THE JUST DISTANCE: A NEW BIOMEDICAL PRINCIPLE

by

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This work argues that the principle of autonomy set forth in the Principalist theory of biomedical ethics should be replaced by "the just distance"—a concept first suggested by Paul Ricoeur. Beginning with the prevailing critique of autonomy in feminist philosophy and medical ethics, the paper then explains why a principle encompassing narrativity, relationality, and singularity would provide a better guiding standard for the doctor-patient encounter than the current rule of "respect for autonomy". The final chapter gives examples of how the just distance can be used in a clinical setting, and responds to possible critiques of this new principle.

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CHAPTER I

INTRODUCTION

Many years ago while still in training, I took care of a young woman with a ruptured tubal pregnancy. Her evaluation showed that she had already lost a considerable amount of blood, and she was in shock—low blood pressure, somewhat decreased mental status. The Operating Room was not quite ready to take her, so I and the other resident working with me began counseling her that she would need blood. With her family beside her she replied that she was a Jehovah's Witness and would refuse all blood products. This was quite distressing to me and my fellow resident because while it would be fairly routine to give her blood and do a straightforward surgery to stop her internal bleeding, it was not clear we could keep her alive without blood products. But I saw a glance to her family that made me wonder if we were really hearing her wishes, so while we were rolling her gurney toward the operating room I asked her again if she was really willing to risk her life by not receiving blood. Seemingly relieved, she responded that she did not consider herself to be a Jehovah's Witness, but that she had not yet told her parents, and yes she wanted blood if we thought it was necessary to save her life. She then requested that we hide the transfusion from her family. She received several units of blood in

surgery and recovery, her family was never aware of the transfusions, and she made an uneventful recovery.

Although there is still a lively discussion within philosophy departments about competing theories of ethics, in medical schools and medical specialty societies this discussion is largely finished and a victor has been declared. My specialty board publishes a monograph on ethics that is completely modeled after the *Principles of Biomedical Ethics* by Beauchamp and Childress—competing theories are mentioned in passing, and this principalist theory is said to be able to encompass and incorporate them within its principles of medical ethics.[1] Beauchamp and Childress set out autonomy, beneficence, non-maleficence, and justice as the four principles that one must reason from when faced with a biomedical ethical decision.

I chose to begin this discussion of medical ethics and the worthiness of the principle of autonomy with this case history not because of the complexity of the ethics involved in this example, but rather because of the potential pitfalls that it presents to a clinician well- versed in the "principalist" theory of medical ethics. Reasoning, as I believe Beauchamp and Childress would have us do, from the principle of autonomy we could have ethically acceded to her initial request to forgo blood products even if it cost her life. Some have also argued that the principle of beneficence could be invoked to override her autonomy and save her life against her stated wishes. But how beneficent is it to disregard a patient's deeply held religious beliefs? However, this is a false ethical dilemma because the ethical argument has

[1] American College of Obstetricians and Gynecologists, *Ethics in Obstetrics and Gynecology, 2nd ed.* (Washington DC: American College of Obstetrics and Gynecology, 2004).

proceeded too quickly from the person in need to ethical principles. Although both inexperienced and stressed by the situation before me, the sidelong glance to her parents reminded me that I knew nothing about her. Our relationship had begun only minutes earlier *and I did not know her story.*

As long as medical ethics is guided by principles that ignore and downplay the importance of relation and narrativity, the principle of autonomy in medical ethics will do more to deny true respect for the selfhood of the other than stand as its safeguard. My response to the four principles of medical ethics is not to abandon them completely, but rather to examine and replace the principle of autonomy with a new principle first suggested by Paul Ricoeur—the just distance—the right relation.[2] Just as the principle of autonomy carries with it a history of philosophy that resonates within it, the just distance will represent a synthesis of feminist ethics and its critique of principalist medical ethics and the narrative/relational philosophy of Paul Ricoeur.

Some feminist critiques of ethics would argue against this limited approach of leaving the four principles intact, and merely replacing the most egregious example of "male" abstract reasoning, but I believe this response is justified both philosophically and pragmatically. Several feminist ethicists, including Susan Sherwin and Eva Kittay, reject autonomy as an accurate descriptor of the human condition, but they do not oppose principles or the normative force of their conclusions. They retain a belief in principals as a foundation of our decision making, while discarding autonomy as a constitutive principle of selfhood.

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[2] Paul Ricoeur, *Reflections on the Just,* trans. David Pellauer (Chicago: The University of Chicago Press, 2007), 220.

Sherwin argues that the principles must be tempered by the concrete, and must reflect accurately human relations *as they should be*, rather than as they are, and here she invokes the principle of justice in her argument:

> Because feminism arises from moral objections to oppression, it must maintain a commitment to the pursuit of social justice; that commitment is not always compatible with preferences derived from existing relationships and attitudes. Hence we must recognize that feminist ethics involves a commitment to consideration of justice, as well as to those of caring.[3]

Moving the principle that informs the patient-doctor relation from autonomy to the just distance is both an effort to accurately describe the relationality of human selfhood and also to reform the existing understanding of the bounds of this relation. The intent is to suggest the possibility of actual change in the behavior of practitioners: this is also the pragmatic aspect of my project. The Principalist theory has become and remains the primary ethical theory of clinicians since its introduction in 1979.[4] If the goal is to influence the thinking and behavior of clinicians, a revision of the theory that has become central to our thinking about medical ethics seems more likely successful than a complete replacement of it. Furthermore, I do not object to the principle-based model p*er se*—it has shown great resiliency and utility in the sense that clinicians do often use it to reason through ethical questions confronting

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[3] Susan Sherwin, *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992), 52.

[4] K. Danner Clouser and Bernard Gert, "A Critique of Principalism," in *Bioethics: An Introduction to the History, Methods, and Practice,* ed. Nancy S. Jecker, Albert R. Jonsen, and Robert A. Pearlman (Sudbury: Jones and Bartlett Publishers, 2007), 153.

them in their practice. Returning to the case history, a principle of right relation would not argue against the respect for her autonomous choices, but it would go beyond this limited dimension to asking the larger question of whether we knew her well enough to understand what her answer really meant.

Beauchamp and Childress acknowledge the possibility of revision to their theory.[5] They also see the principles as pluralistic and non-hierarchical, so changing one principle does not negate the others---although the conclusions of any particular case may now change as the balance between the principles has now shifted.

I begin with a discussion of the Principalist theory, and the principle of autonomy as it is understood in this setting, and then move to the state of current critique in feminist and medical ethics regarding the Principalist theory. The second chapter will discuss the philosophy of Ricoeur and explain why the just distance is a principle that correctly characterizes the doctor-patient relation. This is the groundwork for the third chapter which will continue to argue for a replacement of the principle of autonomy with the principle of respect for the right relation, as well as discuss possible critiques of the just distance. The goal is to remain within a principle-based theory of bioethics but to move from the "one size fits all" principle of autonomy to guide the physician-patient relation to the just distance—a principle that carries with it a recognition of both narrativity and the particularity of each person and therefore each relation. The answer for what is the appropriate relation—what is the correct "distance" between the physician and the patient must be found in

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[5] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics, 5th ed.* (Oxford: Oxford University Press, 2001), 398-399.

each encounter. The myth of respecting patient autonomy is in part that there is one correct answer to this question. Ricoeur's response is that there can never be only one answer, and that the relation itself carries in it the information to determine how to proceed. To this end, while Beauchamp and Childress begin with a principle that cannot be universalized to every patient encounter," respect the autonomous choices of persons,"[6] because not every patient can fulfill the ideal of having the capacity to make autonomous choices, the just distance can impose a directive that is always appropriate—find the right relation in this encounter, with this person, at this time.

[6] Beauchamp and Childress, *Principles of Biomedical Ethics,* 57.

CHAPTER II

AUTONOMY AND ITS CRITICS IN THE PRINCIPALIST THEORY OF BIOMEDICAL ETHICS

When Thomas Percival wrote his treatise on medical ethics in 1803, he argued for an essentially principle-based theory of medical morality, but there were only two principles that a doctor needed to abide by in making medical decisions: beneficence and non-maleficence.[1] The doctor was expected to determine what was best for the patient, and the patient was expected to passively follow this advice. The years between Percival's medical ethics and the beginning of medical ethics as a discipline saw the abuses of the Tuskegee experiments and the eugenics movement, and both of these examples provide support to a principle of patient autonomy. The long tradition of what is now understood as "paternalistic medicine" was already coming to an end when the first edition of Beauchamp and Childress's *Principles of Biomedical Ethics* (PBE) was published in 1979. This text of biomedical ethics established a principle-based theory that gave equal standing to the principles of autonomy, beneficence, non-maleficence, and justice as the foundations for judging biomedical ethical questions and dilemmas.

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[1] Tom L. Beauchamp and James F. Childress. *Principles of Biomedical Ethics*. (Oxford: Oxford University Pres, 2001), 12.

Even critics of the principle of autonomy as described in PBE agree that it has had a beneficial effect in moving clinicians away from a role in which they empower only themselves in the medical decision-making process.[2] It is worth remembering as this critique proceeds that one possible perspective on the use of autonomy as one of the four basic principles of medical ethics is that it served a useful function in time, but that it can now be replaced by a more nuanced understanding of the physician-patient relation without any threat of returning to paternalism. To judge this, we must first understand both how autonomy is described in PBE and also say something about its use and understanding among other ethicists and clinicians.

The four principles are grounded in "common morality" which Beauchamp and Childress define as:

> We will refer to the set of norms that all morally serious persons share as *common morality*. The common morality contains moral norms that bind all persons in all places; no norms are more basic in the moral life. In recent years, the favored category to represent this universal core of morality in public discourse has been human rights, but moral obligation and moral virtue are no less vital parts of the common morality.[3](Italics original)

Their justification for beginning in common morality is in part based upon a concern that ethical systems grounded in a particular theory--deontology or utilitarianism, for example, can be negated by challenges to the underlying theory. They argue that by

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[2] Albert R. Jonsen. "A History of Bioethics as Discipline and Discourse." in *Bioethics: An Introduction to the History, Methods and Practice* eds. Nancy Jecker, Albert Jonsen, and Robert Pearlman. (Boston: Jones and Bartlett Publishers, 2007), 13.

[3] Beauchamp and Childress. *Principles of Biomedical Ethics*, 3.

beginning in common morality rather than a moral theory they avoid this potential source of annulment of the ethical principles that are then derived from this source. But how do they arrive at four principles as the guideposts for all possible decisions and situations in bioethics, beginning as they do in "common morality"—a set of norms that all "morally serious persons" could agree upon? Interestingly, it is the last chapter of PBE that explains and defends common morality theory. This is consistent with their view that any medical ethics grounded on a true ethical theory is made vulnerable by attacks to this underlying justification. Their response is to emphasize elaboration of the four principles as guideposts for bioethical thinking and to de-emphasize defending the basis for these principles, other than to claim they are easily derivable from common morality.

The claim is that by beginning in common morality they are not grounding the principles in a theory at all—that the linkage to common morality is less assailable than principles derived from deontological or utilitarian reasoning:

> We cannot reasonably expect that a contested moral theory will be better for practical decision-making and policy development than the morality that serves our common heritage. Far more social consensus exists about principles and rules drawn from our common morality…than about theories. This is not surprising, given the central social role of the common morality and the fact that its principles appear in some form in all major theories.[4]

[4] Beauchamp and Childress. *Principles of Biomedical Ethics*, 404.

While this contention is itself arguable, my focus is on the principle of autonomy itself, not its derivation. However, since this project seeks not a total dismantling of the four principles, but rather a modification, we will need to return at the end and ask whether we are justified in our new principle in seeking support from common morality. If not, we have created an untenable hybrid, rather than a better statement of principles.

Beauchamp and Childress begin their description of the principle of autonomy by delimiting it and setting it apart from a directly Kantian sense of autonomy. "Respect for the autonomous choices of persons" is their initial statement of the principle, and they then quickly add that they see autonomy as being neither a rejection of the "social nature of individuals," nor a principle "focused on reason".[5] The acknowledgement of the social nature of humans would seem to be more a concession to critics than an intrinsic aspect of their understanding of autonomy because the analogy they use to describe their sense of autonomy is in fact quite individualistic:

> Personal autonomy is, at minimum, self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice. The autonomous individual acts freely in accordance with a self-chosen plan, analogous to the way an independent government manages its territories and sets its policies.[6]

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[5] Beauchamp and Childress. *Principles of Biomedical Ethics,* 57.

[6] Beauchamp and Childress. *Principles of Biomedical Ethics,* 58.

A major aspect of their conception of autonomy is the realm of "informed consent"—the choice made by an autonomous individual in health care must be both non-coerced and well informed. The transformation of the physician's role into teacher and communicator is without question part of the "benign influence" of the emphasis on patient autonomy present in PBE.[7] But Beauchamp and Childress are clear that they do not accept a "shared decision making" model of autonomy—the doctor conveys information, but just as in a business contract, the decision rests solely in the patient's realm. The patient declines or agrees to a procedure or treatment after being adequately apprised of its risks and benefits. Beauchamp and Childress describe the patient role as "authorizing," but only after the patient is informed enough to judge what the options truly represent.[8] This authorization is dependent upon both non-coercion and adequate information. The ability to give consent, and therefore the validity of the consent, also rests upon a determination of competence of the patient.

In a clinical setting, a determination of competence actually precedes the process of giving informed consent: if a person is judged to be incompetent then the giving of authority falls from them, and the process of informed consent occurs with a surrogate decision-maker. Although Beauchamp and Childress discuss the controversy surrounding the concept of competence, they throw their support to a rigid demarcation between competence and incompetence without resolving which standard is the best for determining where this line is to be drawn. Nonetheless, the

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[7] Albert R. Jonsen. "A History of Bioethics as Discipline and Discourse," 13.

[8] Beauchamp and Childress. *Principles of Biomedical Ethics*, 78.

effect of their position is an acknowledgement that the principle of autonomy will not apply in all situations—to be incompetent to make a medical decision is to no longer have autonomy, that is, to no longer be respected and treated as an autonomous individual in one's medical choices.

Beauchamp and Childress recognize another limit to the principle of respecting autonomy based upon the patient's own response to this principle, which in turn is often predicated upon the patient's age, social status, or ethnicity. They make a clear distinction between respecting or offering autonomous choice to every patient (every patient judged to be competent) and actually requiring autonomous, informed choice of every patient. They acknowledge that many patients do not want this role, or feel incapable of carrying it out, even though they meet a technical standard of competence. Beauchamp and Childress are responding to critics and empirical studies that have shown that patients may not wish to have autonomous choice and may perceive the choice as a burden. Furthermore, as they explain, in Navaho culture, the giving of information about a procedure and any discussion of its risks is viewed as detrimental to the patient's chances of a successful recovery because the mere saying of the risks makes them more real or probable.[9] They end this discussion with a nuanced response to criticisms against the principle of autonomy as a possible encumbrance foisted upon some unwilling patients:

> A more adequate interpretation of respecting autonomy will put these problems to rest. There is a fundamental obligation to ensure that patients

[9] Beauchamp and Childress. *Principles of Biomedical Ethics*, 61-63.

> have the right to choose, as well as the right to accept or to decline information. Forced information, forced choice, and evasive disclosure are inconsistent with this obligation...Health professionals should always inquire in general terms about their patient's wishes to receive information and to make decisions, and they should never assume that because a patient belongs to a particular community, he or she affirms that community's world view and values. The fundamental requirement is to respect a particular person's autonomous choices.[10]

Although Beauchamp and Childress are right to respond to their critics by acknowledging that respect for autonomy is an ideal that can be inappropriate in a particular situation or with a particular patient, the effect of this is to limit even further the applicability of their first principle. As a system of principles intended to cover every bioethical question or encounter, it is odd that the first principle, and the only principle that deals directly with the relation between caregiver and patient, has such a narrow scope. If we must treat only substantially autonomous persons autonomously, how do we then treat everyone else? Beauchamp and Childress offer no principle for the rest of humanity. Furthermore to the extent that illness, age and injury can all substantially impair autonomy, it would seem that many specific medical encounters may lack the preconditions of autonomy, even in a previously autonomous person when not in need of health care. The young woman in a serious car accident is substantially autonomous until the event that leads to her need for care.

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[10] Beauchamp and Childress. *Principles of Biomedical Ethics*, 63.

There is a dynamic between autonomy and the need for health care that can work counter to each other: those in greatest need are often the least autonomous at their time of need. PBE offers no guidance for a substantial portion of clinical encounters.

Beauchamp and Childress devote much space in PBE explaining how the four principles are to be understood and used in bioethical reasoning, but two aspects of this discussion are relevant for this paper. The first is that the principles are non-hierarchal—none takes precedent over another. Conflicts between two principles must be decided in view of the actual case. For example, if a psychiatrist decides to warn the police that her patient is contemplating and planning a murder, she has decided in *this instance* that non-maleficence is the more important principle (outweighing autonomy of the patient). This decision does not imply that non-maleficence is always the ascendant principle; it only decides their order in this circumstance. This leads to the second aspect of their use of principles already evident in this example: principles can be ethically violated—they are *prima facie* but not absolute.[11]

However, some supporters of the principalist theory have argued against Beauchamp and Childress that autonomy does, and should, receive greater weight than the other three principles, and that autonomy should only be violated in rare circumstances, if ever:

> …I personally am inclined to see respect for autonomy as *primus inter pares*—first among equals. Firstly, autonomy—by which in summary I

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[11] Beauchamp and Childress. *Principles of Biomedical Ethics*, 14.

> simply mean deliberated self rule…is what makes morality—any sort of morality—possible…Secondly, beneficence and non-maleficence to other autonomous agents both require respect for the autonomy of those agents.[12]

Alfred Tauber, a physician and philosopher agrees that clinicians place autonomy first among the principles in actual practice, but unlike Gillon he worries that the effect of this has been to transform the patient-doctor relation into a market model where the patient "chooses" independently what she wishes from a range of choices offered to her.[13] He is critical of the effect of autonomy on the doctor-patient relation, and seeks a return to "responsibility"—on the part of the physician—as a founding principle in this relation. He also argues against the benefits of the principle of autonomy in that, "so called rituals of trust (the informed consent process) have emerged as substitutes for organic trust."[14] This, he argues, makes medicine contractual, and therefore allows doctors to shift responsibility to the patient. The doctor provides terms of the agreement, and the patient either refuses or enters into the contract. If the patient was informed of the risk, how can she blame the doctor for an outcome that was described as possible? Tauber argues that the principle of autonomy has undermined the physician's sense of responsibility and has been one factor in transforming medicine into a commercial model from a service/caring one based primarily in trust and responsibility. He ends his discussion of autonomy with the plea that autonomy must

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[12] R Gillon, "Ethics needs Principles—Four can Encompass the Rest—and Respect for Autonomy Should be 'First among Equals,'" *Journal of Medical Ethics* 29 (2003): 310.

[13] Alfred I. Tauber, *Patient Autonomy and the Ethics of Responsibility*, (MIT Press: Cambridge, 2005), 61.

[14] Tauber, *Patient Autonomy and the Ethics of Responsibility*, 59.

be understood as relational, a critique that started with the feminist critique of autonomy and principalism.

Beginning with Carol Gilligan, feminist writings have objected to an atomistic, individualistic view of self, and have therefore challenged the validity of autonomy as an accurate descriptor of human agency. If we are created and sustained by relation, can autonomy be a useful concept in healthcare, or for that matter, in any realm? Tauber argues for a new understanding of autonomy rather than a replacement of the principle:

> ...substituting a relational understanding of selfhood for a narrowly atomistic notion fundamentally shifts the definition of autonomy from the exercise of moral choice by a fully independent agent to one who is embedded in relationships, which of themselves confer identity. "Relational autonomy" then becomes a more complete and honest depiction of the doctor-patient relationship, because it more accurately describes the agency of each party. Once autonomy is configured as achieved in cooperation, the defensive and distorted moral posture of the patient may be replaced with ...the healing encounter: the recovery of independence and a sense of self-authority.[15]

There is a tension perhaps to the point of breaking in Tauber's new definition of autonomy. Although Beauchamp and Childress give a nod to the relational aspects of our selfhood, they maintain a "self-rule" version of autonomy that would be at odds with Tauber's attempted compromise. Tauber in my view has the correct view

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[15] Tauber, *Patient Autonomy and the Ethics of Responsibility*, 122.

of selfhood, but he fails to recognize that this is simply not consistent with the history and usage of "autonomy," and he would do well simply to describe the doctor-patient relation as an encounter that involves the relational selfhood of both parties, because in fact both sides share an identity composed in relationality. But this relation is in turn only one aspect of each self that extends to and is defined by other significant relations of family, friends, and as we will discuss later, dependency relations. Each of these relations is taken into the doctor-patient encounter, and each of them may become crucial in a particular decision or choice.

Much of the feminist critique of both autonomy and the doctor-patient relation does take this additional step and jettison autonomy as a useful descriptor of human selfhood and relations. Susan Sherwin's *No Longer Patient* is both a feminist critique of healthcare and a plea to move beyond an autonomy-based system of medical care and medical ethics.[16] Although Sherwin and Tauber both seek to move beyond the traditional conception of autonomy, they make different moves in regards to the doctor-patient relation based upon their differing projects.

Sherwin traces the historical development of feminist ethics, beginning with Carol Gilligan's work that demonstrated women's tendency to solve ethical problems with relational thinking rather than the principle-based theories that men were more inclined to use. Gilligan's conclusion was that both methods of thought were valuable and that women's relational thinking had been undervalued in traditional

[16] Susan Sherwin, *No Longer Patient: Feminist Ethics and Healthcare*, (Temple University Press: Philadelphia, 1992).

ethical philosophy.[17] Sherwin sides with Gilligan over the "pure" care ethicists such as Nel Nodding and Virginia Held, who reject any justice, principle- based ethics in favor of a "feminine" ethics centered in the virtue of care with maternal care as the paradigm. While Sherwin largely agrees with the desire to bring care to the forefront of ethics over abstract principles, she argues that without principles there is no way to determine when care is inappropriate, and how to deal with the other for whom care is not the suitable mode of relation. Her claim is that care is an appropriate mode of relation only where there is already justice in the social sphere—without justice we must relate to others in ways that promote justice but are not necessarily characterized by care. A woman must not care for her abuser. A victim of oppression only furthers the oppression by entering into a caring relation with her oppressor.

Sherwin distinguishes between "feminine ethics" and "feminist ethics" on the basis of whether there is a political response to the oppression of women. Feminine ethics recognizes the relational aspects of female ethics, but it is feminist ethics that pushes also for the social change that would allow a true emergence of feminine values. While Gilligan, Nodding and Held are all responding to the oppressive male-centered ethics, Sherwin worries that an ethics based solely upon care will not necessarily further the cause of women:

> Within the existing patterns of sexism, there is a clear danger that women will understand the prescriptions of feminine ethics to be directing them to pursue the virtues of caring, while men continue to focus on

[17] Sherwin, *No Longer Patient*, 46-48.

> abstractions that protect their rights and autonomy…In a society where the feminine is devalued and equated with inferiority, it is not easy to perceive men embracing a moral approach described as feminine. Because the world is still filled with vulnerable, dependent persons who need care, if men do not assume the responsibilities of caring, then the burden for doing so remains on women.[18]

For Sherwin care must be not a virtue of exclusively women, and only justice and care can together lead to an ethical theory that is comprehensive. But justice must address in a systematic way the causes of oppression in society:

> Feminist ethics focuses instead on the need to develop a moral analysis that fits the world in which we live…that is not to say that feminist ethics involves no concern with principles. It encompasses theories that are committed to concerns about social justice, because it demands criticism of the various patterns of dominance, oppression, and exploitation of one group of persons by another.[19]

She conceives of justice as changing the oppressive power structures and bringing about the transformation that she envisions, where care can then be a primary but shared virtue among women and men. It is this political agenda that separates her critique from Tauber. It also a tension within her thought on autonomy as well.

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[18] Sherwin, *No Longer Patient*, 51.

[19] Sherwin, *No Longer Patient*, 55.

Sherwin begins like Tauber with a rejection of a conception of self that is individualistic and that denies our relational grounding:

> We must reconceive the concept of the individual, which has been taken as the central concept of ethical theory in Western thought. People have historical roots; they develop within specific human contexts, and they are persons, to a significant degree, by virtue of their relations to others like themselves...We cannot speak of the individual as the central unit of analysis, however, without considering that persons only exist in complex, social relationships.[20]

Unlike Tauber, Sherwin sees this conception of selfhood as inconsistent with previous western philosophy that enshrined atomistic autonomy at its center, and she makes no attempt to reconcile relationality and autonomy. But the doctor-patient relation for Sherwin remains problematic even after abandoning autonomy as a regulating principle. This, in turn, relates to her concerns about the history of medicine as an oppressive force against women that may yet again be enacted in a new patient-doctor encounter. Where Tauber will suggest a non-paternalistic relation of care and responsibility as a model of the relation, Sherwin seems clear that women must keep their distance from doctors, seek counsel but remain quite separate in their decision-making:

> ...the historical and continuing records of women's experiences within medicine indicate that medical practice directed specifically at the health

[20] Sherwin, *No Longer Patient*, 53.

> needs of women serves medical interests, and it is, too often, harmful to women.
>
> Hence we should be aware of the complexity of the values that underlie the medical services provided to women. This awareness makes it clear why women must regain control over the determination of their health-care needs and over the delivery of health-related services. Because paternalism encourages patients to trust and not question the authority of their physicians, it should not be accepted as common medical practice.[21]

Sherwin, on the one hand, affirms the relational nature of selfhood, while she expresses concerns about too close a relation in a physician-patient interaction. Where Tauber, Beauchamp and Childress declare the death of paternalism twenty years before the writing of Sherwin's critique of medicine, she still fears paternalism as an active behavior that women must guard themselves against in a physician encounter. Tauber takes a stance that stands in almost direct opposition to Sherwin—his fear is that the relation has become too constrained and commercial in form, and that the principle of respect for autonomy has been part of this unfortunate transformation that has pushed patient and doctor apart.

But Sherwin remains suspicious of the doctor-patient encounter given the unreformed nature of medicine in general, so although she is affirming of caring relations, she does not characterize physician-patient relations as such. The defensive posture that she maintains is in fact quite similar to the one Tauber decries as the

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[21] Sherwin, *No Longer Patient*, 153.

nature of the relation today, and his objection that this prevents a more therapeutic interaction carries no merit for Sherwin:

> Medical practice should be oriented to maximizing patient's ability to make reasonable, informed decisions about their health care. Hasty imposition of authoritarian, paternalistic intervention is more likely to inhibit than support a patient's recovery of independence. Moreover, when paternalistic intervention is called for, the person authorized to act on the patient's behalf should be someone who can be counted on to return authority to the patient as soon as there is sufficient recovery to allow effective participation in the decision-making process. Ordinarily, this person will not be the patient's physician.[22]

The irony here is that having abandoned autonomy as a philosophical descriptor of persons, she then demands respect for autonomy (without calling it this) in her interactions with physicians, because she does not believe the profession can be depended upon to create a caring relation founded upon trust and responsibility as Tauber would have it.

Sherwin does not deny the existence of trustworthy, caring practitioners of medicine; she is critiquing the profession as a whole. Although I believe Tauber is correct that paternalism as a physician behavior has been largely replaced with a too distant, defensive posture on the part of physicians who are only to happy to lay out the choices in a patient's care and have her both decide and then bear the

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[22] Sherwin, *No Longer Patient*, 154.

responsibility for the outcome of the decision, Sherwin's critique rings true at several levels as well. She rightly expresses concern that physicians too often consider interests that are not in the interest of their patients—although I would place time constraints and financial concerns over the maintenance of dominance that worries Sherwin. This is not to deny the history of oppression of women or the role medicine has played in it. Furthermore, 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 progressive 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. The American Medical Association's support of more universal healthcare coverage is a recent move in this direction.[23]

Both Tauber and Sherwin reject the traditional formulation of the principle of autonomy as described in PBE, but they differ in their response to this void. Tauber wants physicians to re-embrace an ethics of responsibility in a new non-paternalistic fashion, whereas Sherwin places responsibility and decision-making squarely back with the patient out of her distrust of the medical profession. I argue that this leaves her in a place that differs little, from a practical standpoint, from the position of Beauchamp and Childress that she initially criticizes since she returns to supporting

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[23] AMA Health Care Policy Group, *Expanding health Care Coverage: The AMA Proposal for Reform*, editors Valerie Carpenter and Robert D. Otten, www.ama-assn.org/ama1/pub/upload/mm/363/ehi1012.pdf.

patient autonomy without ever acknowledging it as such. But where both in their differences are alike is that they seem to replace the principle of respect for autonomy with another somewhat monolithic answer—responsibility in the case of Tauber, and patient independence (or doctor-patient non-relation as it could be better described) in Sherwin's case.

In one sense, Sherwin's critique is an answer to why Tauber's project cannot be successful: some patients will not want the physician to assume the close relation that he believes is ideal for healthcare, and some encounters may have to continue in the absence of trust as their foundation. Similarly, Sherwin's answer is hopefully not the stance toward healthcare that we should all adopt. Perhaps trust should be developed over time, rather than assumed, but long term doctor--patient relations should, I believe, always move in this direction or be replaced by a better match between two people. If Sherwin had a politically progressive feminist physician would she still believe it necessary to place so little trust in that person's recommendations?

Tauber and Sherwin's objections to autonomy center on its meaning as atomistic "separateness." Sherwin argues that none are truly autonomous, although men may seek autonomy out of fear of relation. Eva Kittay's critique of autonomy is an empirical extension of Sherwin's argument. A substantial portion of the population, she explains, is either directly dependent due to age or disability, or indirectly dependent and therefore non-autonomous because they labor as dependence workers. Dependence workers, largely women, do the unpaid or poorly paid

unskilled labor of caring for dependent persons. All of us are dependent persons during some time in our lives, so to refer to persons as autonomous is to ignore or marginalize those who are not, and those who can never be, because they are either permanently dependent or dependency workers. Dependency workers lack autonomy because their roles place demands upon them that cannot easily be unburdened, and because their lack of pay or poor pay make them financially dependent on others. This can be a direct threat to autonomous choice in medical care as a dependency worker may be unable to choose a surgery or treatment she may otherwise need because she cannot afford the time off, or be able to find a replacement during her own recovery. Kittay argues that too many people lack autonomous choice out of their life circumstances to make it a useful principle:

> By excluding this dependency from social and political concerns, we have been able to fashion the pretense that we are independent—that the cooperation between persons that some insist is interdependence is simply the mutual (often voluntary) cooperation between essentially independent persons. The argument of this book is that our mutual dependence cannot be bracketed without excluding both significant parts of our lives and large portions of the population…[24]

Sherwin, Tauber, and Kittay together describe the prevailing critique against a principle of autonomy in a principle-based system of biomedical ethics. Both Sherwin and Tauber argue that conceiving of the person as an independent, self-

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[24] Eva Feder Kittay, *Love's Labor: Essays on Women, Equality, and Dependency*, (New York: Routledge, 1999) xii.

ruling entity is simply not an accurate representation of how we are constituted. Who we are is largely defined by our relations; our place in the world integrated into families, friends and work relations. These relations not only define us, they also delimit us—the relations we have constrain our choices in ways that make autonomy a myth that only a few can possibly believe describes their place in the world. Both Sherwin and Kittay argue that only successful white males actually believe they are autonomous, but even they are forgetting their own periods of dependence, or the dependency relations around them that may contribute to their sense of autonomy.

Although these three authors converge in their critique of autonomy, they see different implications for the doctor-patient relation. Sherwin has too little trust in the medical profession to even see the possibility of the physician-doctor relation becoming a source of relationality that could lead to better decision-making and care of the patient. Instead, she focuses on the way patients need to bring their important people with them into medical encounters to protect them from the ulterior motives that physicians take into the exam room. The relations of friendship, family, and dependency are taken into the exam room, and to forget this is part of the myth of autonomy.

The case presentation at the beginning of this paper showed a woman who saw her family relations as so central to her life that she was willing to risk her life rather than jeopardize them, even for a religious idea that she no longer shared with them. The centrality of autonomy ignores that people do not, or cannot, make medical choices in a vacuum apart from their lives, which are in turn defined by their

relationships. While Beauchamp and Childress acknowledge that a person's choice may be impacted by their relationships, what they miss is that no one makes choices independently. Whether the relationships are empowering or constraining, or both, to affirm "self-rule" is a grave mistake about who confronts a physician in an exam room.

But Sherwin also has a political vision that can be extrapolated, I believe fairly, to the doctor-patient relation. She argues that the problem with care is that it is a feminine attribute, and that justice demands that care be universalized as an ethic if it is to be valorized. Care can and should be central to any healing relation, and Sherwin is right that the modern medical relation often lacks it. Yet the healing of the doctor-patient rift that she describes is exactly the antidote to autonomy-driven medicine. The relationship between the patient and the doctor need not be as lasting or significant in a person's life as their familial or friendship relations, but Tauber is right that without trust and physician responsibility it is also not likely to be therapeutic.

Whether medicine can reform itself sufficiently so that its critics such as Sherwin can trust it enough to allow a closer, non-paternalistic relation to emerge is a question, or problem, that will not be solved entirely at the level of individual encounters—it is ultimately a larger political question that is tied to other institutions that have a history of domination and repression as well. I wish to acknowledge this larger political context before returning to the individual encounter and focusing on

what can be done to reconceive this relation in a way that will promote the care and healing that should be at its center.

CHAPTER III

THE JUST DISTANCE: NARRATIVITY, SINGULARITY, AND RELATIONALITY AS THE SOURCE OF A NEW BIOMEDICAL PRINCIPLE

> It would be impossible to overemphasize the singular character of the caregiving agreement concluded between two unique individuals: this physician and this patient, and the prescription which opens a singular history that of the treatment of this patient confided to this physician.[1]

The critique of autonomy is not simply that it fails to accurately describe the human condition unless it is nuanced as Tauber does, to make autonomy itself to arise in relationality. Kittay's critique is also that it is limited in its scope—few achieve substantial autonomy and only at the expense of others. Furthermore, autonomy is rarely useful in medical encounters where important decisions need to be made because the gravity of the illness is itself an important limiter to autonomy.

When Paul Ricoeur discusses the just distance he is not responding to the principalist theory, but I believe that if medicine remains committed to this ethical theory to regulate its decision-making processes it must replace "respect for

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[1] Paul Ricoeur, *Reflections on the Just,* trans. David Pellauer (Chicago: The University of Chicago Press, 2007), 214.

autonomy" with a principle useful in every clinical encounter. The just distance resonates with much of the prior philosophical work of Ricoeur. His philosophy of narrativity, relationality, singularity and selfhood are not simply consistent with it, they are the concepts embodied in his suggestion that this principle is central to every clinical encounter.

Even prior to Ricoeur's writing of a just distance, his philosophy of narrativity had found proponents in both medicine and medical ethics. Although his descriptions of narrativity are both philosophically technical and not directed at medicine, they have been taken up by Rita Charon and other clinicians and ethicists as useful to reconceptualizing the clinical relation. For Ricoeur, the self is narrative, so to ignore the narrative is to fail to see the person entirely.

Ricoeur makes his argument for the narrative unity of selfhood in both *Time and Narrative* and again in *Oneself as Another*. Although these works do not lend themselves to a brief re-statement, I will try to summarize his conclusions if not all the discussion that precedes it. Like Aristotle, Ricoeur sees humans as teleological—we set goals, we project ourselves into futures, and these goals play an important role in our self perception. We unify ourselves in the present and the past relative to this plot (substituting plot for goal because with emplotment we can now include in our story all the history or facticity that we do not control). As a narrative-making species, we determine meaning through the interaction of these factors, and this meaning determines our deepest sense of self:

> It is indeed in the story recounted, with its qualities of unity, internal structure, and completeness which are conferred by emplotment, that the character preserves throughout the story an identity correlative to the story itself.[2]

Mark Johnson offers further support for this narrative unity by showing the cognitive basis for it. He shows that there is a narrative unity to our experience, so it is only natural that this unity is carried over into our understanding of self and our descriptions or stories that we use to communicate our lives to others. In fact, this narrative core is an imperative to a meaningful, coherent human life:

> Life stories are thus *tasks we perform in composing our lives*, and they are motivated by these sorts of pressing practical and moral considerations, partial solutions to which constitute our present identity. Consequently, living out a narrative quest is not merely optional, if we hope to make sense of our lives at all. Making *at least some* sense of our lives is something we all try to do in varying degrees and with different amounts of success and failure. Whether or not we ever verbalize our self-understanding, we still at least minimally seek to construct our life narratively.[3](Italics original)

The role of narrative in the clinical encounter is actually twofold, and Ricoeur recognizes both aspects. Narrative both defines our selfhood, and in narrative, such as the well taken history in a clinical setting, the patient is given an opportunity to express herself as herself to the doctor. But narrative also allows the incorporation of

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[2] Paul Ricoeur, *Oneself as Another*, trans Kathleen Blamey (Chicago: University of Chicago Press, 1992), 143.

[3] Mark Johnson, *Moral Imagination: Implications of Cognitive Science for Ethics*, (Chicago: University of Chicago Press, 1993), 178.

the contingent into the life story—as humans we both act and *suffer*, and making sense of this suffering can be facilitated by a truly narrative encounter with a care provider.

Narrative philosophy also has two roles in medicine as a profession as well. Narrative ethics uses narrative theory to resolve ethical dilemmas in clinical situations, and opposes itself to the principalist theory.[4] Here the gathering of narrative detail—allowing all the involved parties to fully participate in the "telling of the story" stands as a different path to resolving conflict without resort to outside principles. Narrative medicine has also gathered force as a new way of approaching the clinical encounter that emphasizes listening for and respecting the story of the other as a way of increasing the physician's therapeutic potential by honoring more fully the selfhood of the patient.[5]

In *Reflections on the Just*, Ricoeur explains why narrativity and his concept of a narrative selfhood are so critical to the clinical encounter. Medicine, as a profession directed at helping others, and in particular at ending or reducing suffering, must understand the patient's suffering well enough to address it. Suffering, for Ricoeur is, "not defined solely by physical pain, nor even by mental pain, but by the reduction, even the destruction of the capacity for acting…"[6] He writes this amidst a discussion and defense of Aristotelian ethics—each of us seek goods to achieve our individual,

[4] Rita Charon and Martha Montello, eds, *Stories Matter: The Role of Narrative in Medical Ethics,* (New York: Routledge, 2002).

[5] Rita Charon, *Narrative Medicine: Honoring the Stories of Illness,* (Oxford: Oxford University Press, 2006).

[6] Paul Ricoeur, *Oneself as Another*, 190.

unique conception of "the good life". Our goals in turn inform our sense of self, and are central to our story—our narrative. It is the thought of what we wish to achieve with our lives that frames the story for us. It determines what is important, and what is forgotten:

> …between our aim of a "good life" and our particular choices a sort of hermeneutical circle is traced by virtue of the back and forth motion between the idea of the "good life" and the most important decisions of our existence (career, loves, leisure, etc.) This can be likened to a text in which the whole and the part are to be understood in terms of each other.[7]

The hermeneutic of understanding the part through the whole, and the whole in the part is a crucial skill in medicine that requires narrative competence. In medicine the part is represented by the presenting complaint, and the whole is the person's story or narrative project. They must be "read" together for the full meaning at that moment to be appreciated.

Because the story of self is completely intermeshed in our sense of "the good life," a physician, whose goal is to end or reduce suffering, must know the story to know how to proceed. The example of the young woman in a Jehovah Witness family makes this point quite well. There were many possible wrong turns that would have healed her body, yet increased her suffering—particularly when suffering can be understood as loss of relation. A decision to straightforwardly value beneficence, defined in a narrow sense of doing what is good for the body, and deny her

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[7] Ricoeur, *Oneself as Another*, 179.

"autonomous" choice to refuse blood voiced in front of her family, may well have led to her losing her family's love and support even though she did not choose the blood products. Similarly, respecting her autonomy in a straightforward sense would probably have led to her death. Without what Charon refers to as "narrative competence" either loss of relation or loss of life could have been the result.[8] Both ends fail to relieve suffering, and thus fail in the simplest test of what constitutes a successful therapeutic encounter.

Suffering, defined in the large sense that Ricoeur has given as loss of capacity to act, is the circumstance that initiates a relationship between the physician and the patient with the common goal of relieving the suffering:

> Let me recall what constitutes the heart of medical ethics, the establishment of a caregiving agreement. This is an act between two people, one of whom is suffering, who presents his compliant and requests help from an expert in matters of health and the other of whom knows, knows how, and offers his assistance. Between these two people an agreement is concluded based on trust…[9]

It seems odd to place the physician-patient relationship at the center of medical ethics, but remembering that Ricoeur is working with an Aristotelian sense of ethics makes this clearer. Medicine, whose goal is to relieve suffering, begins in a relationship of trust where the patient's need becomes the physician's objective. They pursue the

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[8] Charon, *Narrative Medicine: Honoring the Stories of Illness,* 110.

[9] Ricoeur, *Reflections on the Just*, 213.

goal together, but this can only be achieved if the physician correctly ascertains the goal of the patient—suffering is more than pain and physical infirmity, so without a sense of the patient's story the physician has little chance of addressing completely the causes of suffering.

The story of the patient is important in the sense just described of clarifying the source of suffering, the perceived lack of the patient, but is also important in a second sense—a relationship of solicitude requires that the self of the patient be revealed to the doctor if the doctor is to be able to correctly diagnose and treat the patient:

> Every case is particular in relation to medical knowledge and general medical know-how. Here too it is necessary to interpret in an appropriate manner the available medical knowledge, through an intelligent use of the ability to classify the disease in question…this also requires, describing, in an appropriate fashion, on the narrative plane…the symptoms of the case, which come from the personal history of the patient.[10]

This is a remarkable insight for a philosopher who has not practiced medicine. The symptoms given by an individual patient are far more meaningful, and are much more likely to lead to a correct diagnosis when they are understood within a narrative context. The same set of symptoms—abdominal pain, vomiting, anorexia can signify appendicitis in one person, and an acute exacerbation of chronic pelvic pain following a history of physical abuse in another. The life story separates, or individuates, the

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[10] Ricoeur, *Reflections on the Just*, 219.

two similar sets of symptoms, because the context of the symptoms is not similar. This is one reason emergency physicians order more tests to make a diagnosis than a primary care physician: not knowing the patient's story, they rely more heavily on technology to separate the life threatening from the less urgent or acute.

Ricoeur's discussion of narrativity is closely related to the singularly of the encounter quoted at the beginning of the chapter, but singularity needs additional description to round out the meaning of "the just distance". Obviously, the move from narrativity to singularity is not a quantum step—the singularity of narrative is crucial to narrative selfhood. We each have a story that is only our story, and although we do not control many aspects of it, our goals are individually chosen. But if illness is not unique, suffering is always singular because suffering represents the intersection of illness and selfhood. The same illness affects different individuals with different life stories, values, and goals very differently.

It is the importance Ricoeur places on the singularity of the patient's history, and the singularity of each encounter that makes the new principle be best articulated as "the just distance" rather than "respect for narrativity" or "respect for autonomy". Finding the just distance is more than giving narrativity it's due—it also requires acknowledging that the correct "distance" for this encounter will be different than the last, and that the story of the patient is part of what determines this distance. The degree of suffering and illness is also part of the dialectic:

> A third precept adds to the ideas of nonsubstitutability and indivisibility that of self-esteem…This precept speaks of more than the respect due another

> person. Esteem has to do with oneself. Yet in the situation of caregiving, particularly when one is hospitalized, there is a tendency to encourage the sick person to regress to dependent forms of behavior…The caregiving agreement ideally implies a correspondence between the two partners in the agreement. But the regression to a situation of dependence, once one enters the phase of serious treatments and situations that may be lethal, tends insidiously to reestablish the situation of inequality that was supposed to be set aside by the caregiving agreement…The only way to fight against such offensive kinds of behavior is to return to the exigency at the base of the caregiving, that is, to the associating of the patient with the carrying out of his treatment or, in other words, to the agreement that makes the physician and patient allies in a common struggle against disease and suffering…In self esteem a human being approves his existence and expresses a need to know that his existence is approved by others.[11]

This long quotation makes several important statements regarding singularity and the just distance. Its central theme is that the caregiver needs to remember to not lose sight of the human dignity of the patient that is at the core of the relation established for healing. Dependency occurs as a necessary result of disease and treatment, but the dignity of the person must be preserved and held by remaining "allies in a common struggle". The just distance is a moving frame of reference particularly in an extended illness with varying degrees of debility and dependence, but the right

[11] Ricoeur, *Reflections on the Just*, 203.

relation is the one that best preserves the patient's self-esteem, and it is the doctor's responsibility to keep this central in her assessment of the relation.

Ricoeur is also correct that with serious illness there can be a tendency for the physician to stop treating the patient as an ally against a disease and instead push the dependent person to the side and fight the disease single-handedly, leaving the patient behind. This tends to happen at times of great dependency when the patient is already feeling a loss of selfhood and the doctor's loss of interest in the patient as a person only reinforces this. It is, as Ricoeur reminds us, at these times especially when the doctor needs to reaffirm the person, the story, the self-esteem of the other. It can be as simple as continuing to consult the patient as much as possible about each new treatment or intervention being proposed rather than moving ahead with what the physician believes to be in the patient's best interest. The respectful dialoging even when the patient is too ill or overwhelmed to truly make each decision in the fullest sense of "informed consent" reminds the patient of her personhood and that the treatment is *for* her, not simply *against* the disease. She remains a part of the team, rather than a bystander.

The quotation also illustrates the many unique factors in each relation that must be brought to bear on a determination of the just distance: the patient, the illness, the level of dependence, the course of the illness (the temporal variability), and the physician as the other side of the relation. Narrativity is crucial to seeing the patient and the disease (the whole and the part) and how together this combines to create a unique instance of suffering. Narrativity implies this singularity, but Ricouer

brings the concept of singularity to the forefront in order to remind us that the just distance can never be "pre-set" or assumed based upon any circumstance except the present.

Ricoeur also sees the caregiving relation as a struggle against a particular form of singularly—the singularity of suffering:

> Suffering…is the ultimate refuge of singularity…It is true that suffering is not just the concern of the practice of medicine. It affects and upsets one's relation to oneself as the bearer of a variety of abilities and also many of our relations with others, in our family, at work…but medicine is one of those practices based on a social relation for which suffering is the basic motivation and whose *telos* is the hope of finding help and perhaps healing.[12]

This dual alienation from self secondary to the patient's loss of ability and from others is one reason suffering is greater than the physical pain itself. The caregiving relation is ideally a reduction of suffering simply by reestablishing relation with the suffering individual. The treatment if successful then directly heals the schism between the patient and herself as her abilities return. These abilities in turn are what allow her to fulfill her commitments to others—and this "promise keeping" is at the heart of Ricoeur's understanding of selfhood.[13]

The quotation at the beginning of this chapter also speaks to the "unique" alliance between physician and patient, and both quotations contain the implicit

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[12] Ricoeur, *Reflections on the Just*, 199.

[13] Ricoeur, *Oneself as Another*, 268.

reminder that the physician is the other side of the relation, and the uniqueness of the agreement includes the physician component as well. The same doctor does not respond similarly to each patient or each situation—Balint analysis has shown that doctors react differently to patients depending upon a host of memories or feelings that may be elicited by an individual patient.[14] This also is part of the unique interchange and may play an important role in what distance will work best for this relation, or even if the relation is workable. The unsaid aspect of the just distance is that sometimes the unique mix does not work at any level, and the best relation is a non-relation with the patient finding a doctor that is capable of hearing and respecting her story.

The other important aspect of the just distance as a principle is the centrality it places on the relation itself. Tauber is correct in criticizing respect for autonomy as a principle that is not relational in its focus, and tends to create too much distance between doctor and patient. His observation is that it has lead to a market economy between physician and patient because the patient essentially becomes a consumer of goods offered by the health care provider after reviewing the options. Like shopping, a choice is made and "let the buyer beware"—the responsibility has shifted to the consumer of the health care product. Ricoeur is clear that this is the wrong direction for medicine to take, and that to do so is to forget its origin as a social relation—a caregiving agreement within a larger context of society, between two people:

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[14] Michael Balint, *The Doctor, His Patient, and the Illness,*(New York: International Universities Press, 1957).

> ...medicine is not a form of commerce. Why? Because the patient, as a person, is not a form of merchandise, even though further along something has to be said concerning the financial costs of providing care, something that stems from the contractual relation and brings into play the social dimension of medicine.[15]

It is a social relation also in the sense that historical rules have developed that govern the behavior of the physician, and as Ricoeur acknowledges, there are financial implications to medicine that go beyond the two people immediately involved in the relation.

The caregiving agreement is a relation of solicitude—but not of friendship. Friendship is a relation between equals, and the doctor-patient relation does not start as a relation between equals:

> In the beginning, a moat and even a noteworthy dissymmetry separate the two protagonists. On the one side is someone who knows what to do; on the other, someone who is suffering. This moat gets filled, and the initial conditions become more equal, through a series of steps beginning from each side of the relationship.[16]

Here Ricoeur's analysis of the caregiving relation breaks sharply with Sherwin's. He acknowledges the initial asymmetry of power, but argues that this asymmetry must not persist in a successful doctor-patient relation. It is a joint commitment to

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[15] Ricoeur, *Reflections on the Just*, 205.

[16] Ricoeur, *Reflections on the Just*, 200.

narrativity that begins the process of equalization—the patient must "bring to language" her suffering, and the physician must "follow" her.[17] Once the story is shared, the next step of equalization involves mutual promise-keeping: the patient promises to follow the doctor's advice and the doctor promises to remain true to the needs of the patient. On the doctor's part this is a promise to place the needs of the patient first, and also to seek the healing of the individual over the needs of medical science itself.

It would seem that this equalization of the relation through mutual promises, Ricoeur refers to it as a "covenant", stands against the variability of relation that I am seeking in the just distance. In fact, the promise-keeping is the pre-condition of the relation, and the variability of the just distance still presupposes this foundation. That is to say without relation, there is no measure of distance, and there must be a mutual commitment to relation for a caregiving agreement to proceed.

Ricoeur's discussion of the relationality involved in the patient encounter is situated in the larger context of his philosophy of relationality. In *Oneself as Another*, Ricoeur argues for both a narrative and relational unification of self. These two concepts are closely related, so there is not only a lack of contradiction in this position, it would be better to see the two terms as different perspectives on the same question. The most obvious connection between narrativity and relationality is the way in which significant events in our life's story interweave with the story of others. The relation between patient and doctor is significant for both—the suffering for the

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[17] Ricoeur, *Reflections on the Just*, 200.

patient, the *telos* of ending suffering and giving solace for the doctor. The relation is part of both narratives—it in fact furthers both narratives, and this is only one aspect of why there can truly be no narrative without relation. Suffering, for Ricoeur, has been defined as a loss of ability. This includes the act of telling one's story:

> But we must go further and take into account more deeply concealed forms of suffering: the incapacity to tell one's story, the insistence of the untellable—phenomena that go far beyond mishaps and adventures, which can always be made meaningful through the strategy of emplotment.[18]

In this statement Ricoeur brings out how suffering and narrativity are connected; that is, that the failure of narrative may enhance or even be central to one's suffering. Relation may then be therapeutic by "giving words" to the untold story—helping the patient find meaning, and thus relief from her suffering. As Charon explains in her description of narrative competence in a medical encounter, the reader (physician) interacts with the narrative to both draw it out, and in the relation, actually change it:

> The skilled reader or clinician learns to select an interpreter who "fits" the particular text or patient—for example some texts need a forgiving reader instead of a skeptical one, and some patients need an authoritarian doctor instead of a collegial one. Developing skill as a reader or a clinician entails knowing which of one's countless registers to bring to bear on each interpretative situation. The reader adopts his or her readerly stance toward the work—based in part on the makeup and behavior of the narrator but also

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[18] Ricoeur, *Oneself as Another*, 320.

> based on the reader's own makeup and behavior—which will *alter* the work. (Italics original)[19]

The narrative is both drawn out by the relation, and in a doctor-patient relation this drawing out is part of the process of healing, and the narrative is changed, or even shaped together in the relation.

The story of our lives is completely dependent upon others—our significant actions of promise keeping, responsibility, and caring all have no meaning except in the context of relationality. There can be no story without relation; the story, and thus our selfhood, is created in our encounters with others. To see the medical encounter as both relational and narrative is itself derivative of the narrative, relational selfhood that Ricoeur posits.

In describing the just distance in terms of narrativity, singularity, and relation I hope to have shown that Ricoeur's principle is not subject to the same critique as the principle of autonomy. It is consistent with a feminist (and Ricoeurian) understanding of selfhood in relation with others, rather than as an atomistic ego. Its unique contribution is the recognition of singularity—that each relation must encompass the stories of the people involved and therefore there can be no single answer that will describe the correct relation—it must be found in the encounter itself.

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[19] Charon, *Narrative Medicine: Honoring the Stories of Illness,* 110.

CHAPTER IV

THE JUST DISTANCE: A RESPONSE TO POSSIBLE CRITIQUES AND ITS APPLICATION IN THE MEDICAL ENCOUNTER

One of the strengths of the principle of autonomy is its simplicity in application. Physicians who have never read Kant nor have any familiarity with the history of autonomy as a philosophical concept have had little trouble adjusting their practice to increase the autonomy of their patients, once this was an accepted goal in medical practice. This simplicity led to certain benefits already described—it ended the acceptability of paternalism, and increased the discussion of risks and benefits buttressing truly informed consent before significant procedures. Perhaps the ascendant time of the principle of autonomy was a developmental phase of medicine, but now it is time for a more inclusive, relational principle: just distance.

The last chapter explained what is philosophically "behind" Ricoeur's conception of the just distance. The work still to be done is to apply the new principle in clinical encounters and show how it would function differently than a principle of autonomy, and to respond to the two most obvious critiques of the just distance. The first critique that I believe needs to be answered by Ricoeur's principle is that it presents too great a challenge in application to the clinical encounter. The

other concern that I see as a possible response to the just distance is that it does not actually articulate any difference in comportment for the good physician in a typical patient interaction.

Objection I. The Just Distance sets too high a standard for clinical relationships

The principle of autonomy is understood outside a philosophical setting, and this understanding differs from the philosophical history more in its depth than by any significant substantive distinction. The just distance has no similar history, so adoption of it as a principle will require a genuine education and re-education of physicians. This is obviously both a challenge to be overcome, and an opportunity to improve physician understanding of narrativity and relationality. As Rita Charon amply demonstrates in her book *Narrative Medicine*, there is a great need to re-teach the basics of a successful clinical encounter to many doctors, and the effect of this would be to improve the lives of patients and doctors alike.[1] But since the adoption of the principalist theory was not preceded by an effort to re-educate existing physicians in its nuances, why should its modification? Doesn't this suggest an untenable closeness to philosophical theory that will not translate well into a clinical setting by doctors neither trained nor comfortable in philosophy?

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[1] Dr. Charon writes that even the classical formula of history taking, beginning with the history of present illness, and then moving to past illness, and only later taking up a "social history" where a patient's opportunity to tell a story outside very narrow confines begins to open a little closes off a narrative telling for the patient, and even the listening is circumscribed to direct answers to questions. Rita Charon, *Narrative Medicine*.

The counter to this is that to not do this work is to ignore problems in medicine that will not improve without attention. Tauber, echoing Charon, sees the autonomy model of care at the heart of the problems plaguing medicine, so if this represents a difficult course correction then that only further signifies how far we have veered from a relationship that truly serves the needs of our patients.

There are also many precedents for retraining the clinical skills of physicians. This year, for example, all physicians in Oregon must spend an additional eight hours of continuing medical education time specifically focused on chronic pain management because it was decided that as a group we lacked an essential skill. To decide at a national level that narrative, relational skills have been undervalued and appreciated and that physicians must acquire this expertise who wish to continue clinical practice is no insurmountable feat. If Tauber is correct that physicians also sense the inadequacy of the current relational model (or non-relational model as I have suggested), then there may be less resistance to this proposal for change.

However, even if the problem is clear to many, and the possibility of teaching a new approach to the clinical encounter is also feasible, the real impediment to improvement is economic. Physicians have been driven by demands for greater productivity, and rising overhead costs, especially malpractice insurance, to see ever greater numbers of patients with less time allotted to each patient. This obviously works strongly counter to developing an ethic of the clinical encounter that relies upon attentive listening and establishing a rapport unique to the situation presented by that encounter. I am not suggesting that this can be done well, or even at all, in a ten

minute visit. Rather the solution to this may be from physicians ourselves if we are willing to trade-off income for job satisfaction—that is treating fewer patients well rather than deriving more income from seeing more patients, but with the physician cost of being left always with the sense of what was not done. This hope is similarly stymied by the increasing number of physicians who work for corporate entities that dictate physician schedules rather than letting them find a pace that works for them. If this discussion has journeyed far from the philosophical question of whether the just distance is a better principle than respect for autonomy it is only because just as this project arose for me in real world concerns, I cannot wholly leave them behind as I try to envision how it could work "in the trenches."

Objection II. The Just Distance is a new name for a good doctor

If the just distance is an obtainable clinical goal, is it actually a new one? Is this not the manner of approach offered by any good doctor given the clinical setting that allows it? One aspect of this argument comes from the justification I have offered for it: if we are narrative, relational beings, it would not seem necessary to put forth a principle instructing doctors to be simply who they are—narrative and relational in their approach to patients. There are both truths and flaws to this response that I would like to elucidate.

Although the just distance is founded upon narrativity, relationality, and singularity, Ricoeur is still suggesting something new rather than a repackaging of his philosophy when he first suggests it. As discussed in the last chapter, the patient-doctor relation is a specialized relation—it is neither friendship, nor commerce. Both

the need of the patient to be rid of suffering, and the implicit promise of the physician to ease that suffering to the extent that she is able, are foundational to the encounter. As a special type of interaction, medical students are trained in its rules. But there is a substantial difference between the training they currently receive and the training that would occur if the principle of the relation was changed from respect for autonomy to finding the right relation—the just distance. Two examples may serve to illustrate this.

I remember an elderly patient (this is a composite without identifying detail and this type of interaction has occurred many times in my clinical practice) with a pelvic mass that could possibly represent cancer, although the radiographic characteristics were not terribly suspicious. A significant surgery was the only option that would give a definitive diagnosis, and constitute treatment, or at least its beginning. However, she also had numerous pre-existing health issues that substantially increased the risks of surgery. She asked me what I would do if I were in her place. Like most physicians, I was taught that to answer this question potentially violates her autonomy because my opinion would carry too much weight, and she would tend to follow it perhaps even over her own judgment. But I could also see that she was having real trouble with the decision, and her husband was equally at a loss, so I gave an answer something like this: "Well, I don't think this mass is a cancer, although I cannot be sure, and the risks of the surgery itself worry me more than the risk of it being cancer, so I think I would forgo the surgery."

Her response shows how, I believe, I had correctly judged this situation and that my answer that some would judge as being too close, too assertive of my values, actually helped her. After hearing my answer she decided to go ahead with the surgery because she said it had clarified the issues for her, and that she was more afraid of cancer than of surgical complications. Ironically, she was able to make a decision that was truly more her own because in closing the distance—that is, by showing her how I thought about it, she was then able to differentiate her thinking from mine, and make a decision that she now trusted. I think the narrative and relational aspects of this example illustrate what is meant by the just distance. It was after listening to her and hearing her struggle with the decision that I decided to speak as I did. Some of her story was known to me, but my response gave her an opportunity to make a decision based upon her fears and values. The closeness of the relation was only possible, or advisable, because I sensed the strength in her to not simply follow my words, or adopt them as her own. The just distance here was quite close, too close by traditional standards, but that was the correct distance once the relation and the situation now allowed it—or perhaps even demanded it.

Sylvia (name changed) came to me a few months ago after visiting other doctors with whom she had been dissatisfied. She made it clear from the outset that she needed to discuss exhaustively all her options and that she was suspicious that doctors just, "wanted to do the hysterectomy and move on." She was both interesting and thoughtful so it was easy to spend the extra time discussing and sometimes re-discussing the risks and benefits of the various treatment options. But as time went

on, particularly after she chose surgery and then continued to come to discuss hormonal side effects, we were spending less time talking about treatment and more time just discussing her life, politics, and life in general. She had set an initial distance that was greater than most encounters—she admitted suspicion and a history of relations with physicians that had not been healing or caring. But in this example the temporality of the just distance is also made evident—the distance changed (closed) over time as suspicion was replaced by trust and mutual respect. The obvious fact that relationships develop over time and that as the needs, concerns, and even sense of autonomy of the patient changes the correct comportment of the physician to the patient must also change is simply not accounted for in the current formulation of the principalist theory.

III. Remaining Issues

I have until now discussed the just distance as a principle in isolation but the proposal is not to replace four principles with one, but rather to replace one of four principles. This is not merely a tactic—it is I believe how Ricoeur would have argued as well. Although there are some proponents of narrative ethics that believe narrativity replaces norms or principles, many others, including Ricoeur himself, believed that principles were still useful when adequately situated in a narrative context, and aided by moral imagination.[2] So although the remaining principles of beneficence, non-maleficence, and social justice may come into play less often, they

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[2] Julian Savulescu, "Autonomy, the Good Life, and Controversial Choices", *The Blackwell Guide to Medical Ethics*, eds Rosamond Rhodes, Leslie Francis, and Anita Silvers,(Malden: Blackwell Publishing, 2007), 18.

are still relevant in many situations. To listen attentively to each patient's story and to seek to work as a partner toward furthering her goals will not always be possible. Sometimes these goals may themselves violate other principles, such as when physically healthy people who seek amputation of normal limbs—a desire arising from perceptions that the patient may not be willing to address.[3] Classical medical ethics cases have also sometimes centered more on the principle of social justice. The allocation of kidney dialysis machines when they were originally far fewer machines than patients is one such example. So although the just distance will do much of the work in the more commonplace clinical encounter, the other principles remain relevant and necessary.

The last concern I wish to return to is whether the just distance can be derived from the "common morality" that Beauchamp and Childress defend as the basis for the four principles. Remembering that the common morality is a set of norms that could be agreed upon by "morally serious people," I believe the just distance similarly meets this standard. The concept of narrativity is itself derived from understanding humans as teleological, and we transmute these goals coupled with the events of our lives both chosen and accidental into a story of ourselves that allows us to make sense of ourselves and the world. While narrative unity of self is not a universally held philosophic belief, the ground of narrativity—the teleological nature of humans does approach this standard. Relationality is an emerging concept, so

[3] Paul Ricoeur, *Reflections on the Just,* trans. David Pellauer (Chicago: The University of Chicago Press, 2007), 213.

much so that adherents of autonomy including Beauchamp, Childress, and even Tauber have tried to reconcile autonomy and relationality. In short, given the tenuous nature of their own linkage to common morality, I do not think that this offers a significant challenge to the addition of just distance to the Principalist theory.

It seems strange to suggest that the time for respect for patient autonomy needs to come to an end. It is not that patients deserve less respect; it is in fact that respect needs to be construed as more inclusive than only autonomy. We must teach instead respect for personhood—in all its narrativity, relationality, and singularity. Unlike the principle of autonomy which can be abrogated by loss of competence or by a cultural desire to not converse about illness in the way in which autonomy as a principle requires, the just distance acknowledges difference—in fact as a recognition of the singularity of each person's story and of each moment in that person's life it is centered in gauging the differences before it, and negotiating the best path through them. This is real respect and care in a doctor –patient relation and this should be the next principle guiding medicine.

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