

Chapter 8

BALANCING MEDICINE'S MORAL LEDGER

Realigning Trust and Responsibility

Alfred I. Tauber

This [language of rights] emphasis is a new kid on the block in medical ethics. Its tone and connotation carry a message, usually reserved for law, that has never before been a part of physicians' thinking about patients. When turned in the direction of medical decision making, it [replaces] the beneficence [responsibility] model with the autonomy model.¹

Notions of moral agency in medical ethics are deeply inconsistent. In American political-judicial culture, autonomy is sacrosanct, yet we must limit autonomy in the clinic and hospital. Patients settle for varying degrees of choice, believing, from a practical standpoint, that they maintain a sense of freedom. But more often than not, they employ such qualifying terms as "sufficiently informed" or "adequately understood," implicitly recognizing the limits of understanding and freedom. Informed consent then becomes a prescribed process, much like following a dance routine.

Yet medical ethics has been preoccupied with asserting patient autonomy as the crucial principle governing clinical care and subordinating beneficence and physician responsibility. Having purged themselves of paternalism, doctors are often seen to be practicing defensive medicine, concerned with malpractice grievances and adherence to risk management directives, with the assumed authority of a long-past era radically reconfigured. In addition, physicians are increasingly employed by corporations or governments, settings in which patients are regarded as clients, so that the

traditional intimacy of the doctor-patient relationship has been altered by these business concerns and the instability of long-term commitments.

Autonomy-based medical ethics originated from disgruntled patients and their advocates, who reacted against what they regarded as physician arrogance and drew upon legal precedent to demand informed consent in medical practice.² The pendulum swung forcefully and unwaveringly toward patient autonomy and away from the older tradition of physician paternalism. This new doctor-patient relationship reoriented medical practices to the needs of individual patients and the body politic primarily because older patterns of trust had been broken. Legal decisions supported patient autonomy; and the expanding idea of informed consent was used by the courts and the legislatures to assure various rights of patients: to have access to information, to participate in decisions, and to exercise choices with respect to whether procedures should be performed. These were necessary and appropriate reforms, but they came with a moral price tag. Indeed, the law could not substitute for physician responsibility arising from a relationship based in trust. As Paul Root Wolpe wryly observes, "informed consent is the modern clinical ritual of trust."³ He might have added, medical ethics is an expression of the erosion of trust between physician and patient. And such a profound realignment not only has had consequences for the local doctor-patient interaction, but has necessitated broad changes in the terms and conditions of medical practice generally.

The irony is that these efforts to assure patient autonomy and offer protections against possible abuse have failed to re-establish trust. Onora O'Neill, after exhaustively reviewing the relevant surveys and studies, correctly observes that public trust in medicine "has faltered *despite* successes, *despite* increased efforts to respect persons and their rights, *despite* stronger regulation to protect"⁴ and then she asks the obvious question: *Why?* I suggest that the loss of trust is intimately related to the ascendancy of autonomy, or more bluntly, mistrust is the price for our current social atomism. The social "glue" that holds us together now requires a different kind of adhesive than older forms of trust that sufficed in another era. The interesting problem for me is not so much how to assure patient rights, as worthy as that might be, but rather how to honor autonomy while enhancing trust and allowing the physician to assume her mandate of responsibility.

THE LOSS OF TRUST

In medicine, the unsteady standing of trust has received increased attention as commentators have focused on both the macro-social factors and micro-

interpersonal elements that have adversely affected the doctor-patient relationship.⁵ The health care dyad, traditionally characterized by trust on the part of the patient, seems too often plagued by doubt. Two dimensions of mistrust spring to mind. The first concerns confidence in professional ability and judgment. There is increasing evidence of physician error⁶ and, perhaps even more important, growing sophistication of patients' understanding of the controversies and uncertainties that plague the science of medicine (that is, the debates that arise as new advances are made in diagnostics and therapies). Thus doctors are increasingly facing an informed consumer, who often presents a skepticism toward medical authority. Such suspicion may be well placed and appropriate, but it is not my concern.

The second dimension of mistrust, my focus here, is the trust question as a *moral* matter. Sown by cynicism and cultivated in a climate of social wariness, patient autonomy assumes its defensive character in a climate of unsteady relationships. Putting aside the degree of patients' confidence in their physicians' technical ability and the prestige of medical science, a deeper and perhaps more menacing question looms concerning the ethics of care. In the corporate setting of a health maintenance organization (HMO), in the emergency ward of a municipal hospital, and even in a private doctor's office, patients increasingly wonder, "Will my doctor do what is best for me?" This question is not about professional competence, but rather concerns the personal commitment of the caregiver who increasingly must account for her divided loyalties.

In the era of managed care, the doctor-patient relationship is now an "encounter" and the doctor has become a "provider," while the patient has become a "client." This corporate vocabulary reflects a different moral tone than that traditionally governing medical practice. Prior to World War II, patients generally saw their own interests and those of their physicians as coinciding. Today, the idea of agreement between physician and patient interests is too often only a nostalgic memory of a more intimate relationship. Physicians in the corporate environment do have conflicts of interest, which may give rise to patient mistrust, and patients are aware of these competing agendas.⁷ Physicians have been known to lie to extract benefits for their patients⁸ and sometimes to refrain from offering potentially useful services because of perceived coverage restrictions.⁹ After all, managed care is a for-profit venture and the ethics of providing good returns on investment are strikingly different from the morals governing health care.¹⁰

While an argument might be made, on the contract model of care (discussed below), that autonomous subscribers make their own choices which do not rely on older forms of trust,¹¹ this is patently false. Employees

typically have little or no choice as to which health plans are offered them.¹² Indeed, autonomy is deeply compromised when patients perceive that they are victim to economic forces that restrict the health care provided to themselves or their loved ones.¹³

But the managed care setting presents only the most obvious example of the shifting relationships between patients and their caregivers. I maintain that a more general ambiguity has replaced the traditional trust characterizing the patient-doctor dyad, and the sources of this misalignment are deeply embedded in contemporary society. Risk management measures, regulations, and legislation—the shadowed presence of others at the bedside to protect the patient—are symptoms of deep mistrust between health care providers and their patients. As Francis Fukuyama observed, “people who do not trust one another will end up cooperating only under a system of formal rules and regulations, which have to be negotiated, agreed to, litigated, and enforced, sometimes by coercive means.”¹⁴ While an invigorated standard of patient autonomy signifies one aspect of the changed social and economic climate in which medicine finds its own place, neither informed consent nor regulations can substitute for primary trust.

Clearly, trust is highly correlated with patient satisfaction.¹⁵ Yet while many theories thrive as to why trust has been eroded,¹⁶ quantifying this problem is difficult, since the categories of assessment are not standardized.¹⁷ Questions that must be addressed include how thoroughly clinical problems are evaluated, how well health care providers understand and empathize with a patient’s individual experience, how effectively they communicate, and how successfully they build an honest and respectful relationship with their patient.¹⁸ These interpersonal features of trust must be linked with, and also be kept distinct from, the question of whether appropriate and effective therapy is provided. Despite patients’ continued high levels of trust in their personal physicians,¹⁹ the data do point toward patient mistrust as a growing problem. Sorting out the mistrust directed at the individual physician versus the system at large is a vexing problem, but by and large, current studies suggest that patients have a higher degree of trust in their physician than in the health care system.²⁰ Yet the strength of the interpersonal commitment is strained by the powerful economic forces in which clinical practice is embedded, and several emerging trends suggest that interpersonal trust will be under assault in coming years due to perceived competition of interests.

While interpersonal trust has until now provided considerable insulation against serious conflict,²¹ the warning signs are apparent. I believe that the dilemma underlying this entire discussion of the doctor-patient rela-

tionship is the problematic status of trust in contemporary American culture, which lies at the very heart of personal identity. I intend not to offer a philosophical anatomy of trust, but to illustrate how trust serves as the moral glue of society. The particular issues with which we have been concerned here cannot be understood independently of the greater social and ethical contexts in which autonomy resides. By defining what trust does sociologically and fulfills morally, I hope to better situate physician responsibility in medicine’s social and moral universes.

THE SOCIAL SETTING

The most basic sources of social solidarity are currently undergoing transformation. Traditional values related to family, work, and discipline are being reconfigured; new patterns of normality determined by a changing social, political, and economic life are appearing; and national identities due to globalization and an increasingly pluralistic culture are being redrawn. So, the questions of how social cooperation and consensus are established and how they might be strengthened have become increasingly apparent.²²

Since the 1960s, Americans have redefined the prior relationships of citizens to their basic institutions—education, government, medical, military, corporate—because of what can only be characterized as a crisis in trust.²³ The general consensus that trust has become increasingly precarious in America is supported by numerous empirical studies that show variation in levels of cooperation in different political and social environments.²⁴

Recently, Robert Putnam has used “social capital” as a sensitive indicator of social cohesion.²⁵ In an important study, he has meticulously documented membership in a variety of social associations ranging from bowling leagues to civic and religious voluntary groups to show that Americans, since World War II, have become increasingly disconnected from each other. Thus fundamental social institutions, for example, church groups and PTAs, have suffered collapse as a result of new social patterns emphasizing atomistic behaviors at the expense of collective communal ones. Echoing Tocqueville, Putnam observes that “the touchstone of social capital is the principle of generalized reciprocity”²⁶—the general understanding that my helping you now is made with the expectation that you will help me later. Confidence in reciprocity is based on deeply ingrained patterns of trust, and indeed, empirical evidence demonstrates that those engaged in community life are both more trusting and more trustworthy than those who isolate themselves.²⁷

Putnam maintains that social trust is a measure of cooperation between individuals and is distinct from trust in institutions or political authorities. Various surveys have measured both, and while correlations exist, for my purposes the measure of the former is most important in establishing a context for the doctor-patient relationship. The data are consistent: since the mid-1960s, Americans have increasingly been suspicious of each other and doubted the honesty of others.²⁸ Surveys measuring trust consistently show a significant decline. For instance, in 1998, Americans believed, by a margin of three to one, that our society is less honest and moral than it used to be. This is not nostalgia for a more innocent time. In studies that compare present responses to those made a generation or two ago, the evidence yields a striking result: "Most, if not all, of the decline in American social trust since the 1960s is attributable to generation succession,"²⁹ a finding confirmed by others using different—and in some ways more sensitive—scales.³⁰ As an older, more trusting generation (a group born before 1940) declines demographically, a cynical post-1960 generation now makes up almost one-third of the population. If one surveys how these generations respond to the question of whether "Most people are honest" (and therefore trustworthy), the older generation affirms their confidence at a rate of 75–80 percent, while their mistrusting grandchildren are less optimistic, agreeing at a rate of 50 percent.³¹ The cohort responses remain constant at the generational level (growing age does not increase the group's trust level), and the net result is a general decline in social trust.

Using a myriad array of measures, the empirical evidence only verifies what most of us already intuit: to rely on trust alone in American society is increasingly regarded as naïve, if not dangerous. Instead, legal recourse, regulations, imposed strictures, and policing agencies have substituted for what heretofore was settled by trusting another to fulfill the expected task.³² And so medical ethics and malpractice law appeared in tandem with a general decline in social trust, whose replacement with regulation and legal mandates saw the exchange of patient autonomy for older forms of trust. From this wider social standpoint, the suspicion of physician authority (and accompanying responsibility) simply reflected the major shifts occurring in society at large.

THE CASE OF MEDICAL PRACTICE

Though medicine as an institution is still trusted more than education, television, major companies, and Congress, confidence in medicine's leaders

has fallen precipitously.³³ Though poll data from the period before 1970 is limited, a 1949 Gallup survey asked American adults to look at a list of six professions and identify those they trusted most. Doctors of medicine topped the list. By 2001 they had fallen to fourth, placing behind nurses, pharmacists, and veterinarians.

However, and not to be minimized, doctors remain high on the list of professions, despite their lowered status relative to other health care providers. Since 1977, according to Gallup polls conducted nearly every year to measure the perceived honesty and ethical standards of numerous occupations and professions, public opinion regarding physicians has remained steady. Forty-seven to fifty-eight percent of those surveyed consistently believe that doctors maintain high ethical standards, placing doctors in the top five professions.³⁴ (Note, about half have a more circumspect opinion.) Yet the "quality of communication and trust" continues to deteriorate,³⁵ which most commentators regard as both a reflection of general trends in American society and an indication of particular problems in health care delivery. The impersonal system of managed care, as discussed earlier, is generally identified as the most influential of these local factors. The perception of care as part of a "medical marketplace" is troubling to many,³⁶ and many patients feel that they must now be "on guard."³⁷ However, if persons are characterized as fundamentally connected and responsible for each other, then trust assumes a different character, one *constitutive* to individuals residing in a group. Rather than risk management or a negotiation between individuals, trust in such a configuration is understood as the "fluid" in which social intercourse occurs with ease. In short, as opposed to regarding trust as the means of negotiating risk, in this latter formulation, trust is the basis by which persons interact successfully. Medicine is the exemplar of this kind of trust, and to make this point, I wish to contrast two models of the doctor-patient relationship, one based on a legal understanding and the other on a voluntary pledge. The two domains certainly overlap, but they are distinct.

CONTRACTS, COVENANTS, AND CLIENTS

Thirty years ago, Robert Veatch and William May debated the character of the doctor-patient relationship.³⁸ Each described what they took to be the most appropriate model characterizing the moral structure of care, and in so doing revealed the difficulties of reducing such a complex interaction to its ethical essentials. Veatch began with rejecting three candidate models: engineering, priestly, and collegial. The engineering model suggested that

the basic relationship between doctor and patient was neutral, with the physician regarded as a scientist or technician; the priestly model captured the paternalistic dominance of the physician; the collegial model depicted doctor and patient as colleagues pursuing mutual goals. Instead of these, Veatch proposed that a contract model was most appropriate, where physician and patient negotiated a sharing of ethical authority and responsibility. Aside from its strengths in clearly defining that specific obligations and duties were incumbent on both parties, Veatch recognized the sociological fact that by the 1970s most health care in the United States was administered in anonymous institutions and that the doctor-patient relationship was hardly intimate or premised on the friend/physician model.³⁹

The contract model is characterized by a mutual agreement between equals. Informed consent is integral to this relationship, and a specific enunciation of rights, duties, conditions, and qualifications both limit the contract and establish the basis for legal enforcement of terms on both parties. The contract thus offers each party some protection and recourse under the law to make the other accountable. By dispensing with a nebulous sense of charity or beneficence to account for physician responsibility, the contract model defines the dignity of the patient within a specific array of legal parameters that are both definable and enforceable.⁴⁰ And most importantly, autonomy is honored and preserved.

May argued that the contract model was not only too restrictive as a moral description of the doctor-patient relationship, but distorting as well. Instead, he presented the "covenant model," and argued it was at odds with the contract model at a deep moral level.⁴¹ The most obvious shortcoming of the contract approach to the doctor-patient relationship is that it eliminates, or at least minimizes, the element of gift or beneficence, and "tends to reduce professional obligation to self-interested minimalism, *quid pro quo*."⁴² But a more fundamental problem is also evident: no contract can exhaustively predict or cover the needs of patients, and the kinds of services rendered by physicians in terms of empathy or compassion can never be specified. Contracts determine only what is required, not necessarily what is just, while a covenant "obliges the more powerful to accept some responsibility for the more vulnerable and powerless of the two parties."⁴³ Contracts are made between equals, or at least the playing field is equalized by the law; relationships based on trust in its looser meaning are typically between parties that are unequal in power and authority.⁴⁴ The contract is a device designed for traders, business executives, and capitalists, not for children, spouses, or patients. Building from Hume's *Treatise*,⁴⁵ Annette Baier explains how promises (contracts) are artifices inasmuch as they enable us

to accept an invitation to trust, whereas in general we cannot trust at will.⁴⁶ As Hume wrote, "promises [contracts] have no natural obligation, and are mere artificial contrivances for the convenience and advantage of society."⁴⁷ Prescriptive contracts are simply too cumbersome, too rigid, too limited to allow for the free exercise of social interaction.

The contract model is hardly sufficient to describe the paradigm of trust between doctor and patient, considering its limited applicability, but it seems to be what governs managed care.⁴⁸ Indeed, managed care organizations have been held accountable through contract law rather than tort law (which, incidentally, generally results in more limited monetary damages than does tort law). HMOs have not been regarded as exceptional to other industries, and the courts have thus allowed them great latitude in pursuing cost-containment controls.

But medicine is obviously more than a business with self-interests protected by contract. If beneficence remains a guiding ethos for the clinical encounter, the covenantal character of medicine is prominently displayed. We normally think of such responsibility as exclusively serving the patient's interests, namely, physicians act in accordance with the ends of medicine to relieve suffering and effect cures, and this is broadly regarded as a good. But the rub is whether the values of the physician coincide with those of the patient and whether the solutions offered reflect the best options for a particular individual. Autonomy in the covenant model is of a different character than that in the contract model, where the independence of the patient must be assured to allow a free association with the physician to take place. In the setting of the covenant model, patient autonomy is used to trump physician values in determining clinical choices when a conflict arises. So, in a simple way we think of physician responsibility in terms of service to the patient; but the inequality of that relationship—essentially a bestowal of physician largess upon her patient—is mitigated by a counter-principle of patient independence and free choice. In a sense, beneficence is opposed to, and limited by, patient autonomy in the covenantal model, whereas in the contract model, individual autonomy is assumed and, indeed, is presupposed as part of the relationship. Autonomy thus assumes a characteristic role that depends on the context in which it is invoked. And, perhaps more to the point, trust assumes a different meaning in each model.

Simply, a hierarchy of trust is determined by the social context in which interpersonal relationships are played. On one end of the spectrum are contracts, which are designed to limit ambiguity about expectations. As John Locke observed, contracts are written promises that define not so much *whom* one trusts, but *what* is entrusted.⁴⁹ Precisely because they are

part of a legal system, contracts are designed to clearly define services and limit liabilities, so, if necessary, adjudication may occur within specified legal channels and with defined rules.

Trust in more intimate settings places relationships within implicit expectations, and because they remain largely unarticulated, they encompass actions that are not—indeed, cannot be—specified. The trust between parent and child, teacher and student, doctor and patient must allow for seemingly infinite possibilities of interactions. They remain “liquid” and “open.” Here we find a key difference between contracts and covenants. Because contracts elicit promises which reflect no human kindness,⁵⁰ they show the limits of trust, not its full character. For Hume, the caustic critic, contracts were designed to protect the contractual parties from each other and thus to stabilize what he regarded as natural selfish behavior.⁵¹ “The beauty of promise and contract is its explicitness. But we can only make explicit provisions for such contingencies as we imagine arising.”⁵² Thus trust must be implicit and infinitely adaptable to myriad social challenges. Reflecting the deepest moral obligation to humanely answer another, medicine becomes an exemplar of trust. When it fails or is denied, the doctor-patient relationship loses its moral bearings and becomes a contract, a business venture governed by certain specifications. This hardly suffices to describe the trust that must ground the healing act.

Tom Beauchamp and Laurence McCullough observe that the beneficence and autonomy principles of health care are at odds simply because of the different perspective each adopts.⁵³ Beneficence is organized around medicine’s point of view, that is, what clinical science might deem best for a patient, while the principle of autonomy is organized around the values and beliefs of the patient. Thus, in the physician covenant the determination of what is most appropriate does not necessarily coincide with the values of the patient, and as the rise of a rights-based culture impacted on medicine, medical ethics has been burdened with attempts to reconcile this basic difference.

One major approach avers to salvage the contract model on the basis of a Rawlsian notion of justice,⁵⁴ and the benefits of an ethics based on the sociological reality that patients and doctors increasingly meet as strangers.⁵⁵ But to admit a sociological reality—that medicine is undeniably a business with self-interests prominently displayed in a market economy, where financial forces commit physicians to contractual relationships with their clients—does not negate medicine’s moral mandate. Indeed, while the current health care lexicon often supplements “patient” with the apt descriptive terms “client,” “customer,” “consumer,” or “covered lives,” this

vocabulary only embarrasses us to admit how profoundly the ancient covenant model has been displaced by market models.⁵⁶ But the ethics of care remains despite the too often opposing demands of a commercial medical economy. I believe that the doctor-patient relationship is better understood as a moral category than a legal one, and therefore the covenant model more closely approximates the ethical dimension of patient care than any contract might. To understand that claim, a more complete characterization of trust is required.

TRUST, A MORAL CATEGORY

Sociology merges into ethics when the social scientist constructs his frame of reference on a moral foundation: “Viable society is perceived not only as a coalition of interests, but as a moral community.”⁵⁷ *Morality* of course refers to how persons relate to each other, and *moral community* refers to the ethical habits and reciprocal moral obligations of community members.⁵⁸ Moral communities have three components, each closely aligned with each other: The first is trust, the expectancy that others will behave in an expected virtuous manner; the second is loyalty, the obligation to refrain from breaching trust; the third is solidarity (or perhaps identification with another), the sense of caring for the interests of others.⁵⁹ But most important is how a moral community configures and determines personal identity. After all, the locus of autonomy is where the individual finds her place within the larger moral space of the group, whose coordinates define one’s obligations “to trust, to be loyal, and to show solidarity to others. In other words it is the indication of the ‘us’ to which ‘I’ feel that I belong.”⁶⁰

To address this ethical dimension, I begin with the Scottish Enlightenment, when modern medical ethics had its first stirring.⁶¹ Francis Hutcheson, Adam Smith, and their colleagues championed individuality in the context of communal interests, and their program of developing the moral sentiments was to find a balance between the needs of satisfying the growing sense of choice and the responsibility of autonomous agents against the wider needs and demands of the larger group.⁶² The atmosphere in which the doctor-patient relation was scrutinized reflects a general concern with an understanding of *civil society* that would promote a moral agenda of reciprocity, mutuality, and cooperation. This tradition joined an older public philosophy of *civic virtue*—originating with ancient Greek and Roman political philosophy and carried into the eighteenth century by Rousseau (via Machiavelli) on the Continent and by the neo-Harringtonians in England.

Their political philosophy subordinated individual interests to the collective good, and in the form of republicanism, citizenship itself was defined in terms of allegiance to, and identification with, the state. Thus civic virtue was less a private attribute than one defined in, and by, the communal context. But by the end of the eighteenth century, this public-based morality was increasingly eclipsed by one grounded in the private personal domain: modern liberal individualism.

Understanding the philosophical foundations of “civil society” shows how self-consciously it described an ethical program.⁶³ The major emphasis on individual agency grew out of Protestant themes of self-responsibility and personal conscience. Indeed, defining public morality in the face of a new individualized morality depended on an entire philosophical construction that posited an inner moral sense. The Scottish Enlightenment devoted itself to this project, whose basic tenets included the declaration of “moral sentiments” independent of reason and arising as a function of individual moral psychology. Thus ethics moved from an external authority to an inner morality, one based on the assumption that humans possessed an innate benevolence, a fundamental constituent of the human character.

What interests me in this history is the core idea of personal morality as predominantly private, but still addressing social concerns and interests, which in the doctor/patient relationship is the sense of physician responsibility. In the mid-eighteenth century, Ferguson, Smith, and their fellow travelers assumed an “interactive self,” one whose existence is fundamentally social, not atomistic. The self in their formulation was thus linked to the social whole by responding to an internalized social or communal “other.”⁶⁴ This ever-present sense of the individual situated firmly within his social context accounts for the natural sympathy and moral affections upon which the Enlightenment moral community is predicated. So while civil society and civic virtue placed the realm of virtue in different domains (private and public, respectively), what is most strikingly different between what became modern liberalism and an older republican tradition is the conception of selfhood. Under the domain of civic virtue, the self is constituted by its identification with a greater collective whole (Durkheim’s “conscious collective”);⁶⁵ in a civil society, the self is reflexive and thereby divided in seeking its proper action in response to inner needs as contested by public demands. Adam Smith, in the *Theory of Moral Sentiments*, posited an internalized “impartial spectator” who allows moral choice to remain private and individualized, but that internal judge probes the community to orient its options.⁶⁶ Thus, this impartial adjudicator is the moral embodiment of a Janus-like faculty, one that simultaneously peers at both private and public

moral domains to find the balance between personal aggrandizement and communal duties.

Smith configured a complex moral agent. Although ethical choices are private, the reflexive individual answers to two moral agendas, one prescribed by personal wants and the other by obligations to the community. In seeking the judgment of an impartial spectator, virtue ostensibly shifted from a public morality to an inner one. But I believe this internalization oversimplifies the duality of Enlightenment morality, which is truly an amalgam of the private and public. The tenet that conscience was private and that choice was personal must be balanced with the deeper idea that there was, in fact, a universal morality, one exercised in the public domain and accessible to all rational persons, which, while leaving moral agency to the individual, placed moral authority above him.

By the end of the twentieth century, the moral logic established two hundred years earlier had borne full fruit. Individualism made morality increasingly a question of personal choice, subordinating a categorical imperative or a divine moral order to those who wished to identify with other transcendentalists.⁶⁷ Indeed, in a pluralistic society characterized by a plethora of social, political, and religious groups from which to choose identification, personal morality became the key precept for autonomous agents. But the historical origins of autonomy assumed a reflexive self that contemplated the moral choices offered by personal desire or need and those of the collective. Without a guiding public morality, something else was required: trust.

As postindustrial society has imposed new identities and new relationships, trust must substitute for a public ethos to which all may subscribe. Indeed, trust is increasingly regarded as a valued and scarce resource in maintaining the dignity and independence of individuals, for what must transpire with the erosion of a public morality is either more rigid legal strictures to guide behaviors or the more elemental solution of trusted reciprocity between strangers. Recognizing the group character of identity, emphasizing the relational basis of personhood, placing rights within a broader moral context of reciprocal duties and obligations, and identifying the domination of community-based identification of individuals playing multiple social roles—all of these point to trust as the common stage upon which moral and social dramas are best enacted. The law certainly holds us together, but it is cumbersome if not antithetical to fluid social intercourse. Most would concur that when the law must be invoked, normal trust has been replaced by a procedure of mechanistic design. Law appears when trust fails.

"Trust cannot be seen any more as an automatic by-product of macro-social or macro-economic processes," argues Barbara Misztal, "but rather it needs to be perceived as an active political accomplishment."⁶⁸ That strengthening the claims of trust might now be construed as a political goal is interesting in its own right. Misztal suggests, and a large critical coterie would agree, that if the communal character of American life is threatened, we might well address our concerns to identifying what is missing and then attempting to remedy that ill. In this sense, medicine is part of a grand social challenge.

Doctors and their patients are caught in a social and moral confusion, which I see as reflecting the precarious role of trust in contemporary society. If trust is the ultimate basis of the doctor-patient relationship, it is no wonder, considering what is occurring in the wider culture, that the clinical dyad is under stress. The law is a poor substitute for a more fluid intercourse. Law cannot substitute for trust. Once mistrust is established, the law can only adjudicate the dispute.

So what is a remedy? I believe two domains of the trust issue need to be demarcated—one situated in the macro-overview and the other in the micro-interpersonal environment. In the first, the general cultural moment has realigned values of individuality and with that shift a change in patterns of interpersonal relations has placed new stress on how we interact. As we each become more immersed in the individually created world of our own making, all the other persons upon whom we are thus dependent must reliably fulfill our expectations. Is our mistrust in fact due to the disparity between expectations and results, or are we implicitly acknowledging that we are, in fact, hardly autonomous of others, only at best believing or hoping that our choices reflect autonomy? If so, we are then left with a tension between the ideal independence that free choice offers and the uncertainty that low levels of trust bequeath. I have maintained that if individualism is to thrive, we must recognize a beguiling paradox: autonomy in its atomistic posture must recede as a cherished value, and relational autonomy must take its place.⁶⁹ Thus I propose to reconfigure autonomy and its underpinnings by advocating a program of enhancing social cohesion and strengthening the trust which holds members of a diverse society together. I cannot address this immense issue further here, but I have argued elsewhere for a communitarian ethics in which medicine would find a more appropriate setting for its own agenda.⁷⁰

On the micro-level of individual action, I suggest we begin by acknowledging that trust and mistrust are the resulting attitudes generated from a sense of *trustworthiness*,⁷¹ and this places the onus on the medical

profession. Relevant questions then include, In what ways have health care providers distanced themselves from their patients? How has the professionalization of young doctors supported dehumanization of their patients? In what ways can the moral milieu of clinical practice be fortified to offset the corporate character of health care delivery and the technological character of modern diagnostics and therapies? These are crucial questions with no ready answers, but to ask them is to ponder to what extent doctors might better earn their patients' trust. Specifically, what might physicians do to personalize their interactions with their patients and treat patients' needs more comprehensively? The answer points to a radical shift from medicine's current self-understanding as fundamentally a scientific endeavor to a more global moral enterprise, one that must combine the objective gaze with the self-reflective *response* to the other.⁷² While I see medical school educational reform as crucial, there is no need to wait. The individual physician may assume the mantle of responsibility and thereby assert the most fundamental of all moral choices, the choice to be responsible for one's own actions.⁷³

NOTES

1. Ruth R. Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986), pp. 94–95.
2. Albert R. Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1998).
3. Paul Root Wolpe, "The Triumph of Autonomy in American Bioethics: A Sociological View," in *Bioethics and Society: Constructing the Ethical Enterprise*, ed. Raymond DeVries and Janardan Subedi (Englewood Cliffs, N.J.: Prentice-Hall, 1998), p. 48.
4. Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: At the University Press, 2002), p. 11.
5. Michael H. Annison and Dan S. Wilford, *Trust Matters: New Directions in Health Care Leadership* (San Francisco: Jossey-Bass Publishers, 1998); John B. McKinlay and Lisa D. Marceau, "The End of the Golden Age of Doctoring," *International Journal of Health Services* 32, no. 2 (2002): 379–416.
6. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds., *To Err Is Human: Building a Safer Health System* (Washington D.C.: National Academy Press, 1999); Donald M. Berwick, "Errors Today and Errors Tomorrow," *New England Journal of Medicine* 348 (2003): 2570–72.
7. Ezekiel J. Emanuel and Nancy N. Dubler, "Preserving the Physician-Patient Relationship in the Era of Managed Care," *JAMA* 273 (1995): 323–29; David Mechanic, "Changing Medical Organization and the Erosion of Trust," *Milbank Quarterly* 74 (1996): 171–89; David Mechanic and Mark Schlesinger, "The Impact

of Managed Care on Patients' Trust in Medical Care and Their Physicians," *JAMA* 275 (1996): 1693-97; Audiey C. Kao et al., "The Relationship between Method of Physician Payment and Patient Trust," *JAMA* 280 (1998): 1708-14; Audiey C. Kao et al., "Patients' Trust in Their Physicians: Effects of Choice, Continuity, and Payment Method," *Journal of General Internal Medicine* 13 (1998): 681-86; Stephen M. Shortell et al., "Physicians as Double Agents: Maintaining Trust in an Era of Multiple Accountabilities," *JAMA* 280 (1998): 1102-8; Allen Buchanan, "Trust in Managed Care Organizations," *Kennedy Institute of Ethics Journal* 10 (2000): 189-212; Peter D. Jacobson and Michael T. Cahill, "Applying Fiduciary Responsibilities in the Managed Care Context," *American Journal of Law and Medicine* 26 (2000): 155-73.

8. Victor G. Freeman et al., "Lying for Patients: Physician Deception of Third Party Payers," *Archives of Internal Medicine* 159 (1999): 2263-70; Matthew K. Wynia et al., "Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place," *JAMA* 283 (2000): 1858-65.

9. Matthew K. Wynia et al., "Do Physicians Not Offer Useful Services Because of Coverage Restriction?" *Health Affairs* 22 (2003): 190-97.

10. Patricia Illingworth, "Bluffing, Puffing, and Spinning in Managed-Care Organizations," *Journal of Medicine and Philosophy* 25 (2000): 62-76. Perhaps the most interesting formal response to the challenge of split allegiance has been made in the Charter on Medical Professionalism (Linda Blank et al., "Medical Professionalization in the New Millennium: A Physician Charter 15 Months Later," *Annals of Internal Medicine* 138 [2003]: 839-41), a broadly adopted code of ethics, which holds that beyond the specific responsibilities to advance the well-being and dignity of their patients, physicians are enjoined to improve patient quality of care, access, and more equitable distribution of resources as part of their moral code. This code of ethics clearly places the physician's loyalties squarely with the patient.

11. E. Haavi Morreim, *Balancing Act: The New Medical Ethics of Medicine's New Economics* (Washington, D.C.: Georgetown University Press, 1995); Wendy Mariner, "Business vs. Business Ethics: Conflicting Standards for Managed Care," *Journal of Law, Medicine and Ethics* 23 (1995): 236-46; Susan D. Goold, "Money and Trust: Relationships between Patients, Physicians, and Health Plans," *Journal of Health Politics, Policy and Law* 23 (1998): 687-95.

12. Karen Davis et al., "Choice Matters: Enrollees' Views of Their Health Plans," *Health Affairs* 14 (1995): 99-112.

13. Thomas Bodenheimer, "The HMO Backlash—Righteous or Reactionary?" *New England Journal of Medicine* 335 (1996): 1601-4; Robert J. Blendon et al., "Understanding the Managed Care Backlash," *Health Affairs* 17 (1998): 80-94.

14. Francis Fukuyama, *Trust: The Social Virtues and the Creation of Prosperity* (New York: Free Press, 1995), p. 27.

15. L. A. Anderson and R. F. Dedrick, "Development of the Trust in Physician Scale: A Measure to Assess Interpersonal Trust in Patient-Physician Relationships," *Psychology Reports* 67 (1990): 1091-1100.

16. Steven D. Pearson and Lisa H. Raeke, "Patients' Trust in Physicians: Many Theories, Few Measures, and Little Data," *Journal of General Internal Medicine* 15 (2000): 509-13.

17. Mark A. Hall et al., "Trust in Physicians and Medical Institutions: What Is It, Can It Be Measured, and Does It Matter?" *Milbank Quarterly* 70 (2001): 613-39.

18. David H. Thom and B. Campbell, "Patient-Physician Trust: An Exploratory Study," *Journal of Family Practice* 44 (1997): 169-76.

19. Robert J. Blendon and John M. Benson, "Americans' Views on Health Policy: A Fifty-Year Historical Perspective," *Health Affairs* 20 (2001): 38-46.

20. Mark A. Hall et al., "Trust in the Medical Profession: Conceptual and Measurement Issues," *Health Services Research* 37 (2002): 1436-39.

21. *Ibid.*

22. Barbara A. Misztal, *Trust in Modern Societies: The Search for the Bases of Social Order* (Cambridge, Mass.: Polity Press, 1996), pp. 4ff.

23. Alan Wolfe, ed., *America at Century's End* (Berkeley: University of California Press, 1991).

24. E.g., Fukuyama, *Trust*; Robert D. Putnam, *Bowling Alone: The Collapse and Revival of American Community* (New York: Simon and Schuster, 2000).

25. "Social capital" has been invented at least six times in the twentieth century and refers to the benefits of social ties. "Whereas physical capital refers to physical objects and human capital refers to properties of individuals, social capital refers to connections among individuals—social networks and the norms of reciprocity and trustworthiness that arise from them. In that sense social capital is closely related to what some have called 'civic virtue'" (Putnam, *Bowling Alone*, p. 19).

26. *Ibid.*, p. 134.

27. *Ibid.*

28. *Ibid.*, pp. 139ff.

29. *Ibid.*, p. 140.

30. Robert V. Robinson and Elton Jackson, "Is Trust in Others Declining in America? An Age-Period-Cohort Analysis," *Social Science Research* 30 (2001): 117-45.

31. Putnam, *Bowling Alone*, p. 141.

32. *Ibid.*, p. 147.

33. Robert J. Blendon, Tracy S. Hyams, and John M. Benson, "Bridging the Gap between Expert and Public Views on Health Care Reform," *JAMA* 269 (1993): 2573-78.

34. George H. Gallup, *The Gallup Poll Public Opinion* (Wilmington, Del.: Scholarly Resources, 1977-1997).

35. Julia Murphy et al., "The Quality of Physician-Patient Relationships: Patients' Experiences 1996-1999," *Journal of Family Practice* 50 (2001): 126.

36. Not all critics, however, are troubled (e.g., Regina E. Herzlinger, *Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry* [San Francisco: Perseus Publishing, 1999] and *Consumer-Driven Health*

Care: Implications for Providers, Payers, and Policy Makers [San Francisco: Jossey-Bass Publishers, 2003]).

37. Mechanic and Schlesinger, "Impact of Managed Care," p. 177.

38. Robert M. Veatch, "Models for Ethical Medicine in a Revolutionary Age," *Hastings Center Report* 2 (1972): 5–7; further developed in Robert M. Veatch, "The Case for Contract in Medical Ethics," in *The Clinical Encounter: The Moral Fabric of the Patient-Physician Relationship*, ed. Earl E. Shelp (Dordrecht: D. Reidel Publishing, 1983), pp. 105–12; William F. May, "Code, Covenant, Contract, or Philanthropy," *Hastings Center Report* 5 (1972): 29–38; and William F. May, *The Physician's Covenant: Images of the Healer in Medical Ethics* (Philadelphia: Westminster Press, 1983).

39. Veatch, "Case for Contract," p. 196.

40. Ibid.; Veatch, "Models for Ethical Medicine."

41. May, *Physician's Covenant*, pp. 116ff.

42. Ibid., p. 118.

43. Ibid., p. 124.

44. Annette C. Baier, "Trust and Antitrust," *Ethics* 96 (1986): 231–60; reprinted in *Moral Prejudices: Essays on Ethics* (Cambridge, Mass.: Harvard University Press, 1994), pp. 95–129.

45. David Hume, *A Treatise of Human Nature* (1739; reprint ed., Oxford: Clarendon Press, 1978), pp. 521ff.

46. Baier, "Trust and Antitrust," pp. 106ff.

47. Hume, *Treatise of Human Nature*, p. 525.

48. Peter D. Jacobson, *Strangers in the Night: Law and Medicine in the Managed Care Era* (New York: Oxford University Press, 2002).

49. Baier, "Trust and Antitrust," p. 101.

50. Hume, *Treatise of Human Nature*, p. 521.

51. Ibid., pp. 519–21.

52. Baier, "Trust and Antitrust," p. 117.

53. Tom L. Beauchamp and Laurence B. McCullough, *Medical Ethics: The Moral Responsibilities of Physicians* (Englewood Cliffs, N.J.: Prentice-Hall, 1984), pp. 22–51.

54. Robert M. Veatch, *A Theory of Medical Ethics* (New York: Basic Books, 1981).

55. Robert M. Veatch, "The Physician as Stranger: The Ethics of the Anonymous Patient-Physician Relationship," in *Clinical Encounter*, ed. Shelp, pp. 105–12.

56. Kevin W. Wildes, "Patient No More: Why Did the Golden Age of Medicine Collapse?" *America* 185 (2001): 8–11. A key challenge is how to recover the "patient" in the corporate setting by a reexamination of how fiduciary responsibilities apply in the managed care context (Jacobson and Cahill, "Applying Fiduciary Responsibilities," pp. 155–73). For patients, even when called clients, customers, or consumers, are still persons seeking aid from other individuals, physicians, who are implicitly entrusted to act on their behalf. The disaffection with managed care largely rests on the growing tension of split responsibilities of doctors, who are often employed, on the one hand, by corporations seeking to reduce costs and increase profits, and, on

the other hand, by their patient who calls upon a more ancient affiliation, where the cost issue remains subordinated, if not moot. And when we look at medical cases, patient recourse for bad outcomes, by and large, is limited to malpractice, not breach of fiduciary responsibility. In other words, the law has directed complaint away from the general protections offered by fiduciary law to damage rewards for technical incompetence and mal-execution.

57. Piotr Sztompka, *Trust: A Sociological Theory* (New York: Cambridge University Press, 1999), p. 4.

58. Fukuyama, *Trust*, p. 7.

59. Sztompka, *Trust*, p. 5.

60. Ibid. The commentary summarized here on the conditions of moral bonds and moral community has a history dating to the mid-nineteenth century, and follows at least five related themes: (1) alienation (associated most closely with Marx) emphasizes the distancing of the individual from his work and political life, which leads to loss of identity, dignity, and purpose; (2) anomie (originating with Durkheim); (3) "revolt of the masses" (Ortega y Gasset); (4) "iron cage" (Weber) themes emphasize the isolated character of modern life resulting from urban mass society, depersonalized bureaucratization of social organizations, and mass government; and finally, (5) the "lonely crowd" theme describes the inward turning of persons as a result of the individualization of social life and the resulting atrophy of moral communities. Such concepts as "civic culture," "civic society," "cultural capital," and "social capital" have been used to characterize what has been lost and why (Sztompka, *Trust*, pp. 6–8).

61. Lisbeth Haakonssen, *Medicine and Morals in the Enlightenment: John Gregory, Thomas Percival and Benjamin Rush* (Amsterdam and Atlanta: Rodopi, 1997).

62. Adam B. Seligman, *The Problem of Trust* (Princeton: Princeton University Press, 1997), pp. 107ff.

63. Adam B. Seligman, *The Idea of Civil Society* (New York: Free Press, 1992).

64. Seligman, *Problem of Trust*, p. 111. Adam Smith's "interactive sympathy" replaced republican "virtue" as the foundation of his vision of the moral community. He separated himself from Ferguson and Hutcheson, whose notion of "mutual sympathy" was a particular type of emotion, by arguing that sympathy was a function of a practical virtue, "propriety," which was assessed by an inner "impartial spectator": "We endeavor to examine our own conduct as we imagine any other fair and impartial spectator would examine it. If, upon placing ourselves in his situation, we thoroughly enter into all the passions and motives which influenced it, we approve of it, by sympathy and with the approbation of this supposed equitable judge. If otherwise, we enter into his disapprobation and condemn it" (Adam Smith, *The Theory of Moral Sentiments* [1790; reprint ed., Indianapolis: Liberty Classics, 1982], p. 110; quoted by Seligman, *Problem of Trust*, p. 112). Smith thus establishes a means by which to tap into common standards, while at the same time creating an independent moral standpoint. As Knud Haakonssen has observed, the continued search for this neutral third-party position is the cornerstone of the eighteenth-century

liberal enterprise (*The Science of a Legislator: The Natural Jurisprudence of David Hume and Adam Smith* [Cambridge: At the University Press, 1981]).

65. Seligman, *Problem of Trust*, p. 115.

66. See note 64 above.

67. Alfred I. Tauber, *Henry David Thoreau and the Moral Agency of Knowing* (Berkeley and Los Angeles: University of California Press, 2001).

68. Misztal, *Trust in Modern Societies*, p. 7.

69. Alfred I. Tauber, "Sick Autonomy," *Perspectives in Biology and Medicine* 46 (2003): 484–95.

70. Alfred I. Tauber, "Medicine, Public Health and the Ethics of Rationing," *Perspectives in Biology and Medicine* 45 (2002): 16–30.

71. Russell Hardin, *Trust and Trustworthiness* (New York: Russell Sage Foundation, 2002).

72. Alfred I. Tauber, *Confessions of a Medicine Man: An Essay in Popular Philosophy* (Cambridge: MIT Press, 1999).

73. Alfred I. Tauber, "Putting Ethics into the Medical Record," *Annals of Internal Medicine* 136 (2002): 559–63. I outline how the individual physician might proceed with the project of being responsible for his or her own actions in *Patient Autonomy and the Ethics of Responsibility*.