

Seeking a voice: the inadequacy of the “four principles” and the need for care ethics in the provision of health care to vulnerable populations

Positionality statement

This article is a collaboration between a pair of experienced rural generalists: one a Girmay and Djirribal man practising on Country in Far North Queensland (LP), the other a non-Indigenous man of Irish, German and English descent practising in rural southern Queensland who is also an early-career academic philosopher (KB). We reflected on our shared experience in an online medical forum where there was a heated debate in the lead-up to the Voice referendum, and ended up asking ourselves, “Why did the framework of the ‘four principles of medical ethics’ seem so inadequate for dealing with this ethical discussion? Where else might it be inadequate?” (Supporting Information). This article is our attempt to answer those questions.

Ethical frameworks: principlism and care ethics

The dominant framework in biomedical ethics is that of principlism. Although in theory medical ethics are much broader than the “four principles”¹ — autonomy, beneficence, non-maleficence, and justice — ethical dilemmas in medicine are often discussed using this framework alone. This article describes some of the deficiencies of principlism and how later developments in moral philosophy provide additional insights for ethical medical practice. We describe how Joan Tronto’s formulation of “an ethics of care” usefully outlines the kinds of moral hazard that can emerge when providing care to vulnerable populations, and how an ethic of care points to possible solutions. Specifically, we explain why Indigenous Voices to health care institutions are a critical component of ethical medical practice.

In the late 1970s, Tom Beauchamp and James Childress developed a framework for biomedical ethics. Subsequently named “principlism”, this framework describes four principles (autonomy, beneficence, non-maleficence, and justice) that encompass the major metaethical theories of consequentialism, deontology, and social contract theory. Because principlism privileges no one theory over the others, it is well suited for framing moral reasoning in a secular, pluralistic society.²

In the 1960s, Lawrence Kohlberg³ demonstrated that capacities for moral reasoning proceed through sequential developmental stages, implying that it is possible, through instruction in a framework such as principlism, to teach moral reasoning as an explicit skill. This was the authors’ experience of medical ethics training at medical school in the 1980s and 1990s.¹ Subsequent research in moral psychology,

especially by Carol Gilligan,⁴ critiqued Kohlberg’s methodology and demonstrated that real-world moral activity outside the laboratory is motivated less by abstract principle-based reasoning and more by caring about those with whom we share networks of commitment, empathy, responsibility and dependence.

Through the 1980s and 1990s, moral philosophers developed additional frameworks to account for Gilligan’s observation that moral practice consists of more than abstract moral reasoning. Foremost among these developments was “care ethics”. Initially, this approach focused on the moral aspects of intimate personal and familial relationships, recognising that the asymmetry and vulnerability often present in such relationships are not captured by previously accepted metaethical frameworks. Later, in the work of Virginia Held and Joan Tronto, “care” was more expansively described as a fundamental aspect of all moral practice, including in impersonal social and political contexts.⁵

Tronto outlined four elements of an ethics of care, not accounted for by frameworks of abstract moral reasoning:

- attentiveness — noticing the need for care;
- responsibility — taking ownership of care;
- competence — care-giving capability; and
- responsiveness — engagement by the cared-for.⁶

We might be oblivious to the opportunity to act morally. We might refuse to accept that an opportunity to act morally is “my problem”. We might be incapable of delivering the morally right action. And we might disregard how those who “benefit” feel about our actions. In any of these cases then, under Tronto’s framework, even if our principle-based moral reasoning is perfect, our moral practice is nonetheless deficient. A clear parallel can be drawn between Tronto’s framework and clinical practice: perfect clinical reasoning can exist alongside inattentive, dismissive, incapable or unresponsive clinical practice. This should be no surprise: health care is a specific embodiment of the more general idea of care.

Care ethics’ applicability in modern health care

One conception of high quality health care emphasises the intimacy, mutual respect, and role-specific responsibilities that exist in a clinician–patient relationship. Where there is reciprocal commitment and a personal, direct engagement between “my doctor” and “my patient”, then the elements of attentiveness, responsibility and responsiveness emerge naturally.

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However, modern societies also express a different type of caring. With the increased scale, complexity and specialisation of contemporary societies, there is both greater dependence on generic others to meet our basic needs (eg, the government, education and health care systems, corporate supply chains), and also reduced dependence on specific others. Modern health care systems are characterised by the manner in which individual clinicians become increasingly interchangeable. Care provision itself is transformed from an expression of ongoing sympathetic and compassionate relationship between two particular people, into a quantifiable commodity that can, in theory, be delivered by the market with minimal emotional engagement between carer and cared-for.

Tronto points out how this sort of impersonal, indirect caring undermines attentiveness: because they are emotionally distanced, carers become less attentive to the unique needs of each care recipient.⁶ But the effects of modernity are broader than that: modernity's characteristic division of labour and relentless pursuit of market efficiency have dramatically expanded our competence to care — especially for whole populations in an equitable manner to mandated standards — but have also diminished our attentiveness, responsibility and responsiveness. This manifests in modern health care as an impressive improvement in measurable outcomes. For example, institutional residential aged care in Australia is generally competent to provide a level of support to its 188 000 clients⁷ that would be unsustainable under a model of in-home family-provided care. However, an employed personal aged care nurse will generally be less attentive, have less sense of personal responsibility, and be less aware of their client's response to their caring than would be the case if that care was provided in-home by family (if only because the nurse's attention, responsibility and responsiveness are being deployed across many clients). The same issues are at play when comparing solo general practice to being doctor-of-the-day at a corporate-owned superclinic: there is an unwitting trend towards enhancing competence to care, while undermining the elements of personal attention, responsibility and responsiveness.

Defining quality health care

One of the implications of care ethics is that it is impossible for a moral agent to “do good” to, for or on behalf of a subject without being responsive to what that subject values as good. The Golden Rule and Kant's Categorical Imperative⁸ presume “the other is exactly like the self;”⁶ so the agent can define “good” (beneficence, non-maleficence, autonomy, justice) on behalf the subject. In theory, dilemmas in medical ethics can be solved by discussion between the relevant clinicians (perhaps with a medical ethicist's guidance) to weigh up the different competing principles involved. However, an ethic of care recognises that care relationships are intrinsically asymmetric: the carer in a position of power, and the cared-for in a position of vulnerability and dependence. Not only might the carer and the cared-for have different conceptions of care, the

power gradient means that, without the element of responsiveness, the carer presumes and imposes their own concept of care. By practising care ethics, a shared idea of “good care” emerges from a collaboration of carer and cared-for, each responding to the uniqueness of the other's situation.

This same evolution in the concept of good care has occurred within health care. Definitions of health care quality have evolved from mere descriptions of improving patient welfare in the 1980s, to making passing mention of patient preferences in the 1990s, to explicit incorporation of patient-centredness as one of three key elements of health care in the 2010s.^{9,10} What constitutes “patient welfare” is no longer assumed to be obvious, either because “doctor knows best” or else because clinicians are implicitly familiar with their patients and those patients' values. Patient welfare now requires explication by the patient themselves. These new definitions of quality health care bind both individual clinicians and health care systems.

Individual clinicians need to recognise the production line nature of much of modern health care and recognise as consequences both the psychological distance between clinician and patient and how this silences patients. In this setting, mutual responsiveness is not the relatively effortless result of two people in a long-standing personal relationship, it is an effortful achievement by two relative strangers. Consultation skills that elicit patient values and ideas are not an optional tool that can be deployed to help solve the “real problem” (as defined by the clinician), they are an essential component of every clinical encounter that, by granting a voice to patients, allows collaborative definition and redefinition of the care that ought to be provided.

Are health care systems responsive to Indigenous Australians?

Efforts of well intentioned clinicians can only go so far. Because so much health care is delivered by systems rather than by individuals, systems themselves need to have robust mechanisms that respond to the values and interests of their clients. In particular, we need to consider whether the interests and values of marginalised groups are being heard, and responded to, by the systems that provide health care. Specifically, do Australian health care institutions actively collaborate with Indigenous organisations and individuals to define the care that ought to be provided?

Since the launch of the Closing the Gap strategy in 2008, there has been a dramatic increase in the amount of data collected about Indigenous Australians' engagement with the health care system.¹¹ According to Tronto's framework, this is evidence of the attentiveness and responsibility elements of care. Similar overt Indigenous-specific care commitments have been made by health education providers,¹² specialty colleges,¹³ and state health departments.¹⁴ More recently, there has been reflection about the responsiveness element of care, and explicit recognition by health care organisations

of the importance of partnering with Indigenous organisations to determine what outcomes are measured and how the results are analysed and used.^{15,16} Examples of this responsiveness are the National Aboriginal and Torres Strait Islander Health Survey that informs the Australian Institute of Health and Welfare (AIHW) reporting,¹⁷ and the development of Indigenous Australian-specific metrics of wellbeing such as the What Matters 2 Adults study.¹⁸

Even so, there are still large gaps in the ability of health care organisations to provide responsive and culturally safe care to clients and staff (Box). Questions are rightly asked about whether cultural competency training and assessment are performed from the perspective of an empowered care provider interacting with an othered client. A scoping review found many elements of cultural safety programs “lacked Indigenous input and had no patient involvement”¹⁹ and this creates numerous mechanisms for potential inadvertent harm,²⁰ as the scenario demonstrates. Consequently, although there are now some formal mechanisms by which the collective voices of Indigenous patients are being presented, we still lack evidence that health care systems are actually responding to these voices: only four of the 17 Closing the Gap targets are on track,²¹ the AIHW reports mixed trends in health system performance,¹¹ and there is a paucity of data to support a conclusion that “culturally competent” medical professionals are associated with positive health outcomes for Indigenous patients.²²

Tronto’s responsiveness element of care has two components: the carer (individual or institution) must first seek out vulnerable care recipients’ values and preferences; they must then respond by providing care concordant with those values and preferences. The former component means that care institutions ought to have permanent mechanisms whereby Indigenous organisations and individuals can collaborate with those care institutions to define the provided care. Such permanent mechanisms could be thought of as a “Voice to [the institution]”. The Australian health care system seems to be moving in the right direction by

Case scenario

A registrar training with a specialty college attends an official college course to practise viva voce examination techniques. The practice examination includes an Indigenous Health question where an Indigenous patient consults the registrar, divulging a past episode when the patient was grossly disrespected by a hypothetical colleague of the registrar. The registrar is asked to describe how she would respond in this situation, both during and after her consultation with the patient.

Being Indigenous herself, the registrar is distressed by the question: she has previously found herself exposed to similar disrespect as that being reported by the patient in the scenario. She struggles to respond to the question in the detached way that the assessors inform her, during formal feedback, was the expectation. It seems as though the scenario assumes that the candidate is a non-Indigenous person, who needs to demonstrate an ability to sensitively engage with an othered patient.

Later, she approaches an Indigenous mentor who, as a senior fellow, raises her concerns discreetly with the college examiners. Subsequently, the college changes its procedures; now the college assessment committee always includes at least one representative from the college’s Indigenous Members’ Group.

creating such Voices, particularly at the higher, whole-of-institution levels that create policy. For example, the Australian Medical Association has had a permanent position on its Federal Council for a representative from the Australian Indigenous Doctors’ Association since May 2018. However, even if culturally safe care delivery is collaboratively defined by higher levels of the organisation and Indigenous Voices, the absence of such Voices at the lower organisational levels that actually implement policy (such as the specialty college assessment committee in the scenario) leads us to question whether that Voice is being heard. This is part of the reason why Indigenous Australians’ health outcomes continue to lag behind those of non-Indigenous Australians. In response, we all — as individual clinicians and as members of health care organisations — have a moral obligation to be more strongly promoting Voices that permit vulnerable groups to collaborate with care providers to define quality care, and that permit those same vulnerable groups to speak out when the agreed care is not delivered.

Conclusion

Reasoning from abstract principles is only part of how people decide on a course of moral action; personal commitments arising from care relationships play a much greater role. In the 1980s, insights about asymmetric care relationships triggered the development of care ethics. This in turn foreshadowed the early 2000s nomination of patient-centredness as an essential component of quality health care: it is no longer ethically acceptable for a clinician to unilaterally presume what patient welfare is.

Because the commodification of health care has led to care relationships that are impersonal, institutional and indirect, it is insufficient for individual care providers to be responsive. Care systems also need robust Voices for presenting and responding to the perspectives of the individuals and communities that they care for. For medicine, this includes not only the public and private organisations that deliver health care, but also medical colleges, medical schools and political organisations that care directly for their members and indirectly for the wider community. Creating structural Voices for care recipients is symbolic and is also a practical method of providing higher quality care. To reject symbolism in favour of practical action, as some commentators call for, risks returning to a 20th century model of caring and morality, where practical action is defined to align with the understandings and goals of the empowered care provider, and the vulnerable care recipient should be silently grateful for care that may ignore their own needs and preferences.

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Supporting Information

Additional Supporting Information is included with the online version of this article.