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Abstract

The aim of this article is to investigate the concept of care in contemporary medical practice and medical ethics. Although care has been hailed throughout the centuries as a crucial ideal in medical practice and as an honourable virtue to be observed in codes of medical ethics, I argue that contemporary medicine and medical ethics suffer from the lack of a theoretically sustainable concept of care and then discuss possible reasons that may help to explain this absence. I draw on the empirical studies of Carol Gilligan on care and connectedness as ontologically situated realities in human life. Based on a philosophical elaboration of her findings on the ethics of care emphasizing relationality, I try to show how the notion of 'relational ontology' originating from this stream of thought may be of help in developing a medical ethics that acknowledges care as a perspective to be observed in all interactions between physicians and patients.

Keywords

care, doctor–patient relationship, ethics of care, medical ethics

Introduction

The ethics of care has exerted an influence in the areas of health care ethics related to nursing; however, it has not wielded the same type of influence within the theoretical frameworks on which physicians mainly rely for their ethical reflection. This is the case even though the concept of care has a long historical tradition within medicine.¹ Thus, whereas care may feature a great deal in the literature of nursing ethics,^{2–4} it is still situated at the margins of much of the ethical thinking in medicine.^{1,5,6} However, there is an ongoing transition in the medical ethical landscape, by which the feasibility of an ethics of care in relation to medical ethics is recognized,^{7–10} and in this article I aim to facilitate this transition even further, exploring the theoretical potential of an ethics of care within medical practices and in relation to the doctor–patient relationship.

My aim is to illustrate how the inclusion of care as a core concept in medical ethical terminology may influence how we perceive, interpret and evaluate situations in medical practice. I point to an ethical challenge that is seldom discussed in medical ethics, namely, the harm to which patients may be exposed owing to a lack of care in the clinical encounter. First, I focus on the ontological features of an ethics of care, taking the notion of relational ontology as my point of departure.^{11–13} I then discuss this important dimension of an ethics of care in relation to what we may denote as the modern ideal of detachment in medicine,¹⁴ and I argue that this ideal may represent an obstacle to making sense of care in medicine, leading to situations in which

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patients are ‘harmed in the absence of care’. Finally, I discuss the ethics of care in relation to the traditional perspectives of care in medicine, and I suggest that medicine, in order to revitalize its ideals and practices of care, needs to implement the important dimension of the relational ontology characteristic of an ethics of care. I now illustrate these points with a case study.

Communication or care?

Martin, a 49-year-old man, has suffered from a severe headache for over a week and is admitted to the hospital for further examinations. The neurologist at the hospital visits the patient late one night and informs him that the MRI scan of his head shows a highly malignant brain tumour. He further informs the patient that operating on the tumour is impossible, and that the patient’s only hope is a few months’ survival while receiving an adjuvant therapy. After informing the patient of this tragic news, the neurologist asks if the patient has any questions and then promptly leaves, leaving the patient alone. ‘I was completely numb and had nothing to say,’ the patient later states, ‘and then the doctor left, leaving me alone the whole night with chaos in my body.’¹⁵

I take this example from an article entitled ‘Barbaric communication’ written by Edvin Schei,¹⁵ a Norwegian general practitioner and professor of medicine. As the title indicates, Schei is concerned about physicians’ communication skills. ‘Why do physicians not practice the art of talking to patients?’ he asks. ‘How can physicians develop routines where they plainly throw an unprepared person into ice water with the words “incurable brain cancer”, thereafter leaving without offering any kind of support?’ Schei then uses the expression ‘information infringement’ to describe the neurologist’s behaviour. To improve the situation, he calls for more communication training in medical schools. In fact, he claims, ‘All physicians have to manage the basic principles for empowering dialogue. Good communication is based on skills that can be taught. Training in communication skills must be made mandatory in all medical education.’

I share the worries about the overall quality of the doctor–patient relationship. However, I do not agree that communication and better communication skills represent the main solution to this problem. A tendency exists within medicine to reduce many of the problems related to the interaction between physicians and patients to a lack of communication skills. However, what the neurologist in this case failed to accomplish was not to communicate, but to connect with the patient, and to recognize the needs of this man who had just received his death sentence. This reflects important ontological and epistemological implications of an ethics of care, pointing to its model of moral agency, which focuses on the self as related and basically connected to others, as well as its emphasis on moral attentiveness and contextual sensitivity in relation to how we gain relevant knowledge required for acting morally. Accordingly, to deal more effectively with these restrictions in the interaction between physicians and patients, I suggest that we bring an ethics of care perspective into the medical ethical discourse. It should be pointed out, however, that the divide between care and communication may not be as sharp as I indicate here. However, in medicine and medical ethics they refer to different theoretical discourses, and my quest for care instead of communication thus reflects the ambition of introducing the conceptual framework of an ethics of care into medicine and medical ethics.

The ethics of care perspective

Today there is no clear cut definition of the term ‘care’; nor is there any close agreement on what we should take its meaning to be.¹³ Care can be understood as a way of acting and responding towards another, as an attitude, a moral virtue, an ideal or value, and as a relational competence and activity. Following Tronto,¹⁶ care may be conceived as consisting of four phases: caring about, taking care of, caregiving, and care

receiving. In relation to medicine and health care, it may also be useful to distinguish between 'taking care of' and 'caring for,' where 'taking care of' refers to physicians' delivery of technical care, and 'caring for' includes an empathic or emotional engagement.^{17,18} Care in medicine, in the meaning of caring for patients, is often recognized as a virtue,^{19–21} while it is at the same time equated with the principle of beneficence.²⁰ Cluff and Binstock suggest that the notion of caring in medicine and health care may refer to:

[the] humane and palliative aspects of health care, [comprising] a wide range of responses to human vulnerability, frailty, pain, and suffering. Many words can be used to describe its elements – compassion, comfort, empathy, sympathy, kindness, tenderness, listening, support, and being there. Caring can range from very active efforts to relatively passive attentiveness. Its unifying essence, however, is concern for and responsiveness to the needs and worth of the person receiving it (p.1).²²

This view is in accordance with the understanding of care as a virtue in medicine by its focus on individual dispositions like compassion, empathy, kindness, etc. However, by pointing to care as an 'active effort', it also embraces care as practice. As Cluff and Binstock, I do not restrict myself to considering care as a virtue; I rather aim to implement an understanding of care as a relational activity or competence, thus emphasizing the relational dimension of care.

An ethics of care puts a focus on care in relationships, and was initiated by the influential book *In a different voice* by the American psychologist, Carol Gilligan.²³ By studying girls' moral reasoning, Gilligan identified another moral voice that focused on caring for others in interpersonal relationships as the main moral concern. Based on her empirical findings, Gilligan articulated a moral perspective that challenged traditional moral philosophy and its failure to include care in interpersonal relationships as part of a moral life. However, her perspective is psychological, not philosophical, focusing on moral development in children, and, therefore, it may not be regarded as a fully-fledged theory of ethics. The theoretical foundations of an ethics of care have thus been widely developed and refined since the publication of Gilligan's seminal study, and it has exerted influence within different theoretical contexts while drawing inspiration from various theoretical positions. In this article I take the position of Gilligan and the philosophical contributions to the theory offered by Tove Pettersen^{11,12} and Virginia Held¹³ as my main point of departure for discussing the potentials of an ethics of care perspective in medicine. Being curious of how the understanding of the moral agent in an ethics of care, 'the related self', relates to the understanding of the moral agent in medicine and medical ethics, I choose to focus on the ontological features of an ethics of care.

The related self

The assumption of human connectedness and dependency is fundamental in Gilligan's theory. Based on her background as a developmental psychologist, she focuses on the importance of relationships in the maturation process of children. We are all dependent on relationships to mature and grow; thus, interdependency is a common human experience. This assumption of human connectedness and dependency constitutes a central ontological feature in Gilligan's theory and is part of what Pettersen denotes as 'relational ontology'.¹¹ The self is thus a related self, 'already, and essentially, immersed in a web of convivial responsibilities'.²⁴ This is not easily or intuitively recognized in an ethical climate where autonomy is emphasized to the point of tending to exclude all other aspects. Thus, the relational ontology of an ethics of care differs from utilitarian and deontological views of the human being and the human situation. Whereas deontological and consequentialist moral theories (of which Kantian moral theory and utilitarianism are the leading examples) focus their attention on the rational decisions of agents assumed to be independent, autonomous individuals, an ethics of care conceptualizes human beings as affected by, and involved in, relations to others.¹³ Virtue theory may also be said to focus on individual persons and their dispositions, but how does an understanding of the

related self comply with the perceptions prevalent in medicine and in medical ethics? What understanding of the moral agent is inherent within the field of medicine and medical ethics? To explore this problem further, I will investigate what we may denote as the modern ideal of detachment in medicine,¹⁴ and I identify the ontological implications of such an ideal. I also point to how the prevailing norm of autonomy in medical ethics may lead to a practice of non-interference with regard to how physicians care for their patients. Subsequently, I relate these insights to the prevailing understanding of care in medicine.

The ideal of detachment in medicine

Detached concern

In her book, *From detached concern to empathy*, Jodi Halpern points to the modern ideal of detachment in medicine,¹⁴ an ideal she perceives as originating from the development and cultivation of the ideal of detached concern and objectivity in medicine. The term ‘detached concern’ was first introduced by Howard Lief and Renée Fox.²⁵ In their influential study they describe the programme or process that medical students are taught to go through in order to detach themselves from emotional involvement with patients. The ideal of detachment, however, came into medicine at an earlier stage, and may be traced back to the development of medicine as a science, and to the start of using technical instruments in the diagnostic process. By the introduction of the stethoscope at the beginning of the nineteenth century, for example, physicians started to put less weight on patients’ narration and their own subjective understanding of patients’ condition, leading to an objectification of disease, as well as of the doctor–patient relationship.^{26,27}

Free of situatedness?

Neutrality towards patients’ and physicians’ emotional state represents an important element in the tradition of detached concern in medicine.^{28–30} Extending the ideal of objectivity into the emotional realm may be said to build on two assumptions. Halpern says, ‘First, that a physician can be free of bias, that is free of his situatedness,’ and ‘second ... that a patient’s emotions are best observed from a neutral physician’s perspective’.¹⁴ Halpern makes an interesting observation by pointing to the assumption that physicians need to be ‘free of [their] situatedness’ to be able objectively to obtain access to the emotional lives of patients. This assumption has an important ontological implication, namely that physicians should be separated from personal, situational and relational clues when interacting with patients. Thus, by following the ideal of ‘detached concern’ physicians must endeavour to remain separate from patients and the problems they exhibit. Consequently, in a model of detached concern, patients and professionals remain two ‘separate parties’;³¹ they emerge as separated selves. Thus, we may trace an ontology of separatedness underlying the ideal of detachment and non-interference in medicine.

Autonomy and non-interference

The separatedness of physicians and patients may also be considered as a possible ‘adverse effect’ of the prominent role attributed to autonomy in medicine. One of the most influential theoretical frameworks within medical ethics is the four principles approach of Beauchamp and Childress. One of the core principles of this approach is autonomy, which has had a great impact within academic medical ethics, medical education, and clinical practice.²⁰ Patient autonomy often refers to patients’ rights, including the right to determine what happens to their own body, the right to informed consent, and the right to participate in the medical decision-making process. Halpern describes this connection and how physicians, in order to respect patients’ autonomy, are often guided by a norm of negative autonomy, which is understood as ‘constraint from

interfering with a patient's self-determination'.¹⁴ Accordingly, autonomy may often be interpreted in a negative sense and understood as freedom from interference, being in line with the 'harm principle' as introduced by John Stuart Mill, claiming that the only justification for interfering with the liberty of individuals, against their will, is to prevent harm to others.³² I will later argue, however, that following this principle in medicine may actually cause harm in the doctor–patient relationship. Following this negative interpretation of autonomy, we may trace an ontology of separation, where people are considered independent from each other and viewed as freed from each other's interference and connectedness.

Thus, because of the prominence attributed to the principle of autonomy in contemporary medical ethics, an understanding of the moral agent in medicine emphasizing individuals' independence and freedom from interference is emerging. Even though such an understanding of autonomy has been questioned and opposed,^{33–35} I maintain that the ideal of detachment and non-interference is still dominant in medicine, especially with regard to how physicians deal with their patients.³⁶

Harm in the absence of care

Not to turn away from someone in need

Such an ideal of detachment and non-interference may represent a possible obstacle to care in medicine. Halpern argues that 'Respecting autonomy too often translates in practice into leaving patients alone, often without social supports to face difficult medical decisions'.¹⁴ Leaving patients alone, as the neurologist did in the example previously mentioned, conflicts with an important ethical concern about an ethics of care; that is, the concern of 'not to turn away from someone in need'.³⁷ The main ethical concern of an ethics of care is, according to Gilligan,²³ the harm caused in relationships owing to a lack of care. In the example referred to above, the patient was actually hurt by being thrown unprepared 'into ice water' with the diagnosis of incurable brain cancer presented as a brute fact and without any provision of emotional support. For him the incident was a traumatic experience and added extra weight to the burden of his disease. Thus, even though the neurologist acted properly in the sense of respecting the patient's autonomy and refraining from harming the patient by offering the best possible treatment, he nevertheless inflicted harm on him, not by what he did but by what he abstained from doing. Thus, it seems as if the neurologist failed to realize the importance of his relationship with the patient in that particular situation, and how the lack of care in relation to the patient involved actually hurt him on a mental and emotional level, causing him to feel abandoned 'in chaos'. For the patient, the episode was a traumatic experience and a source of considerable additional suffering, and also exemplifies what I denote as 'harm in the absence of care'. This is not harm caused deliberately by some kind of destructive activity, or by an unexpected negative event; rather, it is harm caused by the absence of active beneficent participation in the relationship between physicians and patients. This kind of relational harm represents an important moral concern in an ethics of care; however, it is an ethical challenge that is seldom openly acknowledged or discussed in medical ethics.

Empirical findings

Empirical studies indicate that a lack of relational care and consideration may cause pain, sorrow and suffering for the people involved, also in relation to the interaction between health care professionals and patients.³⁸ Some studies point to the co-suffering inflicted by doctors by breaking bad news in an insensitive way,^{39,40} whereas others investigate patients' experiences of humiliation in clinical encounters.^{41,42} Some studies document how relatives whose emotional needs are not acknowledged by health personnel in connection with a critical illness or death of a child or other close relative, suffer more from acute traumatic stress and bereavement,^{43,44} and how they run a higher risk of developing post-traumatic stress disorder.^{45,46} Other

studies point to patients' experiences of being left alone by their doctors, feeling 'deserted', alone, upset, sad, and even embarrassed.^{47,48} The aspect of abandonment that patients may experience in relation to their physicians has also been addressed by Quill and Cassel, who point to 'non-abandonment' as an important moral obligation in medicine.⁴⁹ These findings are interesting because they reflect empirically what I denote as harm in the absence of care.

However, even though my focus in this article has been on harm caused by a lack of care, the opposite possibility of harm resulting from too much care should also be recognized. A physician becoming 'over-attached' may thus exceed the personal limits of patients and break their 'zone of the untouchable', paraphrasing the Danish philosopher, Knud Løgstrup.⁵⁰ We may also think of this kind of harm in a more tangible fashion, pointing to how over-attached physicians may come to inflict harm on their patients by allowing them to undergo too many examinations and possible treatments.

Virtues, beneficence and the related self

Thus far, I have tried to show how the notion of relational ontology originating from the ethics of care perspective as developed by Gilligan and by Pettersen may be of help in developing a medical ethics that acknowledges care as a perspective to be observed in all interactions between physicians and patients. However, how does this perspective relate to the historical notions of care in medicine? What about the altruistic virtues of care and compassion in medicine? What about the principle of beneficence? Do they not account for situations of harm in the absence of care, to which I refer above? These are some of the questions I will now address.

Care as a medical virtue

Care in medicine is traditionally seen as a cluster of altruistic virtues. Especially sympathy and compassion have exerted influence within the profession by motivating the sensitivities of medical practitioners, as well as by representing ethical ideals formulated in the medical codes and oaths. In their analyses of the virtues of medical practice, Pellegrino and Thomasma emphasize compassion as a basic medical virtue.¹⁹ They understand compassion as a moral virtue in the classical sense of the word; that is, as 'a habitual disposition, to act in a certain way',¹⁹ and they connect it to what they denote as the 'caring bond', which includes healing, caring and curing. Furthermore, they draw attention to the special relationship that sickness and the response to illness creates between healers and patients as the moral essence of a health profession. However, instead of taking this relationship as the point of departure for their enquiry and focusing on the caring practices and the relational competence inherent in these practices, Pellegrino and Thomasma concentrate on the disposition of physicians to act in a compassionate, caring way. These two ways of approaching the healing relationship between physicians and patients thus reflect an important difference between an ethics of care and virtue ethics.

Held argues that, in seeing care simply as a virtue, we miss a central feature of care, namely, 'its evaluations of and recommendations concerning relations between persons'.¹³ Held says that: 'Virtue theory has focused on the individual and his dispositions. Care ethics, in contrast, focuses on relations between persons, on such relations as trust, mutual responsiveness, and shared consideration. It employs a concept of the person as relational and historically situated'.¹³ Thus, to be a caring person requires more than the right motives and dispositions towards others. 'It requires the ability to engage in the practice of care, and the exercise of this ability'.¹³

However, Held's understanding of the term 'virtue' may be questioned. It may be argued that to seek to be virtuous is not to be concerned with oneself and with one's own state of virtue. On the contrary, virtues are, by their very nature, relational in that they comprise character traits that are admirable to others for a variety of reasons, including the extent to which those virtues produce good outcomes for others. One is not virtuous for the sake of one's self, but for the sake of others who are benefited by one's virtue. However, the discussion of

whether an ethics of care represents a special form of virtue ethics is an ongoing discussion,^{51–55} and to further expand on this discussion goes beyond the scope of this article. However, even though virtues may be said to be relational, I do not think that seeing care as only a virtue can capture the full depth of the relational dimension of care, certainly not in medicine, where the ideal of detachment and non-interference is dominant. I have difficulty seeing the relational qualities of a physician caring for a patient while at the same time striving for emotional and physical detachment. I think we may trace some of the ambivalence that is to be found towards care in medicine to this ideal of a virtuous and detached physician. What is it to care for a patient, anyway, if we at the same time aim for detachment and non-interference? It may also be argued that a virtue-based ethics in medicine is often more concerned with the relationships within a moral community of professionals than of the actual relationships between professionals and patients.⁵⁶ Held also maintains a feminist argument against treating care as a virtue and an ethics of care as virtue ethics, pointing to the fact that virtue theory has not until recently paid attention to the practices of caring ‘in which women have been so heavily engaged’.¹³ Held writes: ‘The traditional Man of Virtue may be almost as haunted by his patriarchal past as the Man of Reason. The work of care has certainly not been among the virtuous activities to which he has adequately attended’.¹³ I find this argument also relevant for the field of medicine and medical ethics, in which the dichotomies of male/female, physician/nurse, curing/caring have been dominant, and by which the care work for the most part has been employed by nurses.

Care as beneficence and non-maleficence

Beneficence denotes the practice of good deeds and, understood as a principle, it is of major importance in medical ethics. According to Beauchamp and Childress, beneficence must contribute to the welfare of others. They write that ‘agents must take positive steps to help others, not merely refrain from harmful acts’.²⁰ Why, therefore, does beneficence not account for my claim for care in medicine? Does care not also include ‘positive steps’ towards the other in order to help? As I have earlier indicated, I find the prevailing conception and understanding of care in medicine inadequate in the way that it still inherits the idea of the moral agent as separate and detached from the other. This is also the case for beneficence, which is influenced by deontological and utilitarian approaches to ethics, promoting an ideal of disinterested beneficent deliberation and action. Larry Churchill criticizes such an ideal of disinterested beneficence, and rather recommends a notion of beneficence ‘grounded in complex, relational understandings of the self’.²⁴ He says: ‘Hence, the issues of beneficence can no longer be formulated as if the agent were essentially solitary and could contemplate the scope of his or her duties from afar’.²⁴ On the contrary, attending to ‘the second voice’ in moral experience would mean ‘taking the ethical codes of health professionals beyond the contract model and into a recognition of a deeper and more integral bond between healers and the sick, and between health professionals and society’.²⁴ Accordingly, following Churchill’s arguments, to better secure caring in medicine, the notion of beneficence would profit from being grounded in a relational understanding of the self.

The principle of non-maleficence, referring to our moral obligation of not causing harm to anyone, is central to medical ethics. However, how does the principle of non-maleficence relate to the kind of harm that Gilligan is addressing, that is, the emotional and psychological forms of harm arising from a lack of care in a relationship? In their discussion of the concept of harm, Beauchamp and Childress focus mainly on physical harm, ‘especially pain, disability, suffering, and death’, although acknowledging in theory ‘the importance of mental harms and other setbacks to one’s interests’.²⁰ ‘Although harm is a contested concept’, they argue, ‘everyone agrees that significant bodily harms and other setbacks to significant interests are paradigm instances of harm’.²⁰ Consequently, owing to this infringement of harm to include mainly physical harms, the ethical concern related to situations where harm occurs in the absence of care (i.e. mental and emotional harm) is not satisfactorily accounted for by the principle of the non-maleficence approach advocated

by Beauchamp and Childress. This point is further reinforced by Eric Cassell, who identifies how the medical ideals of beneficence and non-maleficence have changed within the last generation, moving physicians from caring for patients to focusing on doing good for the disease: 'We were not far into the era of modern definitions of disease – say, the middle or end of the nineteenth century – when doing good for the patient was clearly equated with doing good for the disease'.⁵⁷ Accordingly, such an approach focusing on treating the disease, and thus reducing the physical harm experienced by patients, may have led to a diminished focus on the ethical concern of mental and emotional harms in the clinical encounter.

In light of this, I suggest that an ethics of care perspective may enrich the principles of non-maleficence and beneficence as they are perceived in medical ethics today. As in the patient with brain cancer, I think the situation would have turned out differently for the patient if the physician had been more aware that acting morally was not just connected to his ability to inform the patient properly, respecting his autonomy, but also to the ethical concern of not turning away from the patient in need. This act of not turning away further requires an ability to evaluate the actual relationship, as well as to come up with recommendations concerning his own actions, with the overall aim of not hurting the patient.

However, it may also be pointed out that my view here represents a too limited approach to situations such as these. What about the physician's moral attentiveness? Does the example of the patient with brain cancer not represent a pure example of lack of empathy on behalf of the physician? Do we need to evoke the deeper issues of ontology to understand what is missing here? My focus in this article has been the ontological aspects of an ethics of care. This does not mean, however, that I do not acknowledge the moral epistemological implications of an ethics of care in relation to medicine and medical ethics. However, the one does not rule out the other. It is more about considering a matter from two different perspectives. My main point is that the understanding of the self may influence how people understand and act in the world – also as physicians. Thus, medicine's ontological 'point of departure' may have an impact on how physicians perceive and interpret their relationships to patients, and how they handle situations in medical practice.

Conclusion

In this article I have argued that the dominant ideal of detachment and non-interference in medicine needs to be challenged, and that medicine and medical ethics may profit from implementing the theoretical insights of an ethics of care, first and foremost its relational ontology. To better secure care in the medical encounter, and thus avoid situations in which patients are 'harmed in the absence of care', medicine needs to acknowledge the relational reality of care, and to work for an understanding of physicians and patients as related selves. Some challenges emerging from such an undertaking are, however, left open for further enquiry. For instance, how do we deal with the didactical challenges related to facilitating such an understanding of the self and of care in medicine?

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Conflict of interest statement

The author declares that there is no conflict of interest.

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