. First, whether patients are harmed or not by the error, the fact

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[69] Benjamin Freedman, "Offering Truth: One Ethical Approach to the Uninformed Cancer Patient," *Archives of Internal Medicine* 153 (1993): 574.

[70] Premi, 840.

[71] Freedman, 574.

[72] Philip C. Hebert, et al., "Bioethics for Clinicians: 23. Disclosure of Medical Error," *CMAJ* 164 no.4 (2001): 511.

that the error occurred falls under the category of information to which the patient is entitled out of respect for the patient's autonomy.[73] In the same way that patients are entitled to disclosure of diagnostic and prognostic information, patients are also entitled to know that the physician made a mistake while taking care of them. Second, disclosure of error is supported by the physician's commitment to the patient's best interests and the selflessness requirement. If physicians refuse to disclose error out of fear of sanctions, they are putting their own interests ahead of their patients' interests. Third, failure to disclose error can have the same harmful consequences for the patient as lying or withholding other information can have with respect to future decisions. If the error has resulted in physical harm to the patient or requires further medical attention, the patient must be made aware of the error so as to make responsible decisions.[74] Fourth, the failure to disclose error can also have the same potentially disastrous impact on the trust the patient has in the physician as dishonesty can have. Finally, studies seem to show that the fear of sanctions is unwarranted, or at least exaggerated. Very few cases of disclosed medical error actually lead to lawsuits, for example, and the ones that do are usually fueled by attempted cover-ups, absence of explanations, and reluctance to apologize on the part of the physicians.[75]

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[73] Ibid., 510.

[74] Ibid.

[75] Ibid., 511.

The arguments outlined above, along with the empirical studies, support a policy of disclosure regarding medical error. Rather than trying to avoid disclosure or cover up the error after it occurs, physicians should be willing to admit the error and discuss the issue with the patient in an open, honest, and sincere manner (the concept of sincerity will be discussed below). Hebert et al. suggest that in disclosing medical error, physicians

> should try not to act defensively or evasively but, rather, to explain what happened in an objective and narrative way, trying to avoid reacting to the charged response that such disclosure can generate. A physician may say "I'm sorry." Patients often appreciate this form of acknowledgment and empathy. [76]

In addition to being honest in the information they convey to patients, understood as both not intentionally deceiving patients and disclosing pertinent information, physicians should also be *open* with patients. Openness is a more general concept than disclosure in that it speaks to a general willingness to communicate. This means that openness requires physicians to be willing to discuss sensitive issues with patients. For example, discussions about end-of-life options, such as resuscitation, tube-feeding, and comfort measures, are often avoided by physicians because many physicians are uncomfortable discussing death and the dying process with their patients. Thus, important decisions are often left unmade, which can create serious conflicts and issues when the patient is no longer able to make decisions. Many clinical ethical issues surrounding end-of-life treatment, substitute decision-making, and family conflicts can likely be avoided if the discussions themselves are not avoided. Encouraging physicians to be open with their

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[76] Ibid., 512.

patients will promote good communication between physicians and their patients and will help to avoid many difficult situations down the road.

In the discussion of medical error, I suggested that physicians should disclose error in an open, honest, and sincere manner. The concept of sincerity is related to the concept of honesty but has a slightly different meaning. While honesty relates to the truthfulness of the information one provides, sincerity relates to how that information is conveyed. A person is sincere if he is genuine in his expression of his feelings; we think he is being insincere if his true feelings do not seem to match his expression of those feelings. In this sense insincerity is a form of deception because it involves a person trying to deceive another into believing that his feelings are something other than what they actually are. For example, a friend can express sympathy toward me regarding the death of a loved one, but if that expression of sympathy appears insincere, I would be insulted and offended rather than comforted.

The problem with sincerity in the context of the physician-patient relationship is that physicians cannot be forced to feel something that they may not feel. Thus, requiring that physicians be sincere with their patients may actually be advocating dishonesty in that they would have to feign sincerity. Because of the impact that insincerity can have on the other person, false sincerity can be a dangerous thing to encourage in physicians. Unless the physician is an excellent actor, false sincerity can have the unfortunate result of offending and insulting the patient.

For this reason it is important that physicians learn to cultivate a sense of empathy, the ability to perceive and understand "the subjective experience of another person."[77] Empathy is what allows us to understand what another person is feeling at a particular point in time. It is different in a subtle but important way from sympathy, which involves feeling sorry for someone. The major difference between empathy and sympathy is that in sympathy one recognizes that someone else is suffering but evaluates it from *one's own* point of view; in empathy, one gains an understanding of the other person's suffering from *that person's* point of view. For example, if my friend's father died and I gave him my condolences thinking to myself, "This must be hard for him, I know it would be hard for me to lose my father," I would be exhibiting *sympathy*. However, if I focused on what losing his father means to him, thinking, "This must be so hard for him, he was so close with his father and he was such an important part of his life," I would be exhibiting *empathy*.

Since the capacity for empathy involves trying to understand the subjective experiences of another person, the more one understands who the other person is and what her interests and values are the more one will be able to empathize with that person. This does not mean, however, that one cannot empathize with strangers. At a very minimum empathy allows one to understand that all people have welfare interests, including an interest in being healthy and free of pain and suffering. Serial killers are able to find pleasure in torturing their victims precisely because they lack the capacity for empathy. They know their victims suffer, since that is what gives them pleasure, but their awareness of the suffering is from a detached perspective –

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[77] Jeanne Levasseur and David R. Vance, "Doctors, Nurses, and Empathy," in *Empathy and the Practice of Medicine*, ed. Howard Spiro, et al. (New Haven: Yale University Press, 1993), 79.

they are simply unable to understand what it must be like for their victims to suffer in that way. Criminal psychology studies have shown that a significant percentage of violent offenders exhibit cruelty and violence toward animals as children, which is considered to be an early demonstration of a lack of empathy.[78]

Thus, at the very least, cultivating the capacity of empathy in physicians means cultivating an awareness of the patient's humanity – remembering that the patient is a person, a human being, and not just a medical case or a vessel for illness or injury. Cultivating this awareness can start in medical school by changing how students are trained. According to Howard Spiro, the problem is that medical students are actually trained to be detached:

> During medical education, we first teach the students science, and then we teach them detachment...The increased emphasis on molecular biology to the exclusion of the humanities encourages students to focus not on patients, but on diseases.[79]

In addition to changing the way medical students are taught medicine, ethics education in medical school and residency programs is another way to help physicians cultivate the capacity for empathy. However, ethics education itself needs to be improved. Ethics education often involves the discussion of cases in a very abstract and simplistic manner, in the attempt to get down to the bare bones of the case (e.g., a conflict between beneficence and respect for autonomy) and to universalize the particular situation. The result is that patients get treated as generic

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[78] John Douglas and Mark Olshaker, *The Anatomy of Motive* (New York: Simon and Schuster, Inc., 1999), 37. Violence toward animals is considered by criminal psychology experts to be one of the "homicidal triad," along with bedwetting beyond an appropriate age and fire starting. The existence of these three behaviors in one child is considered to be a distinct warning sign of a budding violent offender.

[79] Howard M. Spiro, "What is Empathy and Can it be Taught?" in Spiro, et al., *Empathy*, 8-9.

people ("Mrs. F.") and information about their values, family dynamics, and emotional content gets severely limited, if it is discussed at all. Thus, not only should physicians be trained to treat people and not diseases or symptoms, but their ethics training should drive home the point that ethical situations involve real patients, with life histories, family contexts, values and interests, and emotions. This training, combined with the requirement that physicians get to know their patients as individuals (so as to fulfill their commitment to their patients' best interests), will go a long way toward cultivating empathy in physicians, and will thus help physicians be truly sincere in their communication with patients.

Mutual trust

In several places above I have made mention of the importance of the trust patients have in their physicians. For example, one of the factors that supports a policy of physician honesty and openness with patients is that lying to or withholding information from patients can erode the trust patients have in their physicians. The question is, why do patients need to trust their physicians, and what exactly do patients trust their physicians to do?

In answer to the first question, patients need to trust their physicians because of the inherent vulnerability of the patient in the relationship. Recall that one of the major problems with Veatch's collegial and contractual models is that they both assumed a certain degree of equality between physician and patient. The bottom line is that patients are vulnerable in the relationship because the physician both knows more about health and illness and, unlike the patient, has the technical competence that is required in the situation. Thus, patients depend on the knowledge and expertise of their physicians. When we are in need of something, and we do not have the knowledge and competence to achieve it ourselves, we are forced to put our trust in someone else to help us achieve it. We are forced to trust our physicians just as most of us are forced to trust our mechanics when we have car trouble.

Pellegrino and Thomasma specify five elements of trust applicable to physicians: 1) confidence that the person being trusted will be committed to fulfilling what he is trusted to do; 2) an explicit or implicit promise made by the person trusted to respect the interests of the trusting person; 3) the belief that the trusted person needs a certain degree of discretionary latitude to fulfill the trust, and that the trusted person will use this discretionary latitude responsibly; 4) an agreement by both the trusted and trusting person on the first three elements; and 5) faith in the benevolence and good character of the trusted person.[80] These five elements reflect two important features of the trust patients have in their physicians: the attitude the patient takes toward the physician (confidence and faith in the physician) and the responsibilities of the physician that arise from being trusted by someone (respecting the interests of the patient; responsible use of discretionary latitude; and general moral behavior). The trust patients have in their physicians (on an individual or societal scale) can be damaged if physicians either fail to live up to their responsibilities or if their behavior

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[80] Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), 67.

results in patients losing faith and confidence in them. In other words, patients will not trust physicians who are not *trustworthy*.[81] More will be said about this below.

The first condition above states that the patient must have confidence in the physician's commitment to fulfilling what she is trusted to do. But what is it that patients trust their physicians to do? According to Pellegrino and Thomasma, we trust physicians "to serve the healing purpose for which we have given our trust in the first place."[82] This is a somewhat narrow view of the trust between patient and physician because Pellegrino and Thomasma narrowly define the physician-patient relationship as a healing relationship. However, the purpose of a particular physician-patient relationship will depend in part on the particular patient and in part on the medicine being practiced by the physician, and so the trust patients have in different physicians will differ to a large extent. If I required emergency surgery after an automobile accident, the trust I have in the surgeon will be of a very different nature than the trust I would have in a palliative care physician if I were suffering from end-stage terminal cancer. In other words, a patient trusts a physician to fulfill the purpose of that particular physician-patient relationship.

In addition to trusting the physician to achieve the end goal of the relationship (e.g., heal; restore quality of life; provide comfortable death; etc.) the patient will have to trust the physician to do many other things in the pursuit of that end goal. These specific things will fall under the umbrella of the other elements of

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[81] Warren L. Holleman, "Medical Ethics," in *Fundamentals of Clinical Practice*, ed. Mark B. Mengel and Warren L. Holleman (New York: Plenum Publishing Corporation, 1997), 283.

[82] Pellegrino and Thomasma, *The Virtues*, 68.

trust mentioned by Pellegrino and Thomasma, i.e., trust that the physician will use her discretionary latitude responsibly, trust that she will respect the interests of the patient, and faith in the good character of the physician. For example, patients trust that their physicians will not exploit their vulnerability for personal gain.[83] Or, in more general terms, patients trust that their physicians will be motivated by selflessness rather than selfishness. If a physician puts his own interests ahead of his patient's, he violates the patient's trust. Patients also trust that their physicians will be honest and truthful with them and will provide them with the information they request to make health care decisions. When a physician lies or withholds important information, the physician violates that trust.

In the discussion of friendship in Chapter 2, I noted that the trust that exists between friends is grounded in the mutual sharing of personal and intimate information. Since many people share things with their friends that they do not share with anybody else, friends must be able to trust each other that this intimate information will not be shared with others. This trust in one's friends to maintain confidentiality translates directly into the context of the physician-patient relationship. There is perhaps no person with whom we are more willing to share personal and intimate information than our physicians. With a physician,

> We expect to open the most private domains of our bodies, minds, and social and family relationships to her probing gaze. Our vices, foibles, and weaknesses will be exposed to a stranger.[84]

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[83] Ibid.

[84] Ibid.

We share this information with our physicians because it is necessary to achieve the goal of that relationship. Physicians must know our bodies, our personal and family histories, our interests, values, and wishes, and information that we would not want anybody else to know. Patients will only be willing to share this information with their physicians if they can trust that their physicians will maintain their confidentiality and not share this information with others (subject, of course, to the limitations on confidentiality previously discussed).

As Pellegrino and Thomasma note in their third element of trust, part of trusting physicians involves giving them a certain a certain amount of discretionary latitude to achieve the goal that we have trusted them to achieve. That is, to do their jobs correctly, physicians need a certain amount of freedom to use their professional judgment. This is why, for example, physicians are not required to obtain informed consent for every aspect of a patient's plan of care while in hospital. Physicians would not be able to do their jobs effectively if they had to obtain consent for every blood test or administration of medication that is required during the patient's course in hospital. However, trusting the physician means believing that the physician will use this discretionary latitude responsibly, and not run tests (such as HIV tests) or administer treatments that require consent without obtaining consent.

Considering the many ways in which patients must trust physicians, patient distrust in physicians can have disastrous consequences. Not only will individual patients feel betrayed if their physicians lie to them or violate their confidentiality, but those patients will then be more reluctant to trust physicians in the future. If a patient is lied to about risks and side effects of a treatment, for example, the patient may be less likely to follow the physician's recommendation.[85] If a patient's confidentiality is violated, she may be more reluctant to share important information with physicians in the future, which may interfere with her ability to get appropriate medical care. Or, if a patient becomes extremely distrustful of physicians, he may avoid seeking medical attention altogether in the future. If violations of trust occur on a wide scale, the public's confidence in the medical profession could be undermined.[86]

Since the patient's trust in the physician is so important for both individual patients and the patient public, it is important for physicians to do what they can to earn the trust of patients. That is, they have to appear trustworthy to patients. Recall from my discussion of trust in friendship that trust contributes to trustworthiness, and vice-versa. The more physicians are able to maintain their patients' trust, the more trustworthy they will appear to patients; the more trustworthy physicians appear to patients, the more patients will trust them; and the more patients trust physicians, the more opportunity there will be to maintain the trust of patients. Thus, to earn the trust of patients, physicians must appear trustworthy by maintaining patient trust whenever possible. This gives physicians incentive to be honest, open, and sincere with patients, to put their patient's interests ahead of their own, to be loyal to patients, to maintain their patients' confidentiality, and so on. Even in a situation where a physician is obligated to violate confidentiality because of a duty to warn, for

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[85] Holleman, 283.

[86] Hebert, et al., "Truth Telling," 226.

instance, the physician can still maintain the patient's trust by discussing the issue with the patient, informing the patient that she is obligated to warn the third party in this case, and by giving the patient the opportunity to warn the third party himself.

The above considerations focus on the trust patients have in physicians and what physicians can to do earn that trust, but the caring feature I am applying in this section is *mutual* trust. So, is the trust in the physician-patient relationship only one-way, or is it important for the physician to also trust the patient? I maintain that the physician should also trust the patient and, thus, that mutual trust is important in the physician-patient relationship.

One of the concerns with patient trust in physicians is that if physicians lie to patients or withhold information from them, they fail to respect the patient's autonomy. If patients are not able to make responsible, autonomous health care decisions, they will not be able to get appropriate health care. Along the same lines, if patients lie to physicians or withhold information about symptoms or medical history, the physician will not be able to give the patient the care she really needs. However, this does not necessarily establish that physicians should *trust* patients – it only establishes that patients should be open and honest with physicians. Recall that the trust patients have in their physicians is grounded in the inequality in knowledge and expertise between physician and patient and the vulnerability of the patient. Because the patient is dependent on the physician, she is forced to trust the physician. But if the physician is the dominant party in the relationship, on what grounds does the physician need to trust the patient?

Although the physician is the dominant party in the relationship, he is dependent on the patient with respect to certain things. The physician's knowledge and technical competence are only one-half of what is required to provide health care to patients; the other half is what the patient brings to the relationship: her values, interests, subjective experiences of symptoms, family relationships, and medical history. The only way the physician can get access to this information is for the patient to provide it, and so the physician is dependent on the patient for that important information. As Jay Katz states, the inequality in the relationship runs both ways: "Physicians know more about disease. Patients know more about their own needs."[87] If physicians are not willing to trust patients with respect to the information they bring to the relationship, the physician may be inclined to question the truth or accuracy of the patient's information, such as discounting the patient's subjective experiences of symptoms. This can lead physicians to dismiss symptoms as trivial or unworthy of further attention, which can have a detrimental effect on the patient's care.[88] Moreover, if the patient becomes aware of the physician's unwillingness or reluctance to trust the patient's information, the patient may then be less open with the physician. Therefore, physicians not only need to trust their patients to be open, honest, and sincere in the information they provide to physicians, but they also must appear willing to trust the patient, so that the patient can get appropriate health care consistent with his best interests.

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[87] Jay Katz, *The Silent World of Doctor and Patient* (New York: The Free Press, 1984), 102.

[88] W.A. Rogers, "Is there a Moral Duty for Doctors to Trust Patients?" *Journal of Medical Ethics* 28 (2002), 78.

In addition to trusting the patient to be open, honest and sincere in the information she provides to the physician, the physician also needs to trust both the patient's competence and willingness to cooperate with any proposed treatment regimen. These are two more areas in which the physician is dependent on the patient. The care given by the physician depends on the patient's ability to understand and manipulate the information given to her and also on the patient's cooperation. A physician can mitigate her dependence on the patient's competence by tailoring her delivery of information to the particular patient: using non-technical language, particularly with less educated patients; speaking slowly and using translators in cases of a language barrier; encouraging the patient to discuss issues with family; and so on. However, these methods will only help to a certain extent – eventually the physician just has to trust that the patient understands the information. Without some degree of trust in the patient's competence, the physician may end up patronizing and insulting the patient. Moreover, a lack of trust in the patient's competence could lead to the physician withholding information[89] or framing the information in such a way that the patient is not presented with the whole picture.[90] Again, this fails to respect the patient's autonomy and can interfere with the patient's care.

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[89] Ibid.

[90] Framing information involves emphasizing either the positive or negative aspects of something, such as a proposed treatment or intervention. For example, in describing a risky surgery to a patient, a physician could present it as "carrying with it a 25% chance that you will die on the operating table," or as "offering a 75% chance of saving your life." Studies show that how information is framed has a significant impact on the decisions people make, which is called the "framing effect."

The fifth of Pellegrino and Thomasma's elements of trust also plays a role in the physician's trust in the patient: an act of faith in the benevolence and good character of the one trusted. The patient's trust that the physician will not exploit her vulnerability falls under this fifth element. But the physician also must have faith in the benevolence and good character of the patient -- the physician must have faith that the patient is seeking care for the right reasons, such as to seek treatment for an illness or condition, the amelioration of symptoms, or a desire to understand and improve his health. The physician must have faith that the patient's motives in seeking care are not fraudulent, as in the case of a patient who feigns symptoms to get worker's compensation benefits, to scam an insurance company, or simply to get prescription medication.

The main factor that supports the importance of the physician's trust in the patient is that, as with the patient's trust in the physician, distrust can have a negative impact on the patient's ability to get appropriate health care. However, Rogers makes an interesting case for another factor that supports the importance of the physician's trust in the patient: trust in the patient will actually help foster and enhance the patient's autonomy. Since trust contributes to openness and honesty in the information offered by both the physician and the patient, trust contributes to enhanced communication and dialogue between physician and patient. In a trusting climate patients will be more inclined to share their feelings and values, and physicians will be more inclined to bring their values and biases out into the open.

The patient will also gain confidence and moral support from the physician's trust in him, which can help the patient make significant health care decisions.

> Some degree of trust is necessary to create a climate in which honest communication may flourish. Trust allows patients to express their concerns without fear of being disbelieved or disparaged. Over time, the presence of trust facilitates the development of deeper doctor-patient relationships...[91]

Equality in autonomy and authority

One of the most significant differences between the care in friendship and parenthood is the status of the autonomy and authority of the parties involved. Equality in autonomy and authority is not a feature of caring parenthood because parents and children *cannot* be equal in this way. But in the case of friendship, authors like Kupfer and Thomas argue that equality in autonomy and authority is actually a necessary condition for friendship. With respect to this feature, the physician-patient relationship has more in common with parenthood than with friendship. In the real world physicians and patients are not equal in autonomy and authority; but unlike in parenthood, physicians can take steps to mitigate this inequality.

Recall from my discussion of Veatch's collegial model in Chapter 2 that the main problem with that model is that it rests on an unrealistic view of the physician and patient as colleagues – as two people with equal authority and standing who come together to achieve a common goal. Since the typical patient has no choice but to depend on the knowledge and skill of the physician, the typical patient is vulnerable to intimidation and coercion in the relationship. Even the most educated and

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[91] Rogers, 78.

informed patients (such as patients who are themselves physicians) will still depend to a large extent on the knowledge and expertise of the physician, and so the physician will typically be in a position of power in the relationship. Just as children are not equal in autonomy and authority with their parents, because of their dependence on their parents, the patient is also not equal in autonomy and authority with the physician.[92]

That physicians and patients are not equal in autonomy and authority invites the question, *should* physicians try to bring the patient up to a more equal level of authority and autonomy? In other words, should physicians try to counteract the inequality in authority and autonomy by encouraging the patient to be more autonomous and authoritative? As I have argued previously, patient empowerment is an important goal of the physician-patient relationship, just as an important goal of parenting is to raise one's child into an autonomous adult. Illness and/or institutionalization can seriously diminish a patient's autonomy, so it is important for the physician to try to restore the patient's diminished autonomy.

Physicians can help empower patients in many ways, including cultivating some of the caring properties discussed in this chapter. Physicians empower patients by being open and honest with them, by fostering a climate of mutual trust, and by

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[92] One might wonder whether this is really the case, particularly since the patient's values are recognized as an integral part of the decision-making process and there is such a strong focus currently in western medicine on respecting patient autonomy. Physicians may have the leg up in terms of medical knowledge, but the patient brings her values to the process and has the final authority to make the decision. In response I would agree with the point that *ideally* physicians and patients could be equal in autonomy and authority, and *ideally* patients might even have more authority than the physician. But this is the ideal situation – in the real world patients are intimidated by physicians, and physicians unfortunately do fail to respect the wishes of their patients.

providing patients with resources they need to make autonomous decisions (such as more time to think and/or the opportunity to discuss decisions with family). Such approaches will help restore the patient's diminished autonomy, and will also help boost the autonomy of patients in general. Empowering the patient in this way will also help overcome the inequality in knowledge that is inherent in the relationship and that contributes to patients feeling intimidated and vulnerable.

In the same way that disclosure does not imply forcing information on the patient, empowering the patient also means that a patient's wish to remain uninformed or passive in the decision-making process should be respected. Though many patients do want to be as informed and active in the decision-making process as possible, this is not what all patients want from their relationships with their physicians. In the words of Shinebourne and Bush, some patients "just want to be made better."[93] As I noted in the discussion of disclosure and truth-telling, some patients don't want all the details of their diagnosis. Other studies have shown that the extent to which patients want to participate in their medical decisions depends on many factors. For instance, a 1988 study of hospitalized cancer patients in the United States found that 31% of patients interviewed *did not* want to participate in decisions regarding their treatment, and, as with the disclosure study cited above, there was an inverse correlation between age and desire to participate.[94] A 1995 study of

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[93] Shinebourne and Bush, 402.

[94] Christina G. Blanchard, et al.. "Information and Decision-Making Preferences of Hospitalized Adult Cancer Patients," *Social Science Medicine* 27 no.11 (1988): 1141-42.

Winnipeg men with prostate cancer found that the majority (58%) of the patients interviewed actually preferred a *passive* role in treatment decision-making.[95] Respecting the autonomy of these patients means respecting their desire for less information and for a less active role in decision-making. Attempting to bring the patient up to the physician's level of autonomy and authority does not mean forcing the patient to make informed decision; what it means is empowering the patient to control his or her role in the decision-making process, which includes autonomously deciding to remain uninformed or passive in the decision-making process. Therefore, an important feature of a caring physician-patient relationship is that physicians try to equalize the autonomy and authority in the relationship by empowering patients.

Treating the other with equal respect as a person

The final caring feature to apply to the physician-patient relationship is that of treating the other with equal respect as a person. I originally discussed this feature in the context of romantic partnership because I think treating one's partner with disrespect can have an especially destructive impact on the quality of the relationship. Partners who fail to treat each other with respect may denigrate each other, speak badly to or about each other, and possibly physically abuse each other. But what exactly does it meant to treat someone with respect?

Notice that I am talking about *treating someone with respect* as opposed to *having respect for someone.* Having respect for someone refers to a feeling of

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[95] B. Joyce Davison, et al., "Information and Decision-Making Preferences of Men with Prostate Cancer," *Oncology Nursing Forum* 22 no.9 (1995): 1405.

admiration we have for that person, or for certain qualities of that person. For example, we may have respect for people who devote their lives to helping others, or for a professional baseball player's ability to hit a 100-mile-per-hour fastball, or we may simply have respect for someone's intelligence or creativity. But having respect for someone is not necessarily a feature of a caring relationship; it makes perfect sense for me to say that I care about someone even though I don't have respect for him, or for certain things about him. Treating someone with respect is quite different. It is not connected in any way to a feeling of admiration for someone, and so we can still treat someone with respect even if we don't have respect for him.

Treating someone with respect is based on the recognition that all people deserve a certain basic level of decent treatment simply by virtue of being human. I use the term 'human' rather than 'persons' because the notion of treating someone with respect goes beyond just the category of *moral* persons. Treating moral persons with respect typically gets reduced to the idea of respecting the autonomy of others, which excludes categories of people who still deserve to be treated with respect (e.g., children, incapable patients, the mentally challenged, etc.). That all people deserve a basic level of decent treatment implies that we have a responsibility to treat all people a certain way *because* they are people. This is exactly the reasoning behind international laws against torture, for example. The idea is that no matter what a person has done, what crimes a person has committed, or what a person might know, torturing that person would violate the basic decent treatment owed to him simply by virtue of being human.

The notion of treating others with respect that I am defending here goes beyond just respecting a person's basic human rights, such as the right not to be subjected to cruel and unusual punishment. Treating others with respect means that people also deserve to be treated with kindness and consideration. Treating others with respect may also include such things as respecting someone's privacy or personal space. The sorts of behaviors or qualities I have in mind when I think of what it means to treat someone with respect are those that I would argue are important for basic human decency when it comes to our interactions with others. On this view it makes perfect sense to talk about a parent treating a child or even an infant with respect. It means recognizing and remembering that the child is a person (in the broader moral sense), with interests, desires, and feelings, and not a thing or an object. Understanding the notion of treating others with respect in this way also clarifies why it is an important feature of caring relationships. Though it makes sense to say that I care about a person even though I don't *have* respect for him, failing to *treat* him with respect would seem to be evidence that I don't care about him.

This understanding of treating others with respect also helps clarify why it is an important feature for the physician-patient relationship. It relates back to the idea of treating patients as people and not just as vessels for disease or collections of symptoms. Treating the patient with respect means treating the patient as a human being: recognizing that the patient is a person, with interests, desires, and feelings, and not an object; treating the patient with kindness and consideration; respecting the patient's privacy and personal space; and whatever else might be considered part of decent human interaction. Failing to treat the patient with respect in this way violates the dignity of the patient by treating her as less than human.

Coulehan's notion of "positive regard" is an example of how a physician might treat a patient with respect. Positive regard means suspending judgment about the patient and setting aside any negative feelings toward the patient (if the physician feels any), and focusing on caring for the patient.[96] The patient may have a horrible attitude, or terrible personal hygiene, or may need care as a result of stupid or risky behavior. But when the physician-patient relationship is initiated, none of that should matter; the patient is simply a human being who is in need of care.

In his discussion of therapeutic relationships, Carl Rogers offers a view that fits nicely with my notion of treating the patient with respect. He outlines a number of questions that therapists can ask themselves to learn how to become better therapists. One of those questions is, "Can I let myself experience positive attitudes toward this other person – attitudes of warmth, caring, liking, interest, respect?"[97] Of course it cannot be expected that physicians should actually *like* their patients, but the point is that making the patient *feel* liked and respected will go a long way toward cultivating a positive physician-patient relationship.[98] Treating the patient with

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[96] John L. Coulehan, "Being a Physician," in Mengel and Holleman, *Fundamentals*, 79.

[97] Carl R. Rogers, *On Becoming a Person: A Therapist's View of Psychotherapy* (Boston: Houghton Mifflin Company, 1961), 52.

[98] This point does seem inconsistent with my discussion of sincerity earlier – making patients feel liked and respected when the physician does not actually like or respect the patient is insincere and, thus, deceitful. Cultivating a sense of empathy will help in this regard. But does this mean that if a physician does not like or respect a patient, she should rather be sincere and treat the patient according to the way she feels than be insincere and treat the patient *as though* she likes and respects him? Considering the two possibilities I think an argument could be made that this might be one kind of

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respect will help foster an atmosphere of trust, will contribute to openness and honesty between physician and patient, and will generally improve the quality of care experienced by the patient.

A Care-Based Model of the Physician-Patient Relationship

The goal of this chapter was to apply the set of caring properties developed from the analysis of 'care' in the previous chapter to the physician-patient relationship. Though some of the properties were found to be inappropriate for the physician-patient relationship, such as identification with the interests of the other, most of them were found to be important components of a caring physician-patient relationship. The fact that some of them were not appropriate does not work against my approach in this dissertation. The point of the Wittgenstinian approach to conceptual analysis is that there will be a set of caring properties that all apply to caring relationships, but in different combinations. Just as some of the properties were not appropriate or important components of all three relationships discussed in Chapter 2, some of them were also found to be inappropriate for the physician-patient relationship.

In the end, then, I concluded that there are nine general caring properties that come together to establish what a care-based model of the physician-patient relationship would look like. They are all important components of a caring physician-patient relationship and so are not discussed in order of importance. First,

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deception that is justified. On balance I would say it is better to pretend to like and respect a patient and risk being called on it, than to simply treat the patient poorly to begin with. Most patients would probably rather be treated kindly and respectfully, even if it is insincere, than to be treated the opposite way.

physicians should be committed to the best interests of their patients, which incorporates both the patient's welfare and ulterior interests. This means that physicians need to be concerned with not only the health and physical well-being of their patients but also with the more subjectively-oriented (health-related) interests of their patients. Being committed to those interests also means that physician paternalism can sometimes be justified, though in limited cases. The extent to which, or in what situations, physician paternalism would be justified depends in part on how certain the physician is that he or she knows what is in the patient's best interests. Since ulterior interests are subjective, physicians are rarely justified in paternalistically overriding a patient's wishes or consent to protect those interests. Nevertheless, physicians can be justified in acting in a paternalistic manner to protect a patient's ulterior interests, provided the physician is confident that she knows what those interests are. Thus, whether and when physician paternalism is justified depends to a large extent on the particular relationship between the physician and patient, and how well the physician knows the patient.

This connects directly to the second feature of a care-based model of the physician-patient relationship. Since the physician's commitment to the patient's best interests depends on the physician's knowledge of the patient, it is obviously important for physicians to try to get to know their patients as individuals. The extent to which physicians can, or even should, get to know their patients will depend once again on the particular relationship between the physician and patient – long-term care physicians will obviously have more opportunity to get to know their patients than ICU physicians. However, all physicians who have relationships of any sort with patients should make an attempt to get to know their patients as much as possible, even if it means learning about the patient through the patient's family. An important part of knowing the patient as an individual is to avoid two common means of reducing the patient's individuality: transferring the physician's own interests on to the patient, and treating patients as belonging to the generic group "patient" by denying difference between patients.

One of the features that was found to be inappropriate for the physician-patient relationship was that of identification with the other's interests. However, I did argue that there is a middle ground between just knowing what a patient's interests are and actually identifying with those interests that is appropriate for the physician-patient relationship. That middle ground is to understand and *appreciate* the patient's interests. A physician can know what a patient's interests are in the abstract, but understanding or appreciating those interests involves some awareness of what the interests actually *mean* to the patient. Appreciating the patient's interests will help the physician determine how important the particular values and interests are to the patient and, thus, will help the physician judge how strongly he should advocate for those interests.

The fourth feature of a caring physician-patient relationship is dependability, which speaks to the importance of the physician's *continued* commitment to the patient's best interests. Caring about a patient means a physician needs to make the patient feel as though he can depend on the physician to always be there, that he will remain committed to his best interests as long as he is in need of care. Thus, it was argued that continuity of care and nonabandonment are important ingredients in the feature of dependability. Even in cases where physicians do not have continued relationships with particular patients, those physicians can still exhibit dependability by ensuring that they are continually committed to the best interests of patients in general.

The fifth and sixth features were the related concepts of loyalty and selflessness, which also connect to the feature of dependability and trust. The feature of loyalty speaks to the physician's prima facie obligation to make her patients' interests a priority over the interests of patients who are not her own, or patients who are not yet in need of care. Refusing to take care of a patient, such as the "frequent flyer," amounts to a form of patient abandonment. Other things being equal, patients who are under the care of a physician should be a priority over hypothetical patients who are not yet in need of care. The related feature of selflessness speaks to the physician's prima facie obligation to make the interests of the patient a priority over her own interests. This does not mean that it is inappropriate for physicians to have secondary interests, such as prestige or financial success. However, when it comes to taking care of patients, those secondary interests must remain *secondary*; physicians are not committed to the best interests of their patients if they are willing to put their own interests *ahead* of their patients' interests.

The seventh feature was openness/honesty/sincerity, which could have been treated as separate features in the way that loyalty and selflessness were. I chose to treat them as one feature, however, because taken together they form what might be considered the cornerstone of good physician-patient communication. Cultivating a policy of openness and honesty with patients will significantly improve communication between physician and patient, by encouraging open and truthful dialogue and discouraging such things as lying to patients, withholding information from patients, and reluctance to discuss sensitive issues. Sincerity is a more difficult feature because it is not easy to fake sincerity; and insincerity can have a detrimental impact on the physician-patient relationship. To be sincere physicians should try to cultivate a sense of empathy so that they can more genuinely appreciate their patients' feelings and communicate more sincerely with them. I do think, however, that insincerity may be a kind of justified deception in the physician-patient relationship.

The eighth feature of a caring physician-patient relationship is mutual trust – physicians should be both willing to trust patients and be trustworthy. Since the physician and patient both need to trust each other to a certain extent, it is important for the physician to cultivate a trusting climate in her relationship with her patients. A climate of trust will have a positive impact on the quality of the physician-patient relationship, by facilitating open and honest communication and generally improving the care of the patient. Distrust, on the other hand, can have a damaging effect on the physician-patient relationship, both on an individual and societal level.

Finally, it is important for the physician to treat the patient with the respect that is due to him as a person. This means treating the patient with basic human decency: recognizing the patient is a person, being considerate and kind to patients, being respectful of the patient's feelings, positively regarding them, and so on. The fact that patients deserve this respect by virtue of being people is enough reason for physicians to treat them with such respect; but it can also go a long way toward improving physician-patient communication, fostering a climate of trust, and improving the patient's care overall.

Limits on a Caring Physician-Patient Relationship

Before concluding it is necessary to briefly discuss one final issue. I noted at the beginning of this chapter that some of the caring properties might not be appropriate for the physician-patient relationship, and the properties that are appropriate will likely manifest themselves differently in that relationship as compared to the paradigm caring relationships discussed in Chapter 2. This is because the significant difference between the physician-patient relationship and the paradigm caring relationships is that the former is a professional relationship, while the latter might be referred to as personal relationships. With certain exceptions, particularly in the case of parenthood, the personal relationships are not governed by rules, regulations, and codes of conduct in the way that professional relationships are. This means that there will be limits imposed on professional relationships that cannot be accounted for within a model of that relationship. In other words, although my argument in this dissertation is that physicians should care about their patients by cultivating the caring properties discussed in this chapter, there will be certain externally imposed limits on the care that is actually appropriate in that relationship.

The most obvious limit on care in the physician-patient relationship is that imposed by the law. The legal duty to inform, as established in the U.S. *Tarasoff* case, is one example of this limit I already touched upon. Since physicians can be held legally liable for not taking reasonable steps to warn a third party of a harm threatened by their patient, or for not reporting suspected child abuse, the law may actually limit the care that is appropriate between a particular physician and patient. The laws that exist in Canada and most U.S. states prohibiting such practices as active euthanasia or physician-assisted suicide are another example of such a legal limit. These laws are a good example of limits imposed on care because a good argument can be made that active euthanasia and physician-assisted suicide can actually be justified by reference to a caring model of the physician-patient relationship. If that argument can be made, then the law is actually prohibiting physicians from demonstrating that they care about their patients in certain ways. Nevertheless, in pointing out that the law acts as an external limit on care in the physician-patient relationship, I am not saying that physicians should only care about their patients provided their behaviour is not prohibited by law. Not all laws are morally good laws – and we need activists who are willing to take a stand against the law to bring about change. When a physician is faced with the possibility that caring about a patient may require violating the law (as in the case of physician-assisted suicide), that physician must decide for him or herself what is the right course of action.

Another external limit on professional relationships in general is that imposed by the governing body of the profession through codes of conduct. One thing most professions have in common is a governing organization that licenses members of the profession, and expects its members to guide their practices by a code of conduct. Ontario physicians are granted their medical licenses by the College of Physicians and Surgeons of Ontario, which has the authority to suspend or revoke the licenses of physicians who are found guilty by the College of professional misconduct or incompetence.[99] Although there is significant overlap between the conduct prohibited by the College and that prohibited by federal or provincial law, physicians can have their licenses revoked or suspended for behaviour that is not in violation of the law. Thus, physicians can find themselves in a situation where caring about a patient may involve doing something frowned upon by their regulating organization.

A third type of limit on care in the physician-patient relationship is that associated with the integrity or autonomy of the professional. Although much has been written on the topic of patient autonomy, the issue of physician autonomy has been largely neglected in the literature. The question is, aside from the limits imposed by the law and by the profession's regulating body, when (if ever) are physicians justified in saying no to patients? Does caring about a patient mean the physician is obligated to acquiesce to the patient's demands, provided they do not conflict with the law or regulations of the profession? This is a separate issue from that of paternalism, in which the physician is refusing a patient's request out of concern for the patient's best interests. The question here is whether physicians are

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[99] <www.cpcso.on.ca/About_the_College/geninfo.htm>.

justified in refusing patient's requests (or requests of the patient's substitute decision maker) because there are certain things that physicians should not have to do.

Working through the issue of professional autonomy is a dissertation in itself, so I can only offer some initial observations here. Though I admit I have yet to work out where the line should be drawn, I do believe there must be some point at which physicians are justified in saying no to patients for reasons other than legal or professional restrictions, or because it is in the patient's best interests. In Chapter 1 I argued that one of the problems with any model based on unbridled patient autonomy, such as Veatch's engineering or Emanuel and Emanuel's informative models, is that they ignore the fact that the physician also has values that have a role to play in the relationship. "Because the physician is a necessary element in the dyad, his or her moral and medical values obviously are not extraneous factors in clinical decision making."[100] This is why I argued earlier in this chapter that physicians should not be obligated to participate in interventions that would constitute a serious violation of their personal morals. However, it is important to note that physicians bring more than just their personal values to the relationship; they also bring the values that are associated with being a physician.

An example of a value associated with being a physician, some argue, is that physicians should not subject patients to treatments or interventions that are excessively burdensome or for which the potential harms significantly outweigh the

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[100] Allan S. Brett and Laurence B. McCullough, "When Patients Request Specific Interventions: Defining the Limits of the Physician's Obligation," *New England Journal of Medicine* 315 no.21 (1986): 1349.

potential benefits. It is generally accepted that physicians are not obligated to offer treatments or interventions that are clinically *ineffective* (e.g., antibiotics to treat a common cold), but whether physicians are obligated to offer interventions that are clinically effective but support a controversial end is more contentious because such decisions will involve value disagreements.[101] While respect for the patient's autonomy might require physicians to acquiesce to the demands of patients or their families in many (and perhaps most) of these cases, many argue that the principles of beneficence and non-maleficence act as boundaries on the principle of respect for patient autonomy. On this view, physicians are obligated to acquiesce to patient demands up to the point at which the intervention or treatment would impose an excessive burden or significant harms on the patient. For instance, Rosamond Rhodes argues that physicians are justified in saying no to patients when their requests are at odds with the goals of medicine (which would include doing significant harm for little or no benefit).[102] Although there is no consensus yet on where the line should be drawn, I think physician autonomy does act as a legitimate limit on care in the physician-patient relationship.

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[101] Charles Weijer, et al., "Bioethics for Clinicians: 16. Dealing with Demands for Inappropriate Treatment," *CMAJ* 159 no.7 (1998): 818.

[102] Rosamond Rhodes, "Futility and the Goals of Medicine," *The Journal of Clinical Ethics* 9 no.2 (1998), 194-205.

Conclusion

In writing this dissertation I am, in a way, hoping to revive an approach to physician-patient ethics that has been somewhat neglected in the literature on health care ethics: the "models approach". Since Szasz and Hollender's article in the 1950's, only a handful of serious attempts have been made to develop a model of the physician-patient relationship; and the last serious attempt was made by Emanuel and Emanuel ten years ago. As I argued at the beginning of Chapter 1, the models approach is the most promising approach to physician-patient ethics because it focuses on developing in physicians the internal motivation to act morally with their patients. The literature in health care ethics (specifically, clinical ethics) focuses individually on issues like truth-telling, disclosure of medical error, dealing with demands for inappropriate treatment, effective physician-patient communication, and so on. The advantage of the models approach is that the right model of the physician-patient relationship should be able to provide physicians with guidance on all of these issues.

Unfortunately, the models that have been offered in the literature over the past forty years are unable to provide this kind of wide-reaching guidance. The main reason is that most of the models have focused on only one aspect of the physician-patient relationship: the balance between patient autonomy and physician paternalism. Thus, in effect, these models are not so much models of the physician-patient relationship as they are models of physician-patient decision-making; but isolated decisions are only one part of the relationship. Moreover, the focus on the autonomy-paternalism balance (which is a consequence of the glorification of the principle of respect for patient autonomy in the latter part of the twentieth century) has resulted in the physician-patient relationship being characterized as adversarial, which is counterproductive. The focus of a physician-patient relationship model should not be on how much authority either party should have in the relationship; rather, the focus should be on how physicians can cultivate the kind of relationship with their patients that is best able to achieve the health-related goal most appropriate to that particular relationship, while ensuring that the values and interests of the patient and the personal and professional integrity of the physician are respected.

The care-based model of the physician-patient relationship that I have articulated in this dissertation is a significant improvement over the previous models in achieving the above goal. One advantage it has over many of the previous models is that it has a starting point that is more basic and fundamental than the starting points of those other models. Rather than starting with the question, "How should patient autonomy and physician paternalism be balanced in the physician-patient relationship," the starting point for my model is the simple question, "How should physicians relate to their patients?" Approaching the issue in this way not only allows the relationship to start from a less adversarial and more productive position, but it opens the door to dealing with many other issues from a relational starting point rather than dealing with them on an individual basis. In other words, the physician who develops a caring relationship with his or her patients will know how to deal with issues like truth-telling, confidentiality, and paternalism.

A second advantage of my model over previous models is that it incorporates important aspects of the physician-patient relationship that have typically been neglected by other models. For instance, none of the models discussed in Chapter 1 gave much attention to topics like communication and trust, both of which are integral to a good physician-patient relationship. A further advantage of my model is that it is applicable to a wide variety of physician-patient relationships, unlike, for example, Emanuel and Emanuel's deliberative model, which the authors were forced to admit is only appropriate for certain types of physician-patient relationships. In the way I articulated my model, the caring features can manifest themselves and be exhibited differently in different contexts. Thus, any physician who has direct contact with patients could develop caring relationships with those patients. My hope is that if physicians were to adopt care-based relationships with their patients, the delivery of health care to patients in general would be significantly improved.

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