2000

The Ethics of Caring and Medical Education

William T. Branch, Jr. Md, MACP, *Emory University*

ARTICLE

The Ethics of Caring and Medical Education

William T. Branch, Jr., MD

ABSTRACT

The ethics of caring, though the subject of much recent discussion by philosophers, has hardly been applied to medical ethics and medical education. Based on receptivity (that is, empathy and compassion) toward and taking responsibility for other persons, the ethics of caring has particular relevance to medicine. Caring guides the physician always to remain the patient's advocate and to maintain the therapeutic relationship when dealing with and resolving ethical dilemmas. This article discusses the philosophy behind the ethics of caring and then explores three issues that arise within its context: receptivity, taking responsibility, and creating an educational environment that fosters caring.

Acad. Med. 2000;75:127–132.

The traditional triad of principles—beneficence, autonomy, and justice—is very familiar to anyone who has sat in a class on medical ethics. We teach our future doctors to solve ethical dilemmas by juggling the weights of these three principles, which often lie in opposition to each other, until they reach an agreeable outcome. Depending on the decade, we may even offer our bias as to which principle trumps the others; beneficence, long the favorite of the paternalistic medical profession, gave way to autonomy and the idea of patients' self-determination. As economics ever more strongly influences health care delivery, justice may be the principle that takes precedence.

But this detached application of principles need not be the only approach to medical ethics. The ethics of caring, which has been the focus of much recent thinking both outside and within the medical world,[1–5] offers an alternative that may stand alone or enhance the application of other principles and that seems particularly suited to the medical environment. Carol Gilligan, in her landmark studies of the moral development of girls and young women,[1] described this ethical orientation, observing that women solve ethical dilemmas by seeking ways to maintain relationships rather than by making more detached judgments about what would be most fair to each party. Although Gilligan's observations were gender-specific, many philosophers now think that, depending on the circumstances, both men and women may adopt either a principled or a caring approach.[2,3] I have noticed that medical students—of both sexes—naturally approach the ethical aspects of their relationships with patients within a framework of caring.[6] Given an open-ended assignment to describe an important experience with a patient, medical students rarely provide formal reasoning based on principles; they almost always write about empathy and compassion for the patient.[6–8] For all its obvious importance, the ethics of caring has been explored hardly at all in relation to medical education and has previously gone almost unnoticed by those who teach ethics to medical students and graduate trainees. To help rectify this deficiency, it is my priority here to describe the ways in which the ethics of caring can be integrated into medical education.

Dr. Branch *is the Carter Smith, Sr. Professor of Medicine, Department of Medicine, Emory University School of Medicine, Atlanta, Georgia.*

Correspondence and requests for reprints should be addressed to Dr. Branch, The Emory Clinic, 1525 Clifton Road NE, 4th Floor, Atlanta, GA 30322; e-mail: ⟨william_branch@emory.org⟩.

PHILOSOPHY

The ethics of caring emphasizes real moral decisions and face-to-face encounters. To me, traditional debates over the clashes between ethical principles ofter seem rarified, removed from the day-to-day issues of patient care. This may explain why many doctors are uncomfortable with bioethics as it has developed in the past 20 years. But, if we ground our ethics in caring, we refocus on the doctor's responsibility for the individual patient. The patient–doctor relationship and the communication therein once again become the starting point for all ethical discussions.

The ethics of caring assumes that connection to others is central to what it means to be human; that relationships,

rather than alienation, give meaning to our existence.[4] Integral to the idea of connecting is the meeting of needs of significant other persons, which goes beyond being simply fair. This ethics, then, is based on the desire to be receptive to and responsible for others—to be a caring person.

The ethics of caring requires that we feel as well as reason. Our natural impulse to care comes from compassion and human love.[4] Though I believe that true caring incorporates reasoning, it cannot be reduced to problem solving. It emphasizes as much the motivation as the consequences of an action. Instead of striving for impartiality in moral judgments, the ethics of caring acknowledges the importance of partiality and the special bonds and responsibilities that structure our relationships.

Philosophers have termed caring a moral orientation, one in which ethical behavior results not only from moral reasoning but also from moral sensitivity (the ability to recognize a moral problem when it exists), moral motivation (the degree to which one prioritizes moral values over other values or desires), and moral character (the courage, persistence, and skillfulness involved in implementing moral behavior).[9,10] Moreover, an orientation to caring incorporates the attributes of attentiveness, honesty, patience, respect, compassion, trustworthiness, and sensitivity into all aspects of moral behavior.[11]

In the clinical setting, the caring physician exhibits two primary attributes: receptivity and responsibility.[1,4] A receptive physician listens to patients with empathy and compassion.[8] A responsible doctor transforms those feelings into action, meeting the patients' specific needs. I believe that students arrive at medical school already receptive (in fact, many of their ethical difficulties arise from their intense empathy for patients[6–8]). The students then learn to translate that empathy into action by taking responsibility for their patients. Unfortunately, we find that medical education sometimes beats students' ability or willingness to care right out of them. Whatever the outcome, the ethics of caring obviously underlies and permeates medical education. Yet, few students (not to mention educators) are even aware that they are working so much within this moral orientation. My premise is that an understanding of the ethics of caring will be helpful to students and educators alike: it may open their eyes to what should have been obvious all along, that as caring guides their actions, it facilitates and complements the application to patient care of other ethical principles such as beneficence, autonomy, and justice.

In the following sections, I focus on three main aspects of the ethics of caring as it pertains to medical education: (1) preserving receptivity (empathy and compassion) in medical students; (2) teaching students to take responsibility for patients; and (3) ensuring a teaching environment in which these attributes are valued.

BEING RECEPTIVE: FEELING EMPATHY AND COMPASSION FOR PATIENTS

In previous studies, my colleagues and I read more than 200 critical-incident reports written by third-year medical students; the major theme in the majority of them was empathy and compassion for patients.[6–8] One medical student identified with the overwhelming grief of a family of a boy killed in a bicycle accident, but felt somewhat like a voyeur. She desperately wanted to express her feelings, but lacked the words and skills to do so.[7] Another student recoiled when he inflicted pain on a patient during a pelvic exam; on reflection, he was glad he had not become insensitive.[7] A third student found viewing the dead body of her patient disturbing, but was grateful to a nurse who made the experience more human. "Mrs. D's face was blue, her eyes were open, she had hematomas everywhere, and she was not stiff. One of the nurses asked me to stay and then proceeded to change the sheets, put a new johnny on Mrs. D, and close her eyelids. She switched on a soft overhead light, put Mrs. D in a position that looked like she was sleeping soundly, and then left. I wasn't embarrassed to cry."[8]

The students' receptivity to their patients was more intense than what people develop in ordinary, day-to-day interactions. There may be several reasons for this. Students arrive on the wards idealistic. Because they are new, they may also feel like outsiders, and thus relate to some of the emotions that patients experience in the unfamiliar hospital environment. As future doctors, the students are inherently trusted by their patients, and they often have the time to listen to those patients, who, ill and dependent, share their most intimate thoughts and feelings. It seems, then, that students are naturally receptive, at least in the beginning.[6]

Many have observed, however, that doctors lose this intense receptivity to patients later in their training.[12–16] This suggests that medical education fails to maintain and may even suppress students' orientation toward caring. Young doctors suppress feelings and put aside values (temporarily?) in order to get on with their training and work.[17,18] This suppression of empathy not only prevents moral development but may even erode existing moral values.[18–21] In addition to their own suppression, young doctors are assimilated into a ward culture that does not value empathy.[22] I have observed that this assimilation threatens the students' moral sensitivity, moral commitment, and even moral character—all aspects of their ability to care—more than it threatens their ability to reason about ethical issues.

How, then, might we maintain the students' natural receptivity throughout their training? Some have had success by providing medical students with opportunities to reflect on the meaning and purpose of their work in small groups facilitated by carefully selected clinical faculty.[23–25] Small

groups also let students and faculty share feelings and support each other.[25] I think that providing a regularly scheduled time for reflection in small groups in the midst of the intense learning on the wards will help to balance the medical educational process for students in a way that tends to maintain their caring orientation.[6,23] Reflection may to some extent enable them to integrate their empathy for patients into action. And, understanding how the caring orientation underlies medical ethics allows one to understand the ethical importance of incorporating the attributes of caring, attentiveness, compassion, sensitivity, trustworthiness, and empathy in the ways one carries out one's actions. So, students not only should reflect on their values, but also should learn how to put their values into practice. This can be accomplished by combining the teaching of medical ethics with learning patient–doctor communication skills.[24] There are data showing that such efforts are effective.[26–29]

TAKING RESPONSIBILITY: PUTTING THE ETHICS OF CARING INTO ACTION

While receptivity lays the foundation for caring, taking responsibility is the way in which caring is put into action. Students must be taught how to translate receptivity into responsibility. Taking responsibility, within the context of an ethics of caring, means caring for another person despite various obstacles, whether institutional or personal. As part of a regular educational exercise, we ask students to role-play a physician facing such obstacles.

In the role play, students encountered a 60-year-old, homeless, diabetic man. He had earlier been treated with antibiotics for an infected left foot and released, but after several weeks he returned, his leg gangrenous, infested with maggots, and clearly in need of amputation. Although mildly demented, he adamantly and clearly refused amputation. When pressed, he fatalistically expressed the conviction that everyone eventually dies, thus implying a willingness to accept death from sepsis. A psychiatrist judged the patient incompetent, but a social services worker, concluding that the patient understood the implications of refusing amputation, declined to seek a guardian for the patient. The patient then demanded a wheelchair so that he could leave the hospital. We asked the students to talk to this patient about the consequences of his refusal to undergo amputation.

In most cases, the student explained the need for amputation, the patient refused, and the dialog deteriorated into repetitious argument, the student repeating the indications for surgery, the patient adamantly refusing. When later discussing the case, some students reverted to a discussion of ethical principles, identifying the conflict between beneficence and the patient's autonomy, but finding no solution for the conflict. Interestingly, in over a dozen renditions of this role play with medical students and residents, none started by expressing empathic understanding or otherwise attempting to build rapport by getting to know the patient better, and none in the initial go-round began truly to negotiate with the patient. I believe that this role play can be redirected more productively in several ways.

How would the students' approach in this case differ if they explicitly acknowledged that the moral orientation toward the patient would be the ethics of caring? Because of the high value this ethics places on maintaining the relationship, they would almost certainly begin by seeking to understand the patient's viewpoint and getting to know more about him. Also, by focusing their efforts on maintaining a therapeutic relationship, they would necessarily aim the discussion toward a negotiated solution that would provide the best care under the circumstances. This avoids irresolvable conflict between the student–doctor and the patient by opening the discussion to a larger number of possible solutions. For instance, the student and the patient might agree to try a medical therapy, with the understanding that amputation might be necessary if the patient did not get better; the student might agree to provide a wheelchair in return for the patient's agreement to comply with recommended follow-up and possible future treatment; the student might arrange for the patient to talk with an amputee who has mastered the use of a prosthesis; and so forth.

I believe the framework of caring has even deeper ethical implications in cases such as this: it facilitates a deeper integration of ethical principles with one's motives, implementation, and actions than usually results. For example, good care demands that a physician not be deluded by a false sense of respect for autonomy when, in effect, the physician really wants to get rid of a troublesome patient (for instance, by prematurely allowing him to sign out against medical advice). Hence, the ethics of caring tempers the application of the principle of autonomy by insisting that the physician seek a full and deep understanding of why the patient refuses treatment, and that he or she do this with sensitivity, attentiveness, honesty, and respect for the patient. The caring physician, while always respectful, also takes into account the patient as a vulnerable person, less knowledgeable than and dependent on his care providers.

An ethics of caring also avoids the trap of becoming legalistic. Although their actions are limited by the law, if physicians begin with the caring orientation, they avoid becoming adversarial, since they are obliged to approach the patient with the intention of maintaining the caring relationship. This avoids premature closure of the conflict based on legalisms.

Might it be possible that a physician committed to caring would allow the patient to sign out against medical advice? Possibly, because the physician legally would ultimately have

to respect the autonomy of a competent person, but would do so from the ethical viewpoint only if there were truly no preferable alternative acceptable to the patient, short of the caregiver's or institution's becoming unacceptably impaired themselves, so that signing out against medical advice were truly the best that could be done under the circumstances. In the latter case, it would be mandated that all efforts at achieving a better solution were previously exhausted and all efforts to optimize future care for the patient were pursued.

Actions grounded in caring also differ from those based purely on principles in that the caring orientation mandates that physicians honestly seek to identify blind spots, such as frustration, anger, prejudice, and exhaustion, that impair their ability to care for patients. Thus, to be caring requires not only remaining receptive to others and seeking their viewpoints, but also knowing one's own fallibilities.

CREATING A CARING ENVIRONMENT: MODELING ETHICS FOR STUDENTS

I doubt we will ever approach an ideal caring atmosphere for patients unless we extend our caring to our students, residents, peers, and ourselves. Harsh treatment of other caregivers is unlikely to coexist with warmth and support for patients.

The following fictionalized case is a type of situation described not infrequently by third-year medical students. It details one student's feelings of not being cared for.[23] Assisting her attending physician, Dr. Winters, in a late-night cesarean section, Elizabeth was suctioning and cutting sutures when she was stuck by the suture needle. More scolding than concerned, Dr. Winters asked Elizabeth whether she was double-gloved. She then became dismissive: "Needle sticks happen in the OR. After the case, do a good five-minute scrub. But don't worry, it's happened to all of us and we're fine." Later, Elizabeth, in consultation with the nurse in the emergency ward, decided against zidovudine prophylaxis "mostly because she didn't feel she knew enough about it." The next morning, Elizabeth called Dr. Winters to see whether the patient had been tested for HIV. Dr. Winters, sounding distracted, said she thought it was unnecessary, but would try to get around to it soon.

Elizabeth waited until afternoon; hearing nothing from Dr. Winters, she went herself to speak to the patient. Mrs. D, feeling very concerned for Elizabeth, was willing to be tested for hepatitis, but, because a former boyfriend had been an intravenous drug user, she was reluctant to get tested for HIV. Elizabeth understood Mrs. D's hesitation, and they finally reached a compromise when Elizabeth promised to draw the blood herself and not enter the results into Mrs. D's records. Elizabeth, having to wait until Monday for the test results, cancelled her scheduled Saturday rounds and spent the weekend at home. She felt well until Sunday afternoon, when she began to experience an intermittent dry throat, cough, feverishness, and lightheadedness. Nobody from the hospital called to check up on her. Upon her return, she was confronted by Dr. Winters for having circumvented hospital protocol in quietly testing Mrs. D's HIV status.

Elizabeth not only received very little sympathy from her attending physician, but was also left to manage her own decisions regarding HIV prophylaxis and discovery of her patient's HIV status. Lonely and scared, she also felt inadequate to the implied task of ignoring her own needs while forging ahead in her role as a future doctor.

This theme is sadly common in students' stories. The message they are getting is to be tough, stand alone, and not expect to be cared for. By implication, such a message says: let patients suffer their fates in silence. In the story, we sense Elizabeth's vulnerability, but she never expresses her disappointment and hurt over the lack of care, and we know that her spirit will not be broken, nor will she be rendered dysfunctional as a physician by this experience. We do, however, sense a threat to Elizabeth's caring nature when Dr. Winters disparages her warmth toward and supportiveness of Mrs. D. Enough experiences like this take their toll on Elizabeth and on other students in her generation, who come to the role of doctor full of compassion for their suffering patients.[6–8]

Teaching our future physicians in this environment, in which caring is undervalued, raises another ethical question: are we asking caregivers for too much self-sacrifice? In addition to caring for others (both other caregivers and patients) doctors must learn to care for themselves. Not only Dr. Winters' hardened attitude, but also Elizabeth's willingness to suppress her own needs contribute to an environment in which caring is made secondary to other concerns. It is this realization that allows us to conclude that the caregivers should be protected from too much self-sacrifice if caring is to be maintained.

CONCLUSION

The importance of caring as an ethical orientation has been underemphasized in medical ethics, overlooked, perhaps, because it so obviously underlies ethical behavior. What I find compelling about this moral orientation is that it guides the actions of moral agents—by informing their sensitivity, motivations, and skills—in ways that affect their impacts on other persons. I find it compelling that the recognition of the importance of caring as an ethical orientation came not from thinking abstractly about ethical principles but from observing human behavior, i.e., how humans provide care

for each other.[1] One need only watch patients being cared for in a hospital ward to see caregivers applying this philosophy in practice, even in difficult, trying circumstances.

I have addressed the ethics of caring as it pertains to medical education, but I believe that it is also the most suitable moral orientation for practicing physicians. For patients dependent on their doctors, the attitudes with which those doctors deliver care—their attentiveness, kindness, and compassion—are in many cases as therapeutically important as the curative treatments. I am thinking especially of dying patients, but it is also true for many chronically ill persons, where caring is the heart of the matter. More than the framework within which we apply principles such as beneficence and respecting autonomy, the ethics of caring is itself a moral action that benefits the patient.

The ethics of caring may also guide our actions as physicians on the macro level of distributive justice and social action. Thus, when we care for our patients, we seek every possible way to improve their situations, through education, social services, family support, and all other means, before discussing discontinuation of therapy. When limiting therapy does become necessary, especially when it is an issue of the just distribution of resources, I believe that we as caregivers should not be the ones who make this decision. Social bodies such as ethics committees, institutional review boards, and courts are better suited to making such decisions, which need to be fair and applicable to all, not just the poor, the uneducated, and the disadvantaged. But even on this macro level of ethics, we as physicians have a responsibility to bring the ethics of caring to the table by serving on ethics committees and boards, by advocating for the best care for as many patients as possible, and by developing policies that reflect compassion as well as fairness. We will be better prepared to do this if we accept the ethics of caring as having particular relevance to our own medical practice. My point is that, in our responsibilities as doctors to both individual patients and society, we should be their caregivers and advocates, not judges. Understanding this distinction may help many young physicians resolve the discomfort they experience when encountering social pathology and self-destructive behavior by patients.

I have attempted to highlight ways in which the ethics of caring can change medical education, but realize I have fallen short of a systematic exposition of that ethics. I leave this to future work. As there are many interactions of doctors caring for patients, a treasure trove awaits those who wish to explore the ethics of caring in medical education.

REFERENCES

1. Gilligan C. In a Different Voice. Psychological Theory and Women's Development. Cambridge, MA: Harvard University Press, 1982, 1993.
2. Gilligan C. Remapping the moral domain: new images of self and relationship. In: Gilligan C, Ward JV, Taylor JL (eds). Mapping the Moral Domain: A Contribution of Women's Thinking to Psychological Theory and Education. Cambridge, MA: Harvard University Press, 1988.
3. Carse AL. The "voice of care": implications for bioethical education. J Med Philos. 1991;16:5–28.
4. Noddings N. Caring: A Feminine Approach to Ethics and Moral Education. Berkeley and Los Angeles, CA: University of California Press, 1984.
5. Manning RC. A care approach. In: Kuhse H, Singer P (eds). A Companion to Bioethics. Oxford, U.K.: Blackwell, 1998:98–105.
6. Branch WT Jr. Professional and moral development in medical students: the ethics of caring for patients. Trans Am Clin Climatol Assoc. 1998;109:218–30.
7. Branch WT Jr, Pels RJ, Lawrence RS, Arky RA. Becoming a doctor: "critical-incident" reports from third-year medical students. N Engl J Med. 1993;329:1130–2.
8. Branch WT Jr, Hafler JP, Pels RJ. Medical students' development of empathic understanding of their patients. Acad Med. 1998;73:360–3.
9. Duckett L, Rowan-Boyer M, Ryden MB, Crisham P, Savik K, Rest JR. Challenging misperceptions about nurses' moral reasoning. Nurs Res. 1992;41:324–31.
10. Rest JR. Background: theory and research. In: Rest JR (ed). Moral Development in the Professions: Psychology and Applied Ethics. Hillsdale, NJ: Lawrence Erlbaum Associates, 1994:1–26.
11. Wolf Z. The caring concept and nurse identified caring behaviors. Topics Clin Nurs. 1986;8:84–93.
12. Odegaard CE. Dear Doctor. A Personal Letter to a Physician. Menlow Park, CA: Henry J. Kaiser Family Foundation, 1986.
13. Shorter R. Bedside Manners: The Troubled History of Doctors and Patients. New York: Simon and Schuster, 1985.
14. Brice JA. Empathy lost: chronic illness sets a psychiatrist in search of compassion and dignity. Harvard Med Alum Bull. 1986–87;60:28–32.
15. Inglefinger F. Arrogance. N Engl J Med. 1980;303:1507–11.
16. Ort RS, Ford AB, Liske RE. The doctor–patient relationship as described by physicians and medical students. J Health Hum Behav. 1964; 5:25–34.
17. Hundert EM. Characteristics of the informal curriculum and trainees' ethical choices. Acad Med. 1996;71:624–33.
18. Feudtner C, Christakis DA, Christakis NA. Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development. Acad Med. 1994;69:670–9.
19. Self D, Baldwin D. Moral reasoning in medicine. In: Rest JR (ed). Moral Development in the Professions: Psychology and Applied Ethics. Hillsdale, NJ: Lawrence Erlbaum Associates, 1994:147–62.
20. Feudtner C, Christakis DA. Making the rounds: the ethical development of medical students in the context of clinical rotations. Hastings Center Rep. 1994;24(1):6–12.
21. Christakis DA, Feudtner C. Ethics in a short white coat: the ethical dilemmas that medical students confront. Acad Med. 1993;68:249–64.
22. Hafferty F. Characteristics of the informal curriculum and trainees' ethical choices. Acad Med. 1996;71:629–30.
23. Branch WT Jr, Pels RJ, Calkins D, et al. A new educational approach for supporting the professional development of third-year medical students. J Gen Intern Med. 1995;10:691–4.
24. Branch WT Jr, Arky RA, Woo B, Stoeckle JD, Levy DB, Taylor WC. Teaching medicine as a human experience: a patient–doctor relationship course for faculty and first-year medical students. Ann Intern Med. 1991;114:482–9.
25. Branch WT Jr. Notes of a small-group teacher. J Gen Intern Med. 1991; 6:573–8.

26. Moore GT, Block SD, Briggs-Style C, Mitchell R. The influence of the New Pathway curriculum on Harvard medical students. Acad Med. 1994;69:983–9.
27. Smith RC, Lyles JS, Mettler JA, et al. A strategy for improving patient satisfaction by intensive training of residents in psychosocial medicine: a controlled randomized study. Acad Med. 1995;70:729–32.
28. Smith R, Lyles JS, Mettler J, et al. The effectiveness of intensive training for residents in interviewing: a randomized, controlled study. Ann Intern Med. 1998;128:118–26.
29. Maquire P, Booth K, Elliott C, Jones B. Helping health professionals involved in cancer care acquire key interviewing skills: the impact of workshops. Eur J Cancer. 1996;32A:1486–9.

Correction

An inaccurate statement was made on p. 657 of Dr. Mark Albanese's article[1] in the June issue: ". . . the Health Care Financing Administration has made it illegal (and retroactively punishable) for students to make chart entries." This is not true; medical students legally can make chart entries within specified limits and often are allowed to make chart entries. Dr. Albanese regrets this error, but maintains that the larger issue—the marginalizing of both residents and students in the clinical process because of a variety of changes, including changes in the documentation process—remains valid and important.

Reference

1. Albanese M. Rating educational quality: factors in the erosion of professional standards. Acad Med. 1999;74:652–8.