TOWARDS A NEW DOCTOR-PATIENT RELATIONSHIP:

COMPLEMENTING MEDICAL PRINCIPLISM WITH AN ETHICS OF CARE

by

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In this project, I aim to integrate the ethics of care into the doctor-patient relationship.[1] Contemporary medical ethics do well to limit harm to patients. However, they are defined mainly in the negative — as rights of the patient that must not be breached — and lack a positive dimension of responsibility towards one's patient. In many cases, doctors are sacrificing a relationship founded on trust that could open avenues for more empathy and better clinical outcomes. I think the ethics of care can complement the principlist ethics currently dominant in medicine by emphasizing a moral orientation grounded in caring, including values such as attentiveness and receptivity to the other. This mirrors the way that ethics of care scholars such as Held incorporate rights into the private space and responsibilities into the public. Through integrating the ethics of care and associated values, we can build a stronger foundation on which to rest the patient-doctor dyad.

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[1] "Physician" and "doctor" are used interchangeably throughout the paper, although the latter is generally more suited to our purposes.

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I. Introduction

In times of illness, we are forced to confront a fact that we often shove aside: though we may feel fully self-sufficient as we move through our day-to-day lives, we are one mishap away from being rendered powerless and dependent on the care of others, just as we all were as children and most of us will be in our old age. The relationship between a doctor and patient is complex, as it must balance an inherently unequal power dynamic, allowing for the patient to act without coercion, and yet leave room for a relation of trust and empathy to be built between the two. This last point is key, as contemporary medical ethics can have an overreliance on the letter but not the spirit of caring for one's patient. In this paper, we will examine the doctor-patient relationship and see how we can open avenues for more care within the relationship, while working alongside existing principles of medical ethics. To this end, this project will fall within the school of the ethics of care, a branch of feminist ethics that focuses on maintaining relationships rather than making detached judgements about what is most fair, and that is flexible to contingencies rather than being locked into absolute principles.

This project will not merely stay within philosophy, but also supplement biomedical ethics, and hopefully inspire changes in how medical ethics are taught and put into practice. Also, this construct of a well-functioning doctor-patient relationship is not just an ideal, but something I've seen in practice by multiple physicians. I plan to attend medical school and become a physician in the future. Because of this, over the past few years, I have spent several months shadowing a couple of excellent physicians. What I was struck and inspired by more than anything else in their practice was the way they related to their patients; I saw warmth, familiarity, and care in their practice - they were treating their patients as friends in need. This made it all the more confusing when, in the ethics classes I took here at UO, I found out how ethics are taught to doctors. Here, what was stressed was not the warmth and empathy I'd seen, but cut-and-dry principles to apply rigidly to medical cases. This concerned me, because it seemed like the good medical practice I'd seen was not being codified.

The way that medical ethics are taught to undergraduates at Oregon is indicative of a larger trend in how medical students in schools around the country are taught. The field of medical education is dominated by a single ethical perspective, known as principlism, or relying on a set of codified principles to sort out medical dilemmas. Two of the most influential authors in medical ethics, Thomas Beauchamp and James Childress, express this perspective most coherently. These authors base their work around upholding the principles of autonomy, beneficence, non-maleficence, and respect for persons. Their work in ethics is by far the most well-known by medical students. In a survey of the ethics curriculum of all medical schools in the US, researchers found that Beauchamp and Childress were the most-taught authors, and other highly-taught authors relied on their same principlism method of ethics (Dubois and Burkemper 2002). As clinician and OHSU medical school educator Paul Qualtere-Burcher says, of the 3rd and 4th-year students he taught seminars to — who had already received their lectures on medical ethics in the first two years — he "never encountered a medical student who knew any methodology for deliberating on medical ethical issues other than the principalist theory put forth by Beauchamp and Childress" (Qualtere-Burcher 2011, 16).

Beauchamp and Childress' principlism did not evolve in a vacuum. Their ethics emerged in response to historical abuses of power by physicians, to which Beauchamp and Childress specifically designed their principle of respect for patient autonomy to address. However, in their current state, both autonomy and paternalism are impediments to a caring doctor-patient relationship. What's more, we will go on to see that these two apparently dichotomous orientations are actually two sides of the same coin. In a caring doctor-patient relationship, the doctor is responsible for the patient, but they use that responsibility to further the patient's particular goals for their health.

These principlist ethics also align conveniently with another role that has been growing in power in medicine: that of the physician-scientist. As Alfred Tauber, MD, explains, physicians used to be defined primarily by their role as healers, but that changed rapidly throughout the 20th century (Tauber 1999, 10-12). Scientists are taught to relate to objects, not other subjects, and what's more, they learn to relate in an aloof and objective way (Tauber 1999, 13). These skills may serve them well in the lab, but patients do not want dispassionate, removed doctors. They want doctors that can recognize and connect with what they're feeling. According to a 2005 survey of over 10,000 patients of different socioeconomic statuses, 76% said that empathy was "very important" to their current clinical consultation (Mercer et al., 2005).[2] And by several metrics, this need is not being met. Multiple studies show a decrease in empathy in medical students throughout their clinical years, when they first learn how to interact with patients (Hojat et al. 2009, Chen et al. 2007). Authors such as Public Health

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[2] Empathy here was based around the CARE (Clinical and Relational Empathy) measure, and was defined as: " the ability to communicate an understanding of a patient's world and to act on that understanding in a therapeutic way."

Scholar Rebecca Garden suspect this might be due to students being overwhelmed with work, disidentifying with patients, or being made to develop an “emotional crust” in response to an abusive work environment (Marcus, ER, and Braynard MH, as cited in Garden 2008).

This project will be relatively unique in medical ethics in that it advocates what medical ethics scholar and M.D. William Branch calls a “moral orientation.” That is to say, it balances moral sensitivity, motivation, and character, rather than just following set-in-stone ethical codes (Branch 2000). In this way, this project adds to the greater project within humanistic medical ethics of equipping doctors with a holistic way to approach patients. Rather than drawing rigid divides between doctor and patient as current medical ethics tend to do, we will look at the gestalt of the doctor-patient relationship itself and how to strengthen that. Because we are bridging conventional and new approaches to medical ethics, we will have a unique vantage-point to both reflect on the strengths of the doctor-patient relationship as it stands and prescribe ways for it to become even stronger.

There is a lack of diversity within medical ethics education, and so ethical theories that make up for the deficits of medical principlism are valuable in the field. This paper can add another outlook to the discourse within medical ethics. Furthermore, it has been established that this search for a new ethics within medicine responds to a genuine need that patients are asking for. To establish this new ethics, there is no need to tear down the existing project of ethics that has done good work to get us to where we are. Instead, we can build a new ethics of care within medicine alongside the existing medical principlism, and present a moral orientation that speaks to patients’ particular needs and vulnerabilities, building trust with them without having to trample over their boundaries.

In chapter II we will review existing medical ethics and see how they came to be, setting up a groundwork for positive work built on the strengths and weaknesses of historical medical ethics. In chapter III we will go over some of the main obstacles to the doctor-patient relationship: the overreach of the principle of patient autonomy, paternalism, the doctor's role as scientist, physician professionalization, and the economics of US healthcare. In chapter IV we will examine the causes and repercussions of the current lack of empathy in medicine. In chapter V we will summarize the ethics of care and discuss how it can have a positive influence on medicine. In chapter VI we will outline a vision of the doctor-patient relationship in the positive, building on the critiques offered in chapter III. Finally, in chapter VII we will review and address various perceived objections to this project, and chapter VIII will conclude the project.

II. Existing Medical Ethics and How They Came to Be

The practice of medicine used to be a straightforward ordeal. Patients would come to a doctor in need of medical treatment, the doctor would tell them what to do, and they would do it, no questions asked. Since the doctor had the knowledge, they called the shots. This model, now known as *physician paternalism*, meant the doctor made treatment decisions without consulting their patients or even fully explaining what they were doing. Until the mid-20th century, this was widely considered acceptable for physicians, as people either totally trusted their physicians' judgements, or just didn't have the power to put up a fight.

However, over the last century, the ethics governing the doctor-patient relationship have changed greatly and rapidly. After witnessing several high-profile cases of physicians deceiving their patients for their own ends, the public demanded more accountability and power in the medical treatment process. The field of bioethics emerged, and settled upon a guiding principle that was completely out of discussion in the days of paternalism. In his book, *The Birth of Bioethics*, Albert Jonsen says that "as bioethics began, then, the notion that was to become its hallmark, respect for autonomy, was rare in the philosophical air" (Jonsen 334). The notion that patients should be able to make decisions about their own healthcare, called *patient autonomy*, went from unheard-of to becoming the governing principle of medical ethics. Thus, a field that was once dominated by the power of doctors was taken by storm by informed consent and other protections for patients.

a. The Origins of Medical Ethics

Alfred Tauber, MD, recounts the origin of medical ethics in America in his 2005 book, *Patient Autonomy and the Ethics of Responsibility*. When the first formulations of medical ethics emerged, it was understood that patients were to follow their doctor's directives submissively. In the AMA's (American Medical Association) first code of medical ethics in 1847, there was no suggestion of the notions of consent or a patient's right to determine medical treatment that have become widespread today. A popular medical ethics view of the day argued that by withholding information from their patients, physicians could actually *build* public trust (Tauber 2005, 72).

To get a sense of how bad things were, we can look at the writing of Dr. Richard C. Cabot. Cabot practiced in the early 20th century, and advocated for actually informing patients of their conditions and how he would treat them, as well as addressing the personal and social needs of the patient. This approach was considered radical for his time. However, even humanists such as Cabot only went so far as to advocate for doctors explaining patients' conditions and treatments to them, never actually letting patients participate in the treatment decision-making process (Tauber 2005, 74). This paternalism stayed popular until as late as 1955, when supreme court cases such as *Hunt v. Bradshaw* regarded consent and patient disclosure as legally unnecessary (Tauber 2005, 75). It took until the 1970s for physician paternalism to definitively come to an end.

What is so ironic about this history of paternalism is the background in which it unfolded. The first formulations of medical ethics arose into a milieu of individualism, self-determination, and liberty set by Jacksonian politics (Tauber 2005, 72). However, it didn’t occur to physicians to grant personal authority to their patients. As Tauber explains, this thread continued throughout the history of medicine, where medicine has generally been behind the curve in adopting the modern views of the self. First, medicine was late to even adopt the notion of the rational, atomized individual that had already become so entrenched in other disciplines such as economics and politics. Then, by the late time that medicine did adopt this conception, those fields had already moved on to begin to recognize the individual through their social dimensions (Tauber 2003, as cited in Qualtere-Burcher 2011, 49-50). Medicine’s status as a late adopter of understandings of self – autonomous or not -- helps to explain the precarious balancing act of this project between responsibility on the part of the doctor and independence on the part of the patient.

b. The Peak of Paternalism

It took a series of grievous medical atrocities for paternalism to finally receive its due self-scrutiny from the medical community. Paul Qualtere-Burcher[3] writes on the more recent consequences of physician paternalism in his dissertation, *Re-thinking the Patient-doctor Relationship*. The peak of paternalism — and thus, public scrutiny in response — occurred in the mid-20th century. This is when authoritarian biomedical research resulted in some of the most egregious atrocities of modern medical history, including the Tuskegee Syphilis study and the Seattle “God Committee.” In the former, during an experiment from 1932-72, African American men were knowingly withheld treatment to their syphilis when it was developed in the midst of the experiment. The researchers justifying their choice by saying that that the patients were: “clinical

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[3] A MD with a PhD in Philosophy.

material, not sick people" (Tuskegee 2011, as cited in Qualtere-Burcher 2011, 15). In the "God Committee," when determining the allocation of the first dialysis machines in the 1960s, physicians discriminated along categories such as married vs. single and churchgoing vs. atheist, effectively dooming certain groups to death based on their own partial values (Qualtere-Burcher 2011, 14-15). Both these incidents rightfully created large skepticism in the medical establishment, and a change was in order for medical ethics.

The nail in the coffin was the 1975 In Re Quinlan case. In this landmark legal case, the parents of a persistent vegetative patient named Karen Quinlan wanted to cut off her life support, but physicians managing the case disagreed. In the end, the parents went to the New Jersey supreme court and won the case. According to Social Medicine Professor David Rothman, this case:

> announces and promotes a fundamental shift in the doctor-patient, or hospital-patient relationship… if one had to choose just one document to represent the triumph of the autonomy movement, that document would be a court decision, and it would be the Quinlan decision. (Rothman 2001, as cited in Tauber 2005, 76-77)

By this time, a large public pressure had built up against physician paternalism, with patients rightfully indignant that they had no say in medical decisions about their own bodies. Thus, by this point the foundations for modern medical ethics were laid.

c. Modern Medical Ethics

Ultimately, the medical community at large began to cave to the pressure after these 20th century cases. They came together and formed the first generation of modern medical ethics as we know them. Patient autonomy rose up to take the place of paternalism as the leading principle by which physicians governed their practice and orientation towards their patients. The principle of respect for autonomy was soon thereafter formalized as informed consent laws by state. In 1979, Beauchamp and Childress published their first edition of *Principles of Biomedical Ethics*, and began to promote a new set of ethics that championed patient autonomy among other values of beneficence, non-maleficence, and respect for persons (Beauchamp and Childress 1979). This gets us to today, where these principles have long dominated the field of medicine, and as stated, are the most popular to educate doctors.

While Beauchamp and Childress' four principles are supposedly equal, in practice, autonomy takes precedence over the others. As medical ethicist Ranaan Gillion says, respect for autonomy is "primus inter pares — first among equals — among the four principles" (Ranaan Gillion 2003, as cited by Kekewich 2013, 22). This makes sense given the history behind them, and the goal these principles were developed for: fighting paternalism. For example, when the principles of autonomy and beneficence butt heads in medical case studies, beneficence is usually framed as the physician doing what *they* think is best for the patient without the patient's consent/knowledge. In other words, beneficence takes the role of a paternalism that medicine has just broken with and does not want anything to do with, so autonomy is propped up as the better alternative. However, just because autonomy arose to defend against the deceit of paternalism does not mean that it should be free from criticism. On the contrary, as we shall come to see, autonomy has its share of flaws as well.

III. Obstacles to the Doctor-patient Relationship

Now that we have reviewed the historical necessity of patient autonomy, we can begin to examine its problematic aspects. In this chapter, we will review several obstacles impeding a caring doctor-patient relationship. We will start with autonomy, as it has been most examined in the literature. Then, in the chapter that follows, we will examine the empirical repercussions of these obstacles for doctors and patients alike.

a. The Overreach of Autonomy

Autonomy interferes with a trusting doctor-patient relationship in several ways, and for medical ethics to keep advancing, it must go beyond solely focusing on patient autonomy as a guiding star. The issue with a patient-autonomy-centric view of ethics is that while patient autonomy does prevent paternalism, it does not in itself create closeness, and can in fact be a barrier to that closeness. As a practicing physician and medical educator, Qualtere-Burcher has experienced this:

> It is certainly not impossible for physicians to respect patient autonomy while maintaining close, supportive relationships with patients at the same time. The two are not logically exclusive, but in practice, physicians often seem to jump from 'respect autonomy' to 'hands off the patient'—in the sense of providing support or expressing empathy. (Qualtere-Burcher 2011, 51)

Henceforth, let us refer to this extreme doctor-patient relationship style 'hands-off autonomy,' where doctors take the principle of respect for patient autonomy as a synonym for emotional detachment and an excuse not to make a connection with the patient. Throughout this project, we will come to outline the full path through which physicians come to rely on respect for patient autonomy as a shield from forming bonds with their patients. For now, suffice it to say that this ‘hands-off autonomy’ is one of the biggest impediments to the caring doctor-patient relationship we will come up against.

Qualtere-Burcher argues that in hands-off autonomy, doctors often rely on a facts-values delineation wherein they bring the facts to the patient, and the patient provides their personal values, and thus the medical decision is made (Qualtere-Burcher 2011, 62). This seems logical, given that doctors know more about medical facts and patients more about their own lives. However, medical “facts” often also presuppose values, and things quicky go off-script when doctors acknowledge this. Qualtere-Burcher gives the example of “pointing out the contradiction between, for example, desiring long life and a pack-a-day habit of smoking cigarettes” (Qualtere-Burcher 66-67). Clearly, there are values present behind the medical advice to reduce smoking, i.e. living a longer life, but they are such inoffensive values that it make sense to bring them into the equation. Therefore, it makes sense for physicians to make such a case.

We will come to see that this delineation of ‘facts from the doctor, decisions from the patient’ is just a way for doctors to shirk from having to do the real work of critically thinking through the patient’s case and prescribing the best course of action for that patient, all things considered. Thus, hands-off autonomy is seductive for physicians, because they have an opportunity to abdicate responsibility by placing medical decisions and their consequences in the hands of the patients. Such a view is quite different from a relationship based on trust and responsibility on the part of the physician that we will come to outline.

Tauber compiles similar reasons for why the rise of patient autonomy has harmed the doctor-patient relationship. For one, he observes that autonomy and informed consent have come to serve as “rituals of trust [that] have emerged as substitutes for organic trust” (Tauber 1999, as cited in Tauber 2005, 59). However, these rituals can only provisionally replace actual trust, indicating a need for trust in the relationship that we will go on to attempt to meet. Secondly, citing Renée Fox, Tauber argues that it is in the best interest of neoliberal governments and for-profit health-insurance systems to be able to slot the relationship between patient and doctor into the model of “consumer” and “provider” neatly (Fox 1994, as cited in Tauber 2005, 60).

Finally, patient autonomy is, at its strongest, still only a negative right. That is, patients only have the power to refuse treatments, not demand treatments. “Physicians are translators and filterers of information to their patients, who generally defer to physician recommendations regarding definitions of disease and its treatment” (Wolpe 1998, as cited in Tauber 2005, 60). Really, the way in which the physician frames the patient’s illness and their treatment options necessarily limits the many possible applications of medicine to their case, simply because of the vast difference in knowledge between the two. If doctors really don’t think a particular treatment is called for, they can refuse to provide service to a patient.

This leads to another problem with the formulation and practice of the principle of autonomy: just saying the patient is on equal footing with the doctor doesn’t make it so. Physicians were taught to stop being paternalistic, but that doesn’t mean that the power-dynamic at work in the doctor-patient dyad was simply eliminated. Because when the dyad comes together, they do come from quite different places: the patient comes at a vulnerable time, plagued by illness, while the physician has trained for years to have a mastery over illness. This mirrors the power imbalance that we will see at play in many caring relationships. But relationships in medicine are particularly characterized by this knowledge difference because one person has sought out the other just because they know how much the other's knowledge can help them.

In his piece, "Market Liberalism in Health Care: A Dysfunctional View of Respecting 'Consumer' Autonomy," medical ethicist Michael Kekewich argues that patient autonomy in its current formulation is dysfunctional because the physician has to rely on some form of paternalism for a meaningfully therapeutic relationship (Kekewich 2013). Kekewich goes on to argue that some form of patient autonomy is clearly necessary, but there is room to fit it into a mosaic of ethics rather than having it as a monolith to which all other ideas about how a doctor ought to interact with their patient are subservient.

Finally, beyond a critique on the emphasis on autonomy in medical practice, there is a critique to be leveled at the very notion of autonomy. Care ethicists such as Virginia Held specifically critique the "autonomy… of the self-sufficient, atomistic self that can be distilled, uncharitably, from traditional liberal theory" (Held 48). We were born into relationships, dependent on parents to meet our material needs, as well as crafting an initial social identity for us. Then, as we go through life, that identity morphs, somewhat due to our volition, but also largely due to the socially-defined roles we hold: jobs, romantic partners, friends, civic engagements, hobbies, etc. For medicine to overwrite this and say that the two halves of the doctor-patient relationship are fully independent and need nothing from one another is unproductive. In chapter five we will expand on these critiques from care ethicists, and see how we might restructure autonomy as a by-product of a trusting relationship rather than a goal to aim at itself.

Furthermore, much is sacrificed when we idolize the autonomous self at the expense of the social self. As Tauber puts it: “the idealized autonomous person forfeits trust, friendship, loyalty, caring, and responsibility as secondary attributes to those primary values of self-direction, self-determination, and self-realization” (Tauber 2005, 118). Clearly, those former values are important in the practice of medicine as well. Doctors who can cultivate responsibility, trust, and friendship will be much more successful at reaching out and caring for their patients, rather than turning medicine into a disengaged transfer of knowledge that could just as easily occur with a computer interface.

This is not to say that care ethicists believe we are incapable of making autonomous decisions. Rather, as Held explains it, “The autonomy sought within the ethics of care is a capacity to reshape and cultivate new relations, not to ever more closely resemble the unencumbered abstract rational self of liberal and moral theories” (Held 14). Medicine needs to catch up to other fields, where a social understanding of the self has long eclipsed a purely autonomous and independent one. The way forwards is not through doing away with autonomy, but rather through giving it a place alongside other important values such as care and responsibility.

Beauchamp and Childress address many of these complaints in the newer editions of their medical ethics textbooks. Against critiques that autonomy can put undue burdens on patients, they respond that the capacity for medical decision-making is a right, not a duty (Beauchamp and Childress 2009, 105-07). They defend autonomy against critiques of being overly rational and individualistic by saying that autonomy is merely a metric for measuring decisions, not a descriptor for a person (Beauchamp and

Childress 2009, 100). Furthermore, they are pessimistic about the input of doctors into their patients' healthcare decisions. They found that although 93% of patients believed they were benefiting from extra information their doctors told them, only 12% actually utilized that info (Beauchamp and Childress 2009, 123).

Yet Beauchamp and Childress don't fully address these critiques, either, only devoting a brief two pages to cataloging the concerns of care ethicists on medical ethics, and not responding to those concerns directly (Beauchamp and Childress 2009, 36-38). That is where this project comes in. We will not only outline how the ethics of care could be put to use by medicine, but also ways in which the field of medical ethics could be driven to a more productive place through integration of humanistic concerns with existing (and strong) medical ethics principles.

b. Paternalism

Given the thorough critique of autonomy above, one might assume that this paper advocates a return to physician paternalism, as existed before the principle of respect for patient autonomy took hold. This is not the case. Medicine certainly does not need a regression to paternalism, but there are traces of paternalism in the principle of respect for autonomy, only under a different guise.

For our purposes, paternalism in the doctor-patient relationship will be defined as the doctor not explaining what they're doing to the patient, deceiving them, or not letting them in on the decision-making process. Paternalism is motivated by an assumption that the physician knows better what's best for the patient, and knows what the patient wants more than the patient does themselves. Paternalism interferes with the doctor-patient relationship because it prevents open communication and a two-way street between the doctor and the patient. Regardless of the fact that the patient is ill and needs care, that care cannot be administered sensitively nor justly if the patient is excluded. Inefficacy arises when doctors prescribe certain treatments without asking about their patient's preferences or values. In doing so, doctors can also miss crucial information necessary to make medical decisions.

c. Physician as Scientist

Paternalism and autonomy are not the only things getting in the way of a caring doctor-patient relationship, however. Another factor is the role into which physicians are categorized and trained. While intensive changes were happening to the field of medical ethics during the 20th century, the role of the doctor was also shifting. As Alfred Tauber explains in his book, *Confessions of a Medicine Man*, the responsibility of a physician used to be primarily towards healing their particular patients, and building trust with them through humanistic means. However, with the widespread integration of science and technology into medicine in the early 20th century, that responsibility has merged into a responsibility towards science at large. Doctors were forced to morph from physician-healers to physician-scientists. Some of the leading physicians of the time, such as Francis Peabody (1881-1927), warned against these intrusions by science into the formerly humanistic field of medicine: "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient" (Tauber 1999, 16). Dr. Peabody recognized the positive potential that science could bring to medicine today, but also wanted to maintain the medicine he knew that was focused on caring for the whole patient, not just from a certain scientific level of analysis. Unfortunately, he was on the losing side of history.

Nowadays, physicians are primarily scientists as undergraduates before they make the transition to medical school. Just a glance at the required courses for prospective doctors shows a heavy emphasis on the basic sciences of chemistry, biology, and physics, with few if any requirements in the humanities. This primacy on science prepares pre-medical students to take a reductionist approach to healing, focusing more on the science than the patient.

After undergraduate education is complete, this trend continues. Tauber argues that far more weight is given in the medical field to the research one publishes than to the care they give to their patients, or to their capacities as a medical educator: “The rewards in our medical schools do not traditionally go to the teacher or the committed clinician, but rather to the competitive clinician-scientist” (Tauber 1999, 21). Treating the patient humanistically has been side-lined to make room for the physician’s individual growth and pursuit of scientific and research ideals. Medicine has paid the price, though. Science was one of the factors in medicine’s fall from grace in the public eye throughout the 20th century. As ethicist Jonsen puts it: “the scientific training of which modern medicine was so proud seemed to transform the healer into the technician who was remote, difficult to see, and even more difficult to understand” (Jonsen 12). Clearly, the primacy of science is not helping an already-strained relationship between medicine and the public.

This reaches back to the “rituals of trust” of consent paperwork that Tauber argues have come to replace actual trust between the doctor and the patient. The rise of science in medicine coincided with the jump from paternalism to autonomy. Just as doctors were coming to rely more and more on technical means to apply to their patients' bodies, they received a mandate that could be interpreted as saying that getting involved with the patient's emotional and personal life was out-of-bounds. Thus, while doctors had just gotten the opportunity to pivot to a more inclusive decision-making style than paternalism ever offered, they instead chose to retreat behind the shield of scientific objectivity. That scientific approach to medicine might protect doctors, but it also sidelines other important components of care, including developing relationships with patients.

The very premise of physician-as-scientist comes with baggage that can get in the way of the doctor-patient relationship. Scientists are taught to relate to their test subjects in very particular ways. They are the "subject," and the patients are "objects" who are to be observed with a dispassionate clinical technique. The subject-object relationship in science is based on a primacy of division, so that the scientific observer might stand apart and take their object of study objectively (Tauber 1999, 13). Whether or not this type of dispassionate style can be attained in science, it certainly should not be a goal of medicine. Doctors who feel they have to separate themselves from their patients in order to more objectively observe the illness at a distance will leave their patients stranded to struggle with the illness on their own. This can lead to a cool, aloof interaction style that is far from the model of engaged care we are working towards. The language of "subject" and "object" matters - in viewing themselves as the "subjects" doctors can come not only to see themselves as apart from their patients, but also see the patients as being something to act on rather than an equal to make their own decisions. We can read this as another case in which autonomy only runs surface-deep, and can disguise doctors' views of patients as inferior.

More generally, the physician's role as scientist may lead to a dismissive attitude towards medical ethics, that they are the tedious precautions that must be checked off before the real heavy lifting of science-based-medicine can be undergone. They are the parallel of safety protocols that must be followed in the science laboratory, as translated to the clinic with human patients. Tauber argues that the care side of ethics in particular is set up as an obstacle to the physician's true objective: applying science to malfunctioning bodies.

> A prevalent rationale for relegating these moral and emotional dimensions of care to a peripheral role is the vacuous claim that addressing the subjective dimension of the patient putatively distracts from the true agenda of the clinician, namely, her application of technical virtuosity and scientific competence. (Tauber 2005, 48)

Tauber goes on to argue that this view sets up a false dichotomy, and in reality both the humanist and scientific sides are clearly necessary to the practice of modern medicine (Tauber 2005, 48). Science's techniques and raw power definitely aid medicine, but they must be applied through a humanistic style of care, or else doctors risk further estranging their patients.

d. Professionalization

Alongside the doctor's new role of scientist has come the role of provider. Thus, "providers" – even the language is molded towards an economic essence rather than a social role -- have taken on a larger burden of professionalization into their roles. In my own experience working as a caregiver, I was explicitly informed to refer to the people I cared for as "customers" rather than "patients" for liability reasons. While the goal of the professionalization process is supposedly to better serve the patient, it can end up negatively impacting the authentic care they can display towards their patients, and the genuine connection that can be built between the two of them. If doctors feel pressured to become something they're not, to put on a face in order to sell themselves and their treatments as a product, it will inhibit trust and connection with their patients. How can you trust someone who is only trying to sell you on something?

In many ways this mirrors the discussion above on how respecting a patient's autonomy can easily become a justification for limited emotional interaction with the patient in practice. That being said, there is a place for emotions in the clinical encounter, and there is a place to withhold them for the sake of the patient. Ethical case studies can help us to delineate between the positives of demonstrating emotional resonance for the patient and the negatives of being overly affected by the patient's conditions, to the point where they cannot look to the physician for guidance.

In their article, "Professionalism and Appropriate Expression of Empathy When Breaking Bad News," Amy Blair MD and Katherine Wasson PhD utilize a case study to determine the ideal balance between being professional and expressing one's emotions and building connections with patients. In the case study, a young medical student is assigned a patient. At first, the patient doesn't open up to her and feels standoffish. After finding common ground with the patient, however, the patient opens right up to the student and they end their interaction on a happy note. Later that week, the medical student has to break bad news about a cancerous mass to the patient. When she does so, the patient is shocked and begins to cry. The medical student cries in return, and reaches out to rub the patient's hand gently. After the student leaves, her attending doctor —

who never saw her build the initial connection with the patient — reprimands her for how she interacted:

> It’s all right to feel sympathy for patients, but you crossed a line there. Crying can detract attention from the patient, and some patients do not like to be touched. It’s natural to want to help patients, but you need to learn to channel that energy into being a good practitioner and leave the more personal comforting to family and friends… As you see more and more, you won’t feel the emotions as much. (Blair and Wasson)

The authors don’t have a simple metric to determine which doctor is in the right, but they do warn that “learning and maintaining professional boundaries can easily turn into learning and maintaining detachment, which can further be rewarded when detachment is perceived to be synonymous with rationality and clinical objectivity” (Blair and Wasson), a fear that we have begun to unravel in the last several sections.

This article points to a general tension between professionalism and empathy in the doctor-patient relationship. As with the other obstacles to the doctor-patient relationship, there is not a simple resolution here. There is definitely a point at which the physician’s emotional expression can be too much, and this case study pushes on that boundary. However, many doctors like the attending in this story have simply been conditioned to believe that anything is too much, and that they should totally withhold emotional connections with patients. Ultimately, doctors shouldn’t withhold their emotions out of fear for the potential losses to their practice or professional demeanor, but only if it is appropriate for the care of the patient.

e. Economics

While it will not be the main focus of this paper, one cannot touch upon any aspect of healthcare in the United States without acknowledging the economic disparity and inequity of access of services under the current private-insurance-based model. It’s hard for a doctor to build a relationship based on a caring orientation when they're limited by the sheer amount of time they're spending with their patients, or when a patient has to choose between taking prescriptions and paying their rent. What makes this particularly hard is that physicians often take the fall for the systemic inadequacies of the market to deliver affordable care.

As MD Susan Dorr Goold explains in her article, "The Doctor-Patient Relationship: Challenges, Opportunities, and Strategies," doctors take the toll when health care insurance providers over-promise care options. Because of competition to enroll patients, health-care network negotiators promise to cure every single ache and pain the patient has. In reality, they have far from comprehensive service, but the negotiator only puts the limitations of the network in the fine print of the contract with the patient's employer. Then, "Primary care doctors thus become the bearers of the bad news, and are seen as closing gates to the patient's wishes and needs. When this happens, an immediate and enduring barrier to a trust-based patient-doctor relationship is created" (Dorr Goold 1999). While individual physicians do not have many options at their disposal for providing certain methods of care to patients with limited insurance, they still take the blame, and thus impersonal economic failures of the for-profit healthcare system put strain on the personal doctor-patient relationship.

This project, however, is more focused on the ethical component that individual doctors can integrate into their practice to improve their personal relations with patients. Even if medical care were accessible to all Americans, there would still be a need for medical ethics, and the problems we've discussed above would not go away overnight. A purely economic angle does not explain many of the problems patients have with their doctors, as evidenced by the fact that “complaints of friction between doctors and their patients were in abundance well before the rise of HMOs … [so] the problems arising from a disparity in power between doctor and patient cannot be reduced to a new corporate mentality” (Balint 1964; Katz 1984; Brody 1992, as cited in Tauber 2005, 81). That being said, there is a clear need for a health-care system in America that is free at the point of service, and such a program would make it far easier for physicians to put forth the effort to build engaged doctor-patient relationships.

In conjunction, we see the barriers towards strong doctor-patient relationships compiling to strain trust and entrench inequities. Through these negative descriptions, we can begin to see what it is we might be looking for in a doctor-patient relationship. A good place to start is to find the ideal level of engagement with the patient through a Goldilocks approach; between paternalism and hands-off autonomy, is there room for a balanced third option of engaged care? One author, Bioethicist Julien Savulescu helps to delineate between three such styles in his article, “Rational Non-Interventional Paternalism: Why Doctors Ought to Make Judgments of What is Best for their Patients.” Savulescu argues that the problem with paternalism is not only that it blocks patients from sharing personal values that could shift the case, but also that it lets the doctor choose a treatment plan without having to justify it to a patient who could check the doctor’s reasoning and hold them accountable. Anti-paternalistic ways of interacting with the patient, on the other hand, let the patient engage with the doctor's ideas and force them to bring stronger justification for the recommended treatment (Savulescu).

This is where hands-off autonomy fails. When confronted with the prospect of having to actually choose a method of treatment, based on a delicate interplay of medical facts with the values of a patient's life, the hands-off autonomists throw up their hands and walk away from the case, leaving the patients to integrate the facts into their life on their own. In many ways, these hands-off doctors mirror the hardline paternalists who didn’t let their patients get involved with decision-making, as in both cases the physicians refuse to take responsibility for a plan of action and be held accountable if it fails. This is the easy way out. As Savulescu says: “It is easy to turn decision-making over to patients and say: ‘There are the facts - you decide’ ” (Savulescu 331). The alternative is for the doctor to actually take the medical facts, learn about the patient’s life, and then recommend a plan of action. This is easier said than done: “It is difficult to find all the relevant facts, to form evaluative judgments, and critically examine them. It is even more difficult to engage a patient in rational argument and convince him that you are right” (Savalescu 331). While it may be difficult, in doing so, doctors transcend the paternalism-autonomy binary and progress towards actually caring for their patients in an engaged, vulnerable way. As long as there is a failsafe in place where the patient ultimately makes the decision, there is room for the doctor to make a partial case for a certain line of medical treatment that merges their medical knowledge with the patient’s goals for their life. This approach begins to remedy several of the issues we have seen presented in the preceding chapter.

IV. Repercussions of a Faulty Relationship

The repercussions of these obstacles to the doctor-patient relationship have been devastating. Empirical studies help us to understand the urgent need for a doctor-patient relationship of engaged care. We can start by examining the foundations of the doctor-patient relationship, in medical school. Medical students enter the profession filled with a surplus of empathy and sympathy, ready to care for their patients as best they can. However, as they come to adopt the role of detached clinician rather than caring doctor, their emotional resources are strained and can even be pushed to a breaking point. As illustrated by a 2009 study conducted by Hojat et al., we see a decline in empathy throughout the four years of medical school (Hojat et al., 2009), and burnout among doctors in their later careers continues to increase (Kane, Medscape 2020). This decline in empathy calls for an explicit integration of empathy into medical ethics, something we will cover in the following chapters as we outline our ethics project.

Patients also suffer the consequences of disengaged care. They are not satisfied with the role that compassion and empathy are relegated to in medical practice, and feel like their doctors can’t answer their questions or serve as a source of guidance for them. Changing the focus to the priorities patients ask for from their doctors paints a very different picture of an ideal doctor than what the patient-autonomy-centric model of care tries to mold doctors into. Yet this new model is far more reflective of the needs of the cared-for. Here, we shall examine the repercussions of a poor doctor-patient relationship for patients and doctors alike.

a. Repercussions for Doctors

We would hope that medical schools would teach budding doctors not only the technical competencies of medicine, but also how to relate to patients and ease them in their times of suffering. At the very least, we would expect that such traits would be unaffected by education, and thus remain unchanged throughout medical school. However, empirical data shows that after medical students transition from their first two years in the classroom to the later two years in the clinic, they actually become *more* withdrawn from their patients, scoring lower on empathy assessments compared to their prior scores (Hojat et. al). This decline in empathy is ripe for examination in light of the underlying causes of disconnection in medicine studied above.

There is originally a surplus of empathy in those who choose to become doctors. Medical students enter school “enthusiastic, filled with idealism and a genuine intention to serve those in need of help” (Hojat et. al). For many, this is what motivates them to pursue medicine in the first place. However, by their later years, almost three-quarters of medical students have become cynical about the medical profession (Hojat et. al). Hojat et. al conducted a study of empathy levels in medical students across their four years of medical school, and discussed their findings in the article, “The Devil’s in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School.” They found that empathy[4] significantly decreased in the third year[5] of school, when students transition from the classroom to the clinic.

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[4] The researchers used a survey called the Jefferson Scale for Physician Empathy, which asks participants to give ratings based on how much they agree with statements like “Because people are different, it is difficult to see things from patients’ perspectives” (negatively rated).

[5] The researchers found that their scores did not change at all from before the beginning of the first through the end of their second year. However, after that the scores steeply declined for both cohorts studied, and maintained these lower levels throughout the fourth year.

The researchers offer a number of reasons to explain this precipitous drop in empathy. Their main hypothesis is that modern medical education:

> promotes physicians' emotional detachment, affective distance, and clinical neutrality as emphasized through a focus on the science of medicine and a benign neglect of the art of patient care. Students can easily misinterpret these lessons as an endorsement of avoiding interpersonal engagement in patient care. (Hojat et. al)

As a medical student put it: "we are always being reminded to keep a professional distance, but some doctors take it too far" (Hojat et. al). Another prevalent response was that the sheer pressure of the increasing productivity of the hospital left students without the energy or time to invest in their patients. One student said: "it is hard to care 100% about some patients' stories when you are tired and have a ton of people to see" (Hojat et. al). We can't definitively claim that detachment or intense patient burdens are behind this drop in empathy, but they seem likely culprits given the negative effects of such detached styles we theorized in the last chapter.

These are not isolated factors. Physicians do not just happen to both have a hands-off style and be overworked to the bone. In truth, these pressures on the young physicians are what cause them to resort to the hands-off autonomy style referred to above. This helps to explain the origins of the detached relational style introduced earlier. Physicians are not forgoing relationships, rather, because they are under so much economic pressure, they resort to a detached style as a protective measure for themselves. This switch is most clear in young physicians just entering medical school. They enter with a surplus of empathy, but when put through the meat grinder of mechanized hospital interactions, they see how much harder things are than they thought. Fortunately, educating doctors have an easy solution for their proteges: if you just don't get as engaged in your patients' lives, you'll not only be protecting yourself, but you'll also be upholding the almighty principle of patient autonomy.

This decrease in empathy might work for medical students for the time being, but down the line they suffer the consequences of this transition to a more detached style of care. One of the largest such consequences of a faulty doctor-patient relationship for doctors is physician burnout. Harvard Psychiatrist and Director of Empathy Research Helen Riess says that burnout describes what happens when physicians become so detached from their patients that they no longer see them as people.

> Burnout is defined when a few things are happening, called depersonalization, where patients are seen more [like] a number, or a diagnosis, or on a list instead of like real people. [Also,] a sense of decreased effectiveness, just feeling like no matter how hard I work I just don't really feel like I'm doing a good job. And emotional exhaustion. (Craiglow 31:41 - 32:06)

This problem of doctors not really seeing or listening to their patients is something that we are attempting to resolve with this new project of engaged care. The National Academy of Medicine published a report last year estimating the rate of burnout to be between 40 and 54 percent, double the rate of workers in other fields (Craiglow 32:07 - 32:20). While some blame with burnout lies with overbearing supervisors and a preponderance of menial responsibilities at work, these high numbers of burnt-out doctors also point to a disengaged approach by doctors to their patient's care.

However, as Riess explains, it is not physicians' fault that they are experiencing such higher rates of burnout:

> It's not to blame the doctors. I just think that our system right now is working to get the outcome that we're seeing. First of all, medicine has become a business, and whereas we used to have time to get to know

> patients and to really form relationships, it's much more about throughput now, and how many people you can squeeze into an afternoon. The incentives are much higher to see somebody for 20 minutes to just prescribe their medicine than to see them as a whole person. (Craiglow 31:03 - 31:33)

Clearly, the economic pressures of a corporate health-care system and the abilities of individual physicians to form emotionally close relationships with their patients are intimately linked. Under such intense pressure to increase their output of patients treated — note the word choice of "treated" rather than "healed," as is common in the medical literature — it is no wonder they revert to the mechanics of medicine rather than building personal connections with those they are attempting to heal.

There is a vicious cycle at work here. When first exposed to the medical field, young medical students are overwhelmed by the number of patients they must see in so little time. If they practice in a way that upholds the reasons they came into medicine in the first place, they risk over-exerting themselves emotionally. Besides, they don't have the time. So instead, they employ emotional detachment to protect themselves from the burdens of a hefty patient-load and emotional overexertion. However, this strategy becomes self-destructive, as the attempts to cut off emotional harm instead end up furthering that harm in the form of physician burnout.

This narrative of burnout fits right alongside the pressures on doctors to conceal their emotions and withhold connection from patients discussed above. There is almost an incentive to follow the disengaged model of care implicit in the ubiquity of the principle of respect for patient autonomy. Multiple factors align - scientism, professionalism, autonomy, and a simple desire not to get harmed by being too close to patients. In sum, these lead to a doctor-patient relationship that is removed and disconnected. What individual doctors see as a necessary choice to protect themselves is really happening in medicine as a whole, in large part due to increasing corporatization and output pressures.

b. Repercussions for Patients

When doctors provide distant and disengaged care, their patients suffer. Surveys on patient preferences paint a stark contrast with the conventional goals of physicians. A 2004 poll of 2,267 patients asked which attributes they valued from their doctors. The top five most-valued-traits were: “Treats you with dignity and respect,” (85%) “Listens carefully to your health care concerns and questions,” (84%) “Is easy to talk to,” (84%) “Takes your concerns seriously,” (83%) and “Truly cares about you and your health” (81%). Clearly, what is emphasized here is a more engaged and caring approach to the healing process and the doctor-patient dyad. It is not until we get to the patient’s 12th and 14th priorities — “Has a lot of experience treating patients with your medical condition,” (58%) and “Could get you admitted to a leading hospital when you need it,” (55%) respectively — that we see more of the traditional objectives of medicine. Second from last on the list is “Has been trained in one of the best medical schools” (27%), which is ironic given how much prestige is typically associated with medical school among the medical community (Bright for the Wall Street Journal 2004). This aligns with other research into patient preferences, such as the cross-culture desire for empathy cited in the introduction (Mercer et al., 2005).

These demands are unique and stand in contrast to the problems facing the doctor-patient relationship. Patients are not calling for more scientific competence to resolve their health-care matters. They want support and engaged listening from their doctors. It is appropriate to refocus the conversation around patients’ needs rather than doctors' shortcomings, as that is what care is all about: meeting the needs of the other. This attentiveness to the other is true respect for patient autonomy, as we will go on to discuss - autonomy is listening to patients when they ask for more than a barebones clinical encounter.

A particularly telling response is the call for "*true* care" from physicians. As the medical community slowly becomes cognizant of the need to strengthen interpersonal relationships, it has proposed some band aid solutions to the care deficit. These solutions generally fall in the same vein as offering up patient autonomy to resolve physician paternalism, without fully recognizing the failings of that solution. Some in the medical care literature suggest that compassion-based care is an "easy switch." For example, the authors of *Compassionomics: The Revolutionary Scientific Evidence that Caring Makes a Difference*, argue that doctors can respond to appeals like these with the simple addition of a few more questions to the dialogue protocol with their patients, that will take under a minute more time, and actually save money for hospitals because of stronger patient outcomes (Cheney 2020).

However, such responses do not actually address the patients' appeals. Technical solutions like this totally miss the point of what patients want, in a way that reflects the historical disregard for patient preferences on the part of the medical community. These patients are not simply asking for surface-level politeness in their medical care. The variety and depth of their wishes demonstrates that they expect intimate connection and trust from their doctors, much like the engaged care model that we've begun to outline. While it may be true that compassion and care do save hospitals money, that can't be the primary motivation for these attributes; patients already have a rightful mistrust of the medical establishment, and if physicians *act* caring for the mere sake of not having to deal with their patient as much in the future, the patients will be able to sniff out the inauthenticity. Physicians can't fake these attributes, nor can they simply be externalized and added to another checklist as part of the many menial responsibilities clinicians must take up that contribute to burnout. Doctors actually have to internally cultivate care for their patients, and when they do, these external pieces will fall into place.

Individual patients' stories are also an important indicator that there is something missing in the existing relationship with their doctors. In the piece, "I Like to be an Informed Person But…" Sinding et al. conduct a series of qualitative interviews with patients suffering from breast cancer. The patients come from high levels of education, and throughout their treatment process they are presented with materials that encourage them to "educate themselves" on their illness. However, as treatment advances, many of them do not want to deal with the constant responsibility of having to learn bulk medical knowledge and make weighty calls. So they turn to their physicians for guidance. Yet they find their doctors surprisingly trepidatious to give tailored advice, or even their personal opinions. Some patients are reduced to the point of having to resort to semantic trickery to extract real advice from their physicians:

> "If it is your choice what would you do?" [no answer].
> "What would you do?" [No answer].
> "Medically, what's the better choice"
> "My opinion is the more tissue I can remove, the better the risk."
> (Sinding 1098)

Patients are communicated a message that, to stave off illness, they must educate themselves on all the details of their illness. This can slip into responsibility for the negative effects of their treatment choices, and even ultimately culpability for illness recurrence. It is better to have the physicians take responsibility for the illness, while honoring the patients' autonomy. They learn about the patient's life, offer up a set of choices, with their recommendation for one choice, but have the patient makes the ultimate call.

In sum, these measures provide empirical evidence for the concerns previously raised about the state of the doctor-patient relationship. Young prospective doctors enter medical school driven by empathy and care for their future patients, but in their very first year of exposure to patients, overwhelmed by the pressure of medical timetables, they resort to a coping strategy of emotional detachment taught to them by older residents. However, later in their careers, they suffer the consequences of this form of detachment in the form of burnout. Meanwhile, patients suffer from this reservedness in the form of lack of connection with their physicians. As the picture begins to come together, we see the urgent need for engaged care.

We have mainly summarized what the doctor-patient relationship ought *not* look like, with little discussion of a positive vision for this dyad. There are plenty of criticisms about doctors already, but what is rarer and more valuable are methods for doctors to improve the care and connections they have with their patients. Thus, in the chapters that follow we will outline a positive view of how the doctor-patient relationship ought to work, as well as potential limitations of this view.

V. Situating the Doctor-patient Relationship Within the Ethics of Care Literature

So far, we have observed that because of the way medical ethics evolved in response to abuses of physician power, there is an implicit mistrust in the doctor-patient relationship. Safeguards to protect against this mistrust do their job, but also can interfere with building a closer relationship between doctors and their patients. That is why the new style of physician-patient relationship advocated here is grounded in values of trust, empathy, receptivity, and responsibility. Thankfully, we do not have to create such a model from scratch. Ethical scholars have determined that such a style of relationship has long been present in feminine relational styles and can have vast repercussions if it is taken as a foundational good for society. These scholars represent the ethical school known as the ethics of care, which can guide the doctor-patient relationship in ways that promote flourishing, trust, and greater emotional connection between the two. The ethics of care is uniquely suited to answer the lack of a relational ethics in medicine, as scholars have often used it to refute liberal, autonomy-based models of ethics in other fields that mirror Beauchamp and Childress' principles of biomedical ethics.

Care ethics scholars argue that certain types of dependent relationships are ubiquitous and unavoidable. Those can include infancy, severe physical and cognitive disabilities, and old age, all which have received their due study in the ethics of care literature. Illness, however, while it can be fully debilitating and leave a person in need of the care of medical personnel, has not been studied as much in the care ethics literature. What work has been done has been mainly limited to the work of nurses rather than physicians, e.g. Chris Gastmans' work such as the 1999 article, "Care as a Moral Attitude in Nursing" (Gastmans 1999). While it is true that physicians do not experience the same stigmatized and under-compensated conditions that other care-givers do, they can still stand to benefit from the positive formulations of the ethics of care. Here, we will examine the reason for that lack of research, and attempt to broaden the ethics of care discourse by determining how physicians can integrate the ethics of care into their practice. We will use the views of several ethics of care scholars to stand in for the discipline as a whole, in order to begin to introduce how the ethics of care could be actualized in medicine. In the chapter that follows we will refine and outline certain values particularly relevant to medical practice: intensive listening, empathy, and responsibility.

a. What is the Ethics of Care?

Care ethics is a diverse and evolving movement, so it is hard to encapsulate it from a single lens. One of the most comprehensive overviews of the ethics of care is Virginia Held's *The Ethics of Care: Personal, Political, and Global*. In this text, Held applies the ethics of care to a broad set of domains. She also searches for an ethical system that can encompass both justice — rights, principles, and independence from others — and care — relationships and responsibilities to others. She rejects the notion of care for the private sphere, justice for the public, and instead sees the need for each in both domains; those in private abusive relationships certainly need justice, and institutions outside of the home like businesses have a responsibility towards the environment and the citizenry (Held 69). This project will carry this inquiry over into the medical field. Here, it is clear that this voice of justice is effective in preventing coercion and upholding patients' rights. But what is underrepresented in the body of medical ethics is the need for care in clinical relationships. In this project, we will see why and how the moral orientation of care can be utilized by physicians to strengthen their relationships with their patients and provide better treatment.

A note to remember when working with the ethics of care is that in Held's words, they are *ethics*, not merely unbridled care: as such, they can help us prevent against cases "when excessive empathy with others leads to a wrongful degree of self-denial or when benevolent concern crosses over into controlling domination" (Held 11). This well help us provide structure in responding to some of the tough questions we have already encountered of paternalism and overbearing empathy.

I will also integrate several other texts by scholars of the ethics of care in order to ensure that this project is supported by a survey of views within the field, rather than solely those of an individual author. To that end, we will work with Joan Tronto's *Moral Boundaries,* which examines the political implications of an ethics of care. We will include Eva Kittay's *Love's Labor,* which contains a vision of care that is more based around what Kittay calls "dependency work" and determine whether there is room for professionals to utilize care within Kittay's framework. Finally, we will look at Michael Slote's *The Ethics of Care and Empathy*, which integrates the virtue of empathy into the caring relationship.

The ethics of care holds quite different views from the general ethical canon. Traditional schools of ethics have insisted that people make ethical choices as individuals, free from the fetters of their connections to others. As Hobbes put it, men are not born but "sprung out of the Earth, and suddenly, like mushrooms," and from there are able to enter into neutral social contracts as individuals (Hobbes 1966, as cited in Kittay 23). Care ethicists have a different view: care, and human life, starts and ends with dependency. As Kittay says, “The independent individual is always a fictive creation of those men sufficiently privileged to shift the concern for dependence onto others” (Kittay 17). For care ethicists, an understanding of morality is always rooted in our relationships to particular others in our lives, rather than starting with a pretext of a totally isolated, autonomous actor making impartial moral choices. Because women have been historically relegated to roles of care, men have often been able to get by ignorant of the care they are so dependent on, and have thus embraced these individualist ethics despite their actual interdependence.

The ethics of care has some important roots in the work in the 1982 book, *In A Different Voice*, by psychologist Carol Gilligan. Gilligan was studying moral development and noted that boys and girls had different perspectives and priorities when presented with ethical scenarios. While previous research had merely characterized girls as “less developed” than their male counterparts, Gilligan recognized that they were actually following wholly different prerogatives than boys. Masculine ethical development was tied to independence, rights, and disconnection from others, but feminine was tied more to responsibility, relationships, and caring for others (Gilligan 1982, chapter one). These two perspectives have since broadly come to be known as the “voice of justice” and a “voice of care” (Norlock 2019).

Joan Tronto argues that there are three main criteria from which to differentiate these voices. She says that,

> the ethic of care revolves around different moral concepts than Kohberg’s ethic of justice, that is responsibility and relationships rather

> than rights and rules. Second, this morality is tied to concrete circumstances rather than being formal and abstract. Third, this morality is best expressed not as a set of principles but as an activity, the 'activity of care.' (Tronto 78)

Later discussion has contested this binary of care and justice. Some care ethicists, like Nel Noddings, have argued for the superiority of a care perspective (Held 63). Others, such as Held, have made the case that both care and justice are valuable, but care is more foundational to societies in that society can continue without justice but will not last longer than a single generation without care (Held 17). Regardless of the exact formulation, ethics of care scholars do argue for at least some degree of care alongside justice. Held says that, "I am more inclined to say that an adequate, comprehensive moral theory will have to include the insights of both the ethics of care and the ethics of justice" (Held 16). In medical principlism, however, care has fully taken a backseat to justice.

While Gilligan's work laid the foundations for an ethics of care, Gilligan focused more on a criticism of existing ethics rather than a positive vision of a new school of ethics. Such a vision came soon after in Nel Noddings' 1984 text, *Caring*, which explicitly outlined a positive vision of caring. As Slote summarizes Noddings's work, "An action is morally permissible, and even good, if it exhibits caring on the part of its agent… Actions, on the other hand, that display indifference or malice toward (relevant) others count, ethically, as wrong or bad" (Slote 10). This evaluative component of care ethics is particularly important for this project because we do not want to just describe what existing doctors are doing well, but rather build a new school of medical ethics that can fit alongside the prescriptive medical principlism.

Finally, as stated in chapter three, care ethicists are generally critical of the notion of full autonomy, paralleling the rejection of the monolithic principle of respect for patient autonomy that we embark on in this project. Held rejects autonomy in favor of what she calls mutual autonomy, a collaborative process between the carer and cared-for that negotiates the interests of both:

> Mutual autonomy is very different from what traditional autonomy would be, if there were such a thing. Traditionally, autonomy has been understood in terms of self-sufficiency, noninterference, self-direction, rational control, and the like… Holding up liberal ideals of self-sufficiency masks these facts of dependency and interdependence, and distorts the realities of, among other things, caring labor. (Held 55)

Once again, we see that deifying autonomy is not a value-neutral decision, there are other values lost when autonomy is the guiding principle of our ethics. Clearly, while there is room to maneuver the principle of autonomy in medicine into a new more relational definition, it cannot continue to exist in its current formulation. Furthermore, if we are able to actually establish such a relational form of autonomy, then it could be able to enable care, rather than serve as an obstacle against it.

b. Developing Care

The ethics of care emerged from feminine thinking, but it is important to recognize that its insights are not limited to women, nor specifically to women who are relegated to roles of care because of systemic inequality. In Held's view, somebody who learned how to care through their choice, and not because they were forced into it, would have more of an appropriate motive:

> The goal of being a caring person can certainly and should be a matter of autonomous choice. A person who has merely unthinkingly and uncritically followed the caring practices into which she has been brought up can seem in outward appearance to be caring but will lack the

> appropriate motive of consciously and reflectively recognizing the value of care. (Held 49)

Doctors therefore have the potential to take up values of care even if they were not socialized into it, so long as they have the appropriate motives and effort.

That being said, we are not beyond history. Because the patriarchy has had so much sway over gender relations, many women are still relegated to roles of care to this day. While this fact is sometimes framed as a reason that women need to break free from the caring mindset in order to free themselves from oppressive power structures, it could also be taken as a call to action for men to take up the value of care in equal measure. If we recognize care as a valuable trait, and separate it from the inequitable gender delegation it has long been associated with, then the onus falls on men to learn care, not on women to disavow it.

This brings us to an important point in understanding the ethics of care. While the ethics of care stems from feminist traditions, it is unique in that tradition in that it goes beyond simply advocating for equality or elimination of the patriarchy or domination of women, and instead champions a positive view of ethics based on womens' hard-won experience of having to be responsible for so much of the care work of society. This has driven some authors to differentiate the ethics of care as "feminine" rather than "feminist." In their book, *Culturally Relevant Decision-Making in Counseling*, therapy ethicists Felicia Wilczenski, Rick Houser, and MaryAnna Ham explain that, " 'Feminine' " refers to a search for women's unique voice and advocates for an ethic of care. 'Feminist' refers to an argument against male domination and advocates for equal rights" (Wilczenski et al., 40). Here, we take up the feminine framing of these ethics, but also maintain the possibility for others to adopt them as well.

In his book, Slote outlines several ways that all can begin to embrace care. He says that:

> The overall difference in empathic tendencies between men and women might be due largely to differences in the way men and women have been raised, socialized, or educated. If empathy is primarily shaped by practices of child-rearing and socialization, then different practices could lead to men becoming much more empathic than they are, on the whole, nowadays. In particular, if we adopted a care-ethical approach to our social practices and institutions, we could encourage/educate everyone to be emphatically caring in relation to others, and male displays of emotion, nurturing, and altruism generally wouldn't be devalued or looked down on (by males) in the way they tend to be at present. (Slote 72)

This is a culture change that will take more time than is possible to teach to one generation of doctors. Yet change can be made in the near future by bringing care ethics into the medical school curriculum and into the practice of doctors. Furthermore, if Slote's predictions about the differences in levels of practice of care between the genders is accurate, then we would expect to see different interaction styles between male and female doctors, and that is indeed what we see.

Multiple studies corroborate that patients who are attended to by women have lower mortalities than those attended to by men. In sum, if there were only women doctors in the United States, 32,000 fewer patients would die each year (Tsugawa 2017, as cited in Alspach 2018). Researchers have explained this greater efficacy of treatment through some of the very same values emphasized by an ethics of care: "Patient-centered communication (including patients as partners in care and sharing some decision-making)," "Psychosocial counseling (asking more psychosocial questions, offering encouragement and reassurance)," and simply spending "More time with patients" (Alspach 2018). It's hard to say the exact reason for this difference in patient outcomes, but these values are indicative of the type of care we are discussing here.

Tronto, however, would be critical of such findings and their potential to point towards gender essentialism. Tronto argues that early care ethicists' work like Gilligan's dove-tails too nicely with "positive" stereotypes about women as: "less criminal, more nurturing, less likely to tell lies, and so forth" (Tronto 85). But these beliefs can clearly be harmful in that they relegate women to certain roles in society regardless of their desires: "It is still difficult to displace the notion that if women rather than men were involved in some spheres of live, then those spheres of live would change" (Tronto 85). We should keep these concerns in mind as we attempt to carve out a place in medicine for care ethics, making sure we do not simply reinforce stereotypes about women even if they are supposedly positive, as we run the risk of relegating the care labor within medicine to women doctors while men get off free, as has happened in so many other domains of society.

c. Fitting the Ethics of Care Into Medicine

One author, MD and internal medicinist William Branch, proposes various ways that medicine could enact an ethics of care. He argues that it boils down to changing medical ethics and medical education. In a study where he and colleagues analyzed over 200 critical-incident reports by 3rd-year medical students, Branch argues that young medical students come into the field with blossoming receptivity — empathy and compassion — even more intense than everyday people. This must be why they have chosen medicine. However, throughout medical education these budding doctors have this empathy slowly beaten out of them, as they are assimilated to a ward culture with quite different values.

Branch's take on introducing care ethics to medicine hinges centrally on maintaining what he calls the therapeutic relationship (aka the patient-doctor relationship). Branch sees this relationship as crucial, because without it, doctors are left with the possibility of blowing through an encounter with a troublesome patient in the name of respect for autonomy, even allowing them to sign out against medical advice. The ethics of care presents an alternative to this scape-goat line of thinking through putting the responsibility for the good care, not merely care that respects autonomy, on the doctor's shoulders:

> The ethics of caring tempers the application of the principle of autonomy by insisting that the physician seek a full and deep understanding of why the patient refuses treatment, and that he or she do this with sensitivity, attentiveness, honesty, and respect for the patient. The caring physician, while always respectful, also takes into account the patient as a vulnerable person, less knowledgeable than and dependent on his care providers. (Branch 2000, 129)

Branch had students run through a routine education scenario wherein they meet a homeless and diabetic man who returned to the hospital after receiving antibiotics for an infected foot, which was now gangrenous and needed to be amputated. The patient clearly and repeatedly refuses amputation, essentially implying a will to death. Branch notes that while several of the students attempted to utilize *principles* of medical ethics, negotiating the tension between beneficence and autonomy in this case, none of them attempted to understand where the patient was coming from or build a rapport. However, when the students are instructed to shift their focus onto maintaining the relationship with the patient, they are forced to negotiate alternative plans of treatment, such as starting with a therapy, with the future possibility of moving to an amputation if the patient doesn't get better.

Branch acknowledges a strikingly obvious, yet often unstated fact of medical care: doctors are always paternalistic to some degree. Because of their medical know-how, they present a set of choices to patients that has already been tailored and scrubbed of options that they know are simply not medically advisable for the case. The construct of autonomy is applied retroactively, and to discrete decision-points in the care process, when in reality the treatment plan is a constant pruning of options on the medical side, as well as shifts between care providers (Branch 2000).

Finally, the ethics of care challenges a core presupposition of the arrangement of medical practice: the divide between medical ethics and the *actual doing* of medicine. Right now, medical ethics domain deals with the moral questions of medicine, and medical practice deals with the rest in a supposedly value-neutral way. But the ethics of care, as a moral orientation, says that the entire domain of medical practice is subject to care, the moral value. Take, for example, the way that empathy is treated within medicine. Rather than being looked upon as a moral aspect of one's character to cultivate in order to better relate to one's patients, it is systematized and turned into another indicator of professionalism: "clinical empathy." Care ethicists would be skeptical of this professionalist manner of approaching ethics. As Tronto says,

> The care perspective suggests a more integrative approach to questions of ethics in general and in professions as well. Professional ethics should be about more than teaching professionals that it is wrong to lie, to cheat, and to steal. The guiding thought that ethical questions occur in a context should centrally inform professional ethics. (Tronto 134)

Care does not come divided neatly into different skills, but rather is developed as a whole package, reliant on context and one's moral character.

d. One Way of Actualizing Ethics of Care: Narrative Medicine

While the ethics of care has a strong base in our intuitions and presents many compatibilities with our natural systems of ethics that other ethical theories do not, it does suffer some from the fact that it isn’t quite directly prescriptive as those other theories. Because care is a moral orientation, not a mere moral code, it involves not just moral reasoning but also the ability to recognize moral problems, the prioritization of those problems, and the moral character exhibited in following those problems to resolution (Branch 2000). It is impossible to become a caring person merely through study, such a transition must also be accompanied by actions. Thus, it can help to have codified traditions that help to express the ethics of care in ways that are tailored to the discipline one is working in.

In our case, there is an emerging field with medicine known as “narrative medicine,” which involves physicians scrutinizing their patients’ histories as stories (Charon 2001). With attentiveness to small cues the patients and people around them give them off, as well as to traditional biometric measures, doctors can piece together the full story of the case. Narrative medicine builds empathy between the physician and the patient because it helps the physician know to some degree how the patient constructs the story of the illness in their mind, rather than merely the objective symptoms of the illness as noted in the textbook. As Charon says, “Along with scientific ability, physicians need the ability to listen to the narratives of the patient, grasp and honor their meanings, and be moved to act on the patient's behalf” (Charon 2001). What does this illness *mean* to the patient? By the current model, the doctor often approaches the patient with the presumption that they have something specific wrong with them, rather than coming to the table with an open mind, ready to fix whatever arises.

Narrative medicine says that we already naturally understand our lives as a set of stories, and illness is no different. Narrative is both how patients make sense of their illness, and how they share their potentially-isolating experience of illness with others (Charon 2001). If doctors can become more competent at piecing together the story of a patients' illness, both diagnostically and biopsychosocially, they stand to build firmer connections with those patients. Furthermore, narrative medicine can provide a sort of structure as one begins to put caring practices into work in their medical practice.

The existing medical ethics discourse is extensive and has benefited from input and growth for the better half of the last century. But there is room at the sidelines for a humanistic critique of the discipline, and it can naturally grow from this criticism. We don't have to pull up the roots of the principlist method and build from scratch; there is clearly much value with the existing code, but there is room for yet more growth towards a paradigm that emphasizes values of care and empathy alongside maintaining moral and professional standards in clinicians' work. Work by care ethicists can help physicians recognize their situatedness and interpersonal relationships, and become more attentive to the emotions of medical decision-making. What's more, nothing in medicine will trump genuine care -- concern for one's patient -- and obstacles to that care must be addressed by any medical ethics worth its salt. As renowned physician of his day William Peabody said, in response to the encroaching of scientific medicine upon the traditionally humanistic discipline: "The secret of the care for the patient is in caring for the patient" (Peabody, as quoted by Tauber 2005, 59).

VI. What does an Ideal Doctor-patient Relationship Look Like?

While up until this point, this project has mainly focused on outlining the ways in which doctor-patient relationships go astray, from here we will focus on developing a positive image of this relationship. This model will be centered on empathetic, attentive, and engaged care to counteract the detached care that is so present in medicine. That is not to say that we will burn bridges with existing medical ethics; principlism can largely be salvaged so long as it is complemented by a set of humanistic values. Principlism even has several strengths such as simplicity and memorability that could be translated to a new relational model to make it function better.

We will be paying particular attention to the demands of patients outlined in the last chapter, specifically the need for intimacy and true listening on the part of the physician. However, we can only call for so much on the part of individual physicians. Beyond this project, there is still the need for structural reform of the economic side of medicine such that physicians have time to interact with each of their patients long enough to build a connection, and so that patients can have affordable access to all medical products and services. When physicians are forced to meet heavy patient quotas, they are not able to devote their full resources to patients and their care. Thus, this chapter defines an ideal relationship that might not be achievable in many cases without systemic reform alongside it. However, this is also a strength of care ethics and this project. In some cases, medical principlism can function as merely a formula wherein the proper actions yield the ‘correct’ ethical result. The ethics of care, however, allows for perpetual growth towards an ethical ideal rather than the mere checking of boxes.

Here, we will focus on outlining positive moral values rather than limitations on physician activity as are present in current medical ethics. Such values can be fostered, but will not be attained overnight and thus need dedicated institutional support throughout medical school. They can also be taken up and advocated for explicitly by individual physicians to their mentees, as well as simply put into practice by practicing doctors. One of the problems that we will grapple with, however, is that the simplicity of modern medical ethics makes it easier for physicians to remember and stick to them.

Are we asking too much here from doctors by asking them to attain entirely new moral orientations? Perhaps not. Physicians are granted many benefits by society, including high salaries, prestige, and the privilege of having strangers open up about their most vulnerable aspects of their lives to them. Doctors are a guide to people in some of their most defenseless moments of their lives, as they pass through illness, health, and death. While doctors ought to share some traits with other caring professions, there are also immutable differences in status between medicine and fields like childcare, and social work, and those who are relegated to the domestic labor of care. It is reasonable to ask that physicians take up and hone these skills of relating to others, as well as taking responsibility for the charges they are assigned.

In this section, we will review several values physicians ought to attain. These values come from an underlying respect for the patient as another person, and also a recognition for their dependency in this time of illness. By laying out this new perspective after providing a brief review of the ethics of care, we can attain a model of medical care that is authentic but also tempered by the views of other scholars.

a. Listening

The first tenet of this new doctor-patient relationship is receptivity to another. Doctors must be open to receiving the facts of the patient’s illness as well as the broader context of their life. This is not simply a matter of listening to what the patient has to say verbally, but also reading the cues of their body, attending to the patient’s friends and family who are helping them through their illness, and being receptive emotionally to how the patient feels about their ailment. Many times, patients are not explicit with how this ailment connects to the rest of their life, and they rely on doctors to connect the dots between the medical malady they are currently encountering and its broader significance for what gives their life meaning. Illness may be codified in medical textbooks, but the way it presents itself in patients varies. When we multiply this with the unique factors at play in the patient’s life, we see the need for a detailed and delicate care plan.

Attentiveness is so important because the physician is often the only thread of concreteness linking a patient’s unstable and changing experience of illness to a powerful and secure body of medical practice. Sickness invites anxiety, and a doctor who hopes to calm their patient must be responsive to the patient’s many questions and concerns if they are to make the patient feel comfortable in this trying time. But medicine isn’t just about the illness and the insecurity around it. It’s also about wellness - the whole point of healing endeavors is to enable patients to again do what it is they love. In order to enable these avenues, physicians must open themselves to learning what those things are from patients. Thus, physicians must not only learn about the medical facts of the case, but also about the personal values at play in the patient’s life, if they are to resolve this particular illness for this particular patient.

In many ways, attentiveness is already baked into the medical encounter. The doctor explicitly undergoes the recording of a history of the patient’s illness, but they can easily probe a little further, pay attention throughout this process, and let the patient know that they are heard. If a doctor knows what their patient enjoys doing, that might help them to reframe the recovery process as a return to a more enjoyable state of existence; there’s no need to segregate illness from the rest of a patient’s life. This can make a world of difference.

This is not to say that doctors don’t currently listen to their patients — they clearly do on some level to achieve the level of healing that has been so praised by modern medicine — but there is also something left on the table. The problem of a lack of true listening originated with paternalists. Paternalism prioritized the physician’s perspective over the patients, to such a degree that the listening doctors did to patients was usually done in a patronizing fashion, not truly hearing what they had to say but instead just indulging what these doctors saw as child-like worry. Thus, doctors didn’t really think the patients were worthy participants in the medical decision-making process. This is not to say that paternalistic physicians weren’t genuinely sympathetic for the pain their patients were going through, just that while they might express genuine sympathy at their patient’s plight, they would not really deem a patient's contributions as worthy of factoring into their healing calculus. Thus, much valuable information about the patients lives that should’ve been factored into any medical decisions was left on the table.

A lack of listening is a significant problem in medicine, particularly when doctors assess womens' health. Recent research and exposés such as Maya Dusenbury's *Doing Harm: The Truth About How Bad Medicine and Lazy Science Leave Women Dismissed, Misdiagnosed, and Sick* show that women — particularly women of color — face severe discrimination by medical providers. Specifically, doctors often don't believe women when they come in with complaints of pain or even serious illness. Rather than making the effort to hear what they are saying and seek out a diagnosis, doctors often just label the condition "medically unexplained symptoms" (Dusenbury 78), and refuse to give them necessary tests or pain medication. Such problems result from a breakdown in listening on the part of the doctor.

This breakdown in listening is likely related to the medical education process. Young medical students learn that it is easier to block out attentiveness to the emotions of their patients so that they can preserve themselves under such stressful conditions. As we have seen, though this is a false premise that comes back to punish them later, it still happens, and we need to do something about it. So the first domino to fall must be simple listening to the patient. Listening to them when they talk about the details of their experience of illness, and validating their experience of suffering, but also paying attention to the details they give about the rest of their life and seeing how their illness factors into that. Listening is the predecessor for caring.

As we've seen, patients want physicians that will be receptive to what they have to say. The Wall Street Journal patient survey found that 84% of patients want a doctor who "Listens carefully to your health care concerns and questions" and who is "Is easy to talk to." These are clear calls for doctors to be more receptive to their patients. The former appeal is explicit, and the latter is easily met if a physician is willing to let the patient interject without having to dominate the conversation. The fact that these were two of the very-most-wanted needs by patients speaks to the current absence of listening in medical practice. On one hand, the blame for this lies with the vendor-relationship contemporary doctors have with their patients, but once again, we also run into a structural barrier here.

Taking time to listen to one's patient is at direct odds with the contemporary aim of health insurance corporations of producing the most efficient clinical response in the least amount of time. Some proponents of an empathetic approach to medicine would argue that this is a false dichotomy, and that listening actually saves time in the long run, as patients who are attended to properly have better health outcomes. This may or may not be true, but cannot base the principles for caring for our sick on efficient output. We choose listening not because it functions better mechanically, but because it better responds to the needs of the ill. We have seen the efficiency model of medicine close in on its goals in the last several decades, and all we have to show for it is ruptured relationships between patients and doctors. We must prioritize care over output if we are to have a medicine that allows doctors to fully attend to their patients, as patients desire.

b. Empathy

Listening comes hand-in-hand with the potential for resonance. While the confident battle-tested doctor reassuring the insecure patient is a positive vision of the doctor-patient relation, we can ask for more. When the patient learns that the one behind the stethoscope has also struggled, and can relate to the strife they're going through, then there is the basis for trust between the two. Then, the patient will be more willing to open up to their doctor. As we noted in the introduction, there is a consistent finding in the literature that patients want more empathetic doctors (Mercer et al., 2005). When doctors detach from their patients, empathy is the first thing to go. Here, we will define empathy as being able to put oneself in the shoes of another through imagination and relating one's past experiences.

Listening and empathy both play significant roles in the ethics of care, although they are part of a larger value of care itself, and there is a diversity of viewpoints when it comes to empathy in the ethics of care. Noddings valued a certain type of empathy present in the ethics of care called "engrossment," which is caring about another so deeply that one accesses a window to their reality, experiencing their thoughts, hopes, and dreams (Noddings 1984, as cited in Slote 12). Modern critiques have expanded on Noddings' work in important ways..

Noddings saw empathy as more of an emotional reflection than as the cognitive ability to put oneself in another's shoes. Recently, however, ethics of care scholar Michael Slote has argued that there is actually more value in so-called 'cognitive empathy' in the practice of care than was previously thought. He argues that as we develop more advanced structures of empathy, we can not only feel the emotions that others are visibly feeling, but we can also,

> for example, feel an acute empathic sadness on seeing a person we know to have terminal cancer boisterously enjoy himself in seeming or in actual ignorance of his own fatal condition… We learn to empathize not just with what a person is actually feeling, but with what they will feel or what they would feel, if we did certain things or certain things happened. (Slote 15)

This type of prognostic empathy is invaluable for physicians, as it allows them to deliver bad news in the most comforting way, or frame medical treatment plans in ways that will help the patient understand what their options are.

Slote also discusses the principle of autonomy in his book, explaining that empathy is more closely related to autonomy than we might think. For Slote, the discussion of autonomy boils down to the *respect* component of the "respect for patient autonomy" principle. Slote argues that behind disregard for autonomy is a lack of respect for the other, and behind that lack of respect is a lack of empathy:

> One shows respect for someone if, and only if, one exhibits appropriate empathic concern for them in one's dealings with them… It would appear that a morality of empathic caring requires one to respect other people's autonomy and not just or simply to be concerned with their welfare. (Slote 57)

Thus, Slote builds up a conception of autonomy from a kernel of empathy, of connection with another and understanding their needs and abilities, without attempting to constrain those abilities. This is a totally different way of approaching the notion of autonomy than the liberal formulation. Instead of starting from the outside, and viewing another as a sealed vessel of which autonomy is a barrier to entry, Slote says that we build genuine respect for autonomy from the bottom up; through coming to know another at a deep level and listening to them fully we are able to see what they truly want, respect those wants, and enable them to pursue them. "If it is wrong to treat people with disrespect, then… at the heart of that wrongdoing (or wronging) is a failure of empathy" (Slote 60). Slote's empathic care therefore yields autonomy as a byproduct. If we can aim for this in doctor-patient relationships, then we solve several issues. We can not only achieve the patient autonomy that is so touted by current medical ethics, but we can also build patient-doctor connections in the doing.

That being said, it is also important to recognize the emotional components of empathy. This is where researchers like Hojat et a. go astray. While their research into clinical empathy is valuable for showing what doctors are lacking, the solutions they offer up deify cognitive identity and segregate it from emotion. Their empathy is strictly differentiated from sympathy, which they define as an emotional attribute that involves feeling another's pain or suffering. They align empathy and sympathy with a reason-emotion dichotomy, and then only favor the former. This view negates the important component that emotion plays in care.

Ethics of care scholars would be more careful with this binary. While Hojat et. al make a valuable contribution in pointing out the decline in empathy throughout medical school, we should be wary of dividing the functions of physicians too neatly into emotional, innate, inefficacious *sympathy*, and cognitive, mutable, productive *empathy*. Instead, physicians ought to recognize and embody both the emotional and intellectual sides of relating to another. In some cases, they will have the personal experiences to be able to share emotions with patients, while in other cases they will have to rely on their capabilities of imagining themselves in their patient's shoes, or imagining how their patient might feel where an illness to play out a certain way.

Empathy is particularly valuable for physicians as it lets them understand the significance of their healing work through the patient's eyes. Healing is far more meaningful if doctors are able to connect the recovery to the patient being able to work towards their life-meaning. Learning about others' projects — their meaning that gets them up in the mornings — and then having the opportunity to enable them to reach that goal is a profoundly empowering thing, and something that can be achieved through empathizing with one’s patients. Thus, empathy can counteract the increased rates of burnouts seen in the medical profession in recent years. As Riess explains, there are two keys to preventing burnout: seeing one’s patients as individuals rather than sets of symptoms, and then seeing oneself as competent (Craiglow 2020). Empathetic care achieves both these objectives through allowing doctors to learn about the emotions of their particular patient, and through helping them recognize the profound power their work has for that patient.

Empathy in medicine is a thinly-balanced act, though. Slote also helps us to draw boundaries between where it is appropriate to express empathy and where one is crossing a line, as we searched for earlier in the case study of the student doctor grieving for her patient’s illness. Slote says that the line is crossed when the one-caring is so engaged with the other that they fail to be able to differentiate and attend to the other’s needs: “someone who is overinvolved with another person may have difficulty in separating their own needs and desires from those of the other, and this may mean they fail to respond empathically to what the other needs or wants” (Slote 57). He gives the example of parents who are so invested in their childrens’ success that they stifle their childrens’ own vision of what success might look like to them in favor of the parents’ vision so that they can live vicariously through the child. In contrast, a healthy parenting style involves respecting one’s children and thus realizing that they might want different things for their lives than their parents do. While we must be cautious not to replicate paternalistic relational styles in our new ethics, we can recognize the value of empathy in the doctor-patient relationship to let another see what is best for themselves, much more so when they are equals and not children.

c. Responsibility

Only once a doctor has attentively listened to their patient — and understood on some cognitive and emotional level the experience their patient is going through — are they ready to make a decision about medical care. This is where the engaged aspect of care comes in. Physicians ought to take an active stand on the way to deal with the health matter confronting the patient. That might not seem like a bold claim, but as we've seen, modern physicians have begun to shy away from vouching for a particular path of medical treatment. However, because our physicians practicing engaged care already have skin in the game, this likely won't be as much of a problem as it is for current physicians, who don't go out of their way to learn about their patients. Many medical ethicists hear the sound of active advocacy of one of the means at the disposal of the physician, and automatically assume that that represents a return to paternalism. This does not have to be the case. Instead, there is a middle ground where doctors can advocate a certain treatment without enforcing it. In contrast to the days of paternalism, because we now have the useful protections of autonomy, physicians are able to stake out a claim about their clinical guidance for the patient, without making the patient follow that guidance if they don't want to.

This active advocacy of a position through both knowledge and experience – or clinical judgement -- resolves some of the tension between patients wanting more guidance from their doctors that we observed in Sinding et al.'s study. Patients will no longer be put in the awkward place of having to semantically trick doctors into admitting what they would do if it was their own health at risk. Instead, doctors will be forthfront with their preferred plan of action, and it is up to patients if they want to debate that plan or go with another. The default is the physician’s plan, though, so patients who are already overwhelmed by the experience of illness and suffering have a simple option for their medical care without having to come up with their own plan or prod one out of their doctor.

The most important tenet of achieving engaged care is two-way communication between the doctor and the patient. That is why the physician must set the groundwork of listening and understanding their patient’s situation before prescribing a treatment. At that point, this responsibility for the patient’s suffering will be a natural byproduct of learning about a patient’s life and actually coming to care for them and about what happens to them.

It is important that we do not regress to paternalism, so the ultimate say in responding to such decisions must be the patients. They cannot be forced or coerced into responding a particular way. One might argue that simply advocating for a line of treatment will put pressure on a patient to adopt that line, but this is in fact the entire point of the medical encounter. To encounter a patient, learn about their ailment, values, and potential treatments, then to suggest one to them. Patients come to doctors for guidance, not for detached concern.

Of course, in some cases patients want to fully handle their illness on their own, and that’s fine. This is where attentive listening is key: patients will make clear the level of involvement that they want in their life. Some patients want full support and guidance from their physician, others have things under control and just want their physician there to prescribe medications and get on with their day. Relational styles anywhere on this spectrum are fine, but doctors must be willing to take responsibility when the patient wants them to. Right now, many patients' appeals for guidance go unanswered in the name of "hands off the patient."

Here, we have outlined three values to focus on to make the doctor-patient relationship more conducive to trust and more responsive to patients' appeals. Putting this chapter together with the prior, we began to develop here a "voice of care" that could complement the "voice of justice" that is prevalent in medicine. As we move forward, we will balance a vision of the ethics of care against potential criticisms from other sources.

VII. Potential Shortcomings of an Ethics of Care in Medicine

In the previous chapters, we looked at caring ways that doctors can relate to their patients in an effort to supplement existing medical ethics. However, the process outlined is not infallible, and there are several criticisms that can be leveled at this model of care in this doctor-patient relationship. Thus, in this chapter we shall examine four potential drawbacks of the application of an ethics of care in medicine, and ways to overcome those obstacles.

First, we will look at one of the more troubling findings we have come across, and the elephant in the room when dealing with any dimension of healthcare in the United States - the economics of medical insurance. As stated earlier, if patients don't have access to health insurance whatsoever, there is no room to build a foundation for a caring patient-doctor relationship. Secondly, some feminists argue that doctors are still struggling to fully embrace patient autonomy, so it is premature to move past autonomy as a guiding principle of medical ethics. Feminist scholars such as Susan Sherwin argue that physicians have not yet demonstrated that they can treat patients without discrimination without the shield of autonomy corralling them to do so. Thirdly, we will examine an argument by some ethics of care scholars, particularly Eva Kittay, that doctors and other professionals aren't actually engaging in dependency work. While they are "caring" for patients, Kittay argues that they do not adopt the same role as less statused jobs, such as nursing (Kittay 39). Finally, we will review one of the main defenses of existing medical ethics against more holistic ethical schools: the simplicity of principles. One of the main appeals of a deontological set of ethics is that it comes in simple packaging, and for medical professionals who already have to spend years upon years in intensive scientific and clinical education, providing an ethical code that doesn't require much work or reflection is a tempting offer.

a. Economics

So far, we have mainly focused on the individual in remedying the doctor-patient relationship. This approach has its strengths, after all, care ethics is defined by its focus on the particular relationships in one's life. With this focus, we can best give advice to individual doctors on how they ought to relate to particular patients they are actually practicing medicine on. However, by focusing on the individual, there is necessarily less light shone on the structures behind why doctor-patient relationships are so poor, namely, the health insurance structures providing healthcare to some but certainly not adequate care to all.

Throughout the preceding chapters we have seen the manifold ways through which a lack of reasonable healthcare strains doctor-patient relationships. In 3d, we saw that physicians are being pigeonholed into more and more "professional" roles by their contracts, so that they come to be less healer and more provider of services, with their patients as customers. In 3e, we found that insurance networks are often forced to overpromise services in order to make themselves competitive, and then physicians take the fall when they are not able to deliver these services to patients. A model of physician as provider of a good also neatly aligns with the autonomy-based medical principlism that we've identified as a barrier to good medical care. Thus, in chapter four, we saw that the mechanism through which physicians build up resistance to connecting with patients starts with overbearing economic pressures. Pressures on the health industry to increase output lead young medical students to accept hefty workloads during their training, and in response to these workloads the students often shut down and stop responding to their patients desire for emotional connection. Clearly, economic factors explain a large part of why it is so hard for doctors to build relationships with their patients. Furthermore, it *is* more important that we get medical treatment to patients in the first place than that that treatment is guided by the principles of care.

With all that said, this paper still focuses on relationships between individuals. The reasoning for not focusing on such economic factors is that while they are extremely important, they have already been studied in depth, and in recent years have been brought into the public eye for critical examination. The push for a single-payer healthcare system in the United States such as Medicare for All is increasingly popular (Jones 2020). Bringing more care into medicine, on the other hand, has not been brought to the limelight in anywhere near the same capacity, despite the fact that patients overwhelmingly want a turn to a more compassionate style of care from their doctors (Bright for the Wall Street Journal 2004, Mercer et al. 2005).

Thus, while care might be a secondary goal overall to reforming the economics of healthcare in the United States, it is also an important objective in its own right. We have examined several perspectives for balancing personal and structural changes to enable care in medicine - one being that simply reforming health insurance overnight would not resolve the entrenched patterns of lack of care among physicians for their patients. A more mature perspective, though, dictates that reforms in health insurance will work symbiotically with a turn to more caring doctor-patient relationships. Transitioning to a more accessible model of health insurance will provide physicians with the material resources to care for their patients, and prioritizing a perspective of care is a valuable precursor to achieving reforms in healthcare; in many ways it is a lack of compassion in favor of profit-seeking that has landed us in this messy medical-insurance situation in the first place. The original work here relies on connecting the dots between these economic factors that affect medicine at large and the manner of practice of individual doctors with their patients.

b. Sexism in Medicine

A point that we have argued, alongside those such as Tauber (Tauber 2005, 59-60) and Qualtere-Burcher (Qualtere-Burcher 2011, 51), is that medical ethics put too much weight on autonomy. Our medical ethics cannot just be a defense against the specter of paternalism. Yet one point that some feminists make in response to this claim is that paternalism is alive and well — particularly when it comes to doctors treating female patients — and we still need safeguards such as explicit protection of autonomy at every turn of the road. One of the foremost authors who espouses this view is Susan Sherwin. Sherwin agrees with some humanistic critiques of modern medicine, such as that it has too much of an emphasis on science. She claims that an effect of the role of physician-as-scientist is that doctors no longer taking their patients as "complex, integrated human beings," (Sherwin 1992, 145-48) which we have certainly found ground for throughout this paper. However, she also argues that the alternative to this model, of doctors treating medicine as more of an art, just means that those doctors will be exerting personal authority over their patients instead of institutional authority. Either way, doctors are susceptible to the urge to control their patients. The problem in Sherwin's eyes is not that doctors take too little responsibility for their patients, but too much. To this end, Sherwin actually warns against patients having too much trust in their physicians, because it opens the door for manipulation (Sherwin 1992, 155). Sherwin says that doctors should yield to their patients' (autonomous) decisions, only offering information rather than judgement.

Sherwin's critique of care within medicine speaks to a larger discourse within feminist ethics about whether care can be salvaged from discrimination against women or must be done away with. Kathryn Norlock says of this discourse: "[these] criticisms tend to proceed from a view that it is problematic that an ethic of care is predicated on seeing femininity as valuable" (Norlock 2019). Some critics of the ethics of care have accused it of glorifying the gender roles feminists have been fighting so hard to free themselves from[6]. Others have worried that it opens up caregivers to exploitation[7], and that it can become an insular ethics if care is only relegated to those with whom one has connections as forged on certain material and political realities[8]. These criticisms hinge on the notion of whether or not we ought to see femininity as valuable; they suggest that we might want to doubt the value of femininity (Norlock 2019). The ultimate question, then, is whether the very construct of feminine ethics is oppressive by nature, or if it can stand on its own two feet as an authentic contributor to ethical discussion that corrects or overrides the faults of ethics of justice.

There is also anecdotal and empirical gravity behind Sherwin's concerns, as pointed to in Dusenbury's account of medical gaslighting referenced earlier. In this paper, we call for more responsibility on the part of physicians. However, this work

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[6] Card 1996, as cited in Norlock 2019

[7] Houston 1990; Card 1990; Davion 1993, as cited in Norlock 2019

[8] Hoagland 1990, as cited in Norlock 2019

raises the question of whether doctors are really ready to handle the responsibility of providing good care without discrimination.

How do we resolve this tension between calling for more caring responsibility on the part of the physician and fighting sexism within medicine? Qualtere-Burcher gives a somewhat convincing answer. In reviewing Sherwin's claims, he agrees with her that physicians have often disregarded patients' concerns, but he thinks the blame for this lies with simple time and financial constraints, less nefarious than a thirst for dominance that Sherwin attributes to them (Qualtere-Burcher 2008, 23). I agree with Qualtere-Burcher in this sentiment.

However, Qualtere-Burcher goes on to make a more polarizing claim when allocating the blame for discrimination within medicine. Rather than faulting their individual interaction style, as Sherwin does, he blames their lack of support for institutional reform to fight sexism and other reforms within medicine:

> Physicians have been slow to take up progressive causes such as universal health care, because they fear the impact of such reforms on their income and status. If physicians are to regain some modicum of trust from critics such as Sherwin, they will need to be more politically progresswive and truly champion the causes of the oppressed and underserved, whether this arises from gender, race or class. Physicians will not regain trust at an individual level; it must be as a profession. (Qualtere-Burcher 23, 2008)

Institutional reform is certainly important; as we discussed in the last section, an increase in a caring style of medical practice fits right alongside a change in the systemic barriers to health care. What's more, doctors have significant political leverage and could be the ones to move the needle on these types of issues. However, this is far from a perfect resolution. It seems too neat of a solution to simply divide up the different aspects of feminism within medicine, granting individual doctors the positives of care while placing the blame for discrimination on institutions. It feels too much as though we are letting doctors off the hook so long as they pay lip service to certain political causes.

Ultimately, the best defense of integrating an ethics of care into medicine may simply be the demand and necessity for care as central to the therapeutic relationship between doctor and patient, and the inaccuracy of full autonomy for describing our life-situations. If we are going to embrace this aspect of feminist ethics within medicine, however, it is disingenuous to turn a blind eye to the discrimination that goes on within medicine towards women. We cannot have feminine ethics without feminist ethics as well. Doctors who take up the mantle of care must also take up the mantle of anti-discrimination alongside it, not just through their calls for political reform but also through their own individual lives and practices. Doctors must actively engage with liberatory movements, and particularly become aware of the historical and continued discrimination against women and people of color in medicine -- for example, in research and in the problem of gaslighting patients who do not present with readily-diagnosable symptoms -- so as to avoid these faults.

c. Caring Isn't the Doctor's Job

One challenge that has been posed to the inclusion of doctors into an ethics of care is that their social status privileges them in ways that traditional care workers do not benefit from. Thus, the ethics of care categorically cannot be applied to their situation. Because of this view, care has been more typically associated with nursing than with medicine. Furthermore, nurses' work is neither remunerated monetarily nor through social status in the way that that of doctors is. This lack of societal value mirrors much of the work that care ethicists speak about, including the unpaid labor of parenting.

Some care ethicists, like Eva Kittay, argue that only nurses and other similarly-devalued workers such as childcare workers ought to be included in her category of “dependency work.” She explicitly disavows the idea of physicians and other professionals being considered as doing dependency work: “The patient’s well-being, even her life, is dependent on her physician… Still, these professional services are not dependency work, even in the extended sense” (Kittay 38). While doctors do put the well-being of another as a priority, unlike most care workers, they accrue significant societal benefits from this sacrifice: “The potential self-effacement of the other-directed character of professional work is offset by the autonomy, detachment, and achievement accorded to the professional” (Kittay 39). For Kittay, dependency work is associated with a low status in society while medicine is not. Thus, it seems we are at an impasse.

This is how care has historically played out in medicine, neatly broken down with nursing being characterized as the ‘caring’ side of healing and medicine as the ‘curing’ side. Such a binary is reflected in the often gender-coded job roles and manners of interaction of doctors, nurses, and other health professions. One can easily imagine the brisk, business-like doctor meeting with a patient to “tell it to them straight” about their condition, followed up by the gentler, caring nurse to tend to the emotions of the patient. As gender stigma breaks down, however, with men making inroads to nursing (Egan 2021) and women to medicine -- women composed a majority of medical students for the first time in 2019 (Boyle 2019) -- we need to transcend such binaries. While it’s true that doctors have specialized knowledge and thus more responsibility for the medical conditions of their patients, and a lot on their plate, there is no reason for the caring side of illness to be relegated entirely to other health professions. Doctors can take up the orientation of care, as they are the touchpoint for determining decisions with patients. And expanding the ethics of care to doctors is ultimately in the best interest of their patients as well.

d. Simplicity

A large part of the defense of existing medical ethics hinges on the simplicity with which doctors can learn and remember them, in order to apply to their medical practice. And as we learned when reviewing the history of medicine, patient autonomy is vastly superior to the alternative of physician paternalism. The ideal of autonomy and like principles have several benefits in that they are simply rules that doctors can easily remember and put into practice in their clinic. If our work is to stick, we must translate some of these more intricate ethical analyses into similarly easily digestible and actionable steps. That is the strength of principlism, and hopefully we can work off that strength to translate some of the insights gleaned here to new principles. This is largely why this project focuses on just a few values[9], and ones that physicians already practice to some degree. By making these values explicit and prioritizing them alongside the existing principles of medical ethics, the clinical encounter can be strengthened and the doctor-patient relationship can reach its true potential.

As we engage in this new ethical project, we keep Beauchamp and Childress' principles of Autonomy, Beneficence, Non-maleficence, and Respect for persons close

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[9] Integrating other values into medical ethics in the approach discussed here could be an avenue for future research

at hand. These principles serve as appropriate limitations and barriers that the physician must not cross. Beneficence in particular is representative of the engaged, caring approach we've outlined here. So in many ways, we are only advocating for a more balanced application of these principles, instead of one focused primarily on the principle of respect for autonomy.

Furthermore, in this mosaic of existing medical rules and novel medical values that we are constructing, there is more cohesion than might be expected. For example, responding to patients' demands is a more accurate reflection of respect for patient autonomy than is leaving them isolated to deal with the clinical encounter and decision-making process alone. If patients are asking for more engaged listening from their physicians, it is only appropriate by the logic of respect for patient autonomy that those physicians answer the appeals of their patients. Fundamentally, there is a false dichotomy between Beauchamp and Childress' principles of respect for patient autonomy and beneficence. Patient autonomy, when properly exercised instead of in a flattened and prescribed manner, involves doctors sharing their knowledge and guidance with their patients. Clearly, patients want what is best for them, which is why they come to doctors in the first place, rather than toughing out their illness on their own where they'd have perfect autonomy. Through this project we have come to establish a more mature version of autonomy, that is enabled through respect and trust rather than being a surface-level defense mechanism.

There are certainly still criticisms to be made of this project, but we have integrated several of the main points here. Economic factors, while an important explaining factor here, have had their time in the limelight whereas care has not. While it is true that medicine has been responsible for much discrimination amongst marginalized groups, the ethics of care presents such value to the doctor-patient relationship that medical ethics would be remiss not to integrate it to some degree, even by a profession that would not be traditionally considered as engaging in caring labor such as doctors. As far as simplicity goes, we have found some success in translating the ethics of care into simple values. However, it is also important to remember that one of the very strengths of care ethics is that it does not attempt to reduce human relations to something they are not, and therefore it may well have more complexity than simple principles meant to stand in all cases.

VIII. Conclusion

In this project, we set out to determine how doctors can best relate to their patients, with the help of the school of the ethics of care. We've learned a lot along the way, and here we will take a little time to dissect those findings. Most importantly, we entered this project with a hypothesis that the ethics of care would benefit the doctor-patient relationship, and that has largely proved true. Furthermore, we learned through doing this project that the ethics of care is particularly tailored to the shortcomings of that relationship. Through combining the ethics of care with existing medical ethics, we can achieve a new set of more comprehensive medical ethics. This new ethics would not only teach doctors how to protect their patients, but also positive interaction styles, and wouldn't give them an easy way out of figuring out the patient's problems and how those interact with the rest of their life.

One of the most important lessons learned is that the economics of healthcare and the personal relationship between individual doctors and their patients are inextricably linked. In the beginning of this project, it was unclear whether to focus more on the individual relationships held between doctors and their patients or the relationship between medicine and the public at large. Both approaches were present in the literature, but ultimately the vast majority of this piece centered on that of individual patient-doctor relationships. We had to sacrifice that larger lens of analysis in order to focus the project. We did, at times, however, talk about the public trust or opinion (and lack thereof) in the medical profession and doctors as a whole.

Looking at the systematic factors involved in medical training did show not to place the blame on the physician. This leads to one of the most important insights that this project yielded - there is a surprisingly direct connection between the personal interaction style within a doctor and their patient and the economic factors of medicine at large. Much research has examined the lack of health insurance in America and its repercussions for those in poverty, as well as marginalized groups. There has been a little work in more humanistic medical ethics. But a unique motif that we saw throughout this project was the link between the two: doctors train and work under intense pressure to go through more patients in less and less time, which is an intrinsic barrier to being able to care for all of their patients. Once again, the connection between justice and care arises.

This leads to this project's important implications for physician burnout, an unexpected finding. One would assume that most of the benefits of a caring doctor would accrue on the side of the patient. However, as is typical of an ethical school such as the ethics of care that emphasizes gestalt over individuals, this new style of ethics actually ends up benefiting both parties. It clearly meets the demands of patients, as seen from multiple empirical measures that patients want a more engaged and thoughtful style from their doctors and their relationships. It also meets the needs of burnt-out doctors, though. At first, this may seem counter-intuitive, as the last thing that doctors who are already burnt-out in their practice would want to do is spend even more time in that practice. However, we can come to characterize burn-out and other similar disaffections with a lack of empathy rather than an overabundance of empathy. A doctor burns out when they stop caring, not when they care too much. Thus, the ethics of care can outline a way that doctors can counteract the overwhelming pressures of their jobs.

Granted, this is a band aid solution. In the long term, the health system must be reformed to be able to relieve physicians from these pressures in the first place.

We were unable to fully reconcile feminist and "feminine" ethics in medicine. Future work could help to delineate the differences between these two domains of feminist philosophy more, and see how they might integrate into medical practice. There is a fundamental tension when attempting to put into place the ethics of care in a profession that historically and currently continues to discriminate against women, as though doctors haven't earned the trust to be able to exercise caring medicine, that they must first demonstrate that they can practice medicine without discrimination.

There is also the hard project of putting this research into practice. Medicine is currently dominated by a single school and set of principles of medical ethics. Only the medical ethicists themselves are the ones who know the diversity of thought in the field. Doctors are merely taught one set of rules to follow. This is unhealthy because a diversity of ethical views is necessary in such an important venture as medicine. For that reason, future doctors and medical ethicists must collaborate to bring more viewpoints to the table. Clearly, a primary way through which care ethics will achieve popularity and widespread application in medicine is through education. Many medical students are taught entire classes based around Beauchamp and Childress' ethical principles, and there's no reason that they couldn't have a similar type of education about the ethics of care. Yet there is the tension of prescribing something as intricate and case-dependent as the ethics of care on an institutional level, a fear that the nuance and the emotional valence will be lost. Future research into teaching the ethics of care can help to explore such educational avenues in medicine without routinizing it as merely another check-box on the clinical checklist.

Finally, there is autonomy to deal with. Medical ethics cannot just be defensive against wrong-doing, it must also have a positive dimension of doing good by the patient. The ethics of care can provide this in spades, as it is all about taking on responsibility rather than doing the bare minimum. In truth, that is the core of medicine. Doctors should not be able to get by in medical practice just by giving their patients treatment options, they ought to take an active stake in their patients' care and advocate particular treatments. This will ultimately strengthen the bond between doctors and patients, both on the level of individuals and in society at large. If patients know that doctors are there not just to apply scientific knowledge as a researcher might, but also to care for them as a person, as a healer, then that can begin to remediate the many wrongs done by medicine throughout its history.

This project comes at a time when the public eye has shifted to the medical community, for good and bad reasons. For one, doctors, nurses, and the like have risen to the occasion to fight the coronavirus pandemic. In doing so, they have demonstrated the responsibility advocated here - acting selflessly in a time when the country was in desperate need of care. However, there is also increased scrutiny on the medical community, as vast health disparities between black and white Americans are brought to light and exacerbated during the pandemic. Many hospitals and medical professionals have sworn to do better in the light of these realities, but it remains to be seen how seriously they will take these commitments. Furthermore, an initial mistrust of the Covid vaccine among minority communities calls back to medical experimentation that has repeatedly exploited these groups, such as the Tuskegee Syphilis study. The doctor-patient relationship between society at large and the medical community is coming to terms with its past. Thus, this moment serves both as a chance to reflect on what responsibility and care can look like in the best of cases, but also a chance for sustained reflection on what we can do better.

What's left to do to apply the ethics of care to the practice of medicine? In truth, we have only begun to outline how a doctor-patient relationship might look when guided under the ethics of care. That's a good thing, though. The ethics of care is characterized by its flexibility to circumstance, not being codified. Therefore, if there is only one image offered here, then it is because there is no overbearing, top-down mandate of how care ought to be. Besides, many of the doctors we have referenced here — Paul Qualtere-Burcher, Alfred Tauber, Rita Charon, William Branch — are practicing or have practiced medicine in their own right, and much of the work of discovering how best to care for another comes about through practice, rather than writing about it. That's why I'm excited to put these ideas into work in my own career in medicine. Combining practice and theory, weaving a thread of responsibility that grounds the patient with the certainty of science-based medicine yet lets them know there is also a person on the other side of the table, that is the essence of the project that we have just outlined.

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