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THE PHYSICIAN AS FRIEND TO THE PATIENT

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My question in this chapter is this: could (and should) the role of the physician be construed as that of a friend to the patient? The question, to be clear, is not whether it is morally permissible for physicians to be friends with their patients – for example, whether it is morally permissible for a physician to go out to a movie or to play golf with a patient. Rather, the question is whether the physician–patient relationship *itself* should be understood in terms of what I will call a "physician-qua-friend model." I begin by briefly discussing the "friendship model" of the physician–patient relationship – according to which physicians and patients could, and perhaps should, be friends – as well as its history and limitations. Given these limitations, I focus on the more one-sided idea that the *physician* could, and perhaps should, be a friend to the patient. I show that given recent developments in our understanding of the physician–patient relationship, this idea is far from asinine (section 1). I then make the case that the most plausible conception of the physician-qua-friend model incorporates the following components: (a) a common goal, that is, one that physician and patient share; (b) certain forms of equality between physician and patient; (c) an ideal of a caring physician. This model should be understood as a *normative* ideal, toward which (many) actual physician–patient interactions may aspire (section 2). Finally, I show how the model can be instantiated in a certain type of physician–patient interaction, namely, in physician-assisted dying (PAD). Among other things, I argue that the physician-qua-friend model allows for the possibility of physicians justifying their participation in PAD, while also enhancing patient trust in them and in the medical profession (section 3). I conclude by noting limitations of my argument (section 4).

1. Friendship in the Physician–Patient Relationship: An Overview

The association between the physician–patient relationship and friendship, which I shall call "the friendship model," has a long history. For example, Plato (1997) famously argued that "a sick man" is "a friend to the doctor" (*Lysis*: 218e), and Seneca (2011), who asks why it is "that I owe something more to my doctor and my teacher, but I do not quit my debt by payment," answers that "from being a doctor or a teacher they turn into a friend" (*On Benefits*: 6, 16.1). In his much-discussed book, *Doctor and Patient*, Lain Entralgo (1969: 17–23) argues that for the ancient Greeks, the relation between doctor and patient is one of *philia*, or "friendship." Although *philia* is much broader than our contemporary understanding of friendship, Entralgo demonstrates that the image of the physician as friend to the patient has been prominent throughout the Western medical tradition, concluding with a normative claim according to which "insofar as man is an individual and his illness a state affecting his personality, the medical relation […] should be a friendship" (ibid.: 242). The long history of the friendship model – or, at least, "picture" – of the physician–patient relationship might be explained in part by the "Hippocratic ethic," which has dominated the Western medical tradition. According to the Hippocratic Oath, the physician is required to benefit the sick according to her ability and judgment as well as keep them from harm and injustice (Kass 1985: 229). As Veatch (1983: 192) points out, in such a tradition, the friendship model is of importance, since the physician's task is to use her judgment to benefit the patient, and this often requires intimate knowledge of the patient and his life, which is attained, so the thought goes, in the context of long-standing friendship. Some physicians (and others) still understand their practice in terms of a friendship model. Thus, Pellegrino and Thomasma (1981: 64) argue that the clinical interaction is "a relationship of friendship," a theme that they develop throughout their work. And Bleuler (1973: 73) writes, in a manner that will be of importance shortly, that

> in the patient's pain, in his despair, in his misery, the patient called for a friend, a friend whom he can trust, a friend whose wisdom, whose willingness to help, whose integrity is beyond question, a man who understands his most secret and most personal problems, and the Doctor must be such a friend.

Despite its long history and contemporary proponents, the friendship model of the physician–patient relationship has been criticized for various reasons. These reasons can be divided into two kinds, namely, psychological and structural. Psychologically, the physician–patient relationship is, on the face of it, different from one between friends. For example, while friends want to spend time with each other, this reciprocal desire to share experiences is not part of the physician–patient relationship (Erde and Jones 1983: 305). Indeed, neither patients nor physicians necessarily desire to be friends with each other. In terms of patients, some patients might actually prefer, as Veatch (1983: 202) notes, the physician as stranger, at least for certain kinds of sensitive medical care encounters, such as those pertaining to abortions, venereal disease treatment, and mental health therapy; and some people have personality types that favor more compartmentalized lives and prefer to lead their lives so that those they know in one sphere are not involved in other spheres. More generally, it seems reasonable to assume that friendship is not what patients want from their physicians. Rather than friendship, many patients simply want their physician's committed but disinterested attention as part of competent medical care; they do not want physicians to feel their pain or to circumvent their usual stark procedures, lest they be incapacitated or make mistakes (Montgomery 2006: 182–4). And as Illingworth (1988) has argued, since most patients do not desire a friendship with their physicians, the friendship model might risk violating patient autonomy; this is so, since saddling patients with a friendship that they do not desire fails to respect patient claims to self-determination. She further argues that even if patients desire a friendship with their physicians, it does not necessarily follow that this desire should be satisfied: if patients want to befriend their physicians, this might be because patients are psychologically oppressed.

For example, patients might regard themselves as the medical profession tends to view them, as agents with diminished capacities for self-determination. If this is true, it is unlikely that patients themselves would endorse their desire for such a friendship. And it is certainly also the case that most physicians do not necessarily desire a friendship with their patients. Indeed, insofar as the friendship model dictates otherwise, it is at risk of conflicting with medicine's ideal of openness to all in need, or, alternatively, of being impractical, since friendship with every patient would be emotionally exhausting, and even perilous, for physicians (Montgomery 2006: 180).

The physician–patient relationship is also different from one between friends for structural reasons. First, as Veatch (1983: 187) notes, the institutional structure of the health-care system available to many people dictates that health care will often be delivered in a model in which the physician is a stranger; for example, when patients see specialists for one-time referral consultations. Moreover, the physician is often professionally required to be a stranger in the sense that she needs to be detached from the patient in order to dispassionately analyze the situation. Detachment is especially crucial when physicians must inflict pain or produce disfigurement, or when they have to deal with patients who are abusive or belligerent, or for whom the physician feels a strong dislike (Loewy 1994: 55–6). Second, the physician–patient relationship is different from one between friends in its inherently inegalitarian nature. For example, it is patients' needs (real and felt) that always give rise to medical relationships. Patients also pay physicians for their care and do not have reciprocal loyalties (Childress and Siegler 1984: 20). More specifically, as many have noted, the patient, who is usually vulnerable, is confronted with a physician, who has the requisite knowledge and skills to help the patient, as well as a socially conferred authority to determine what counts as sickness or health and who warrants labeling as sick or healthy (Brody 1992: 16–20; Davis 2000: 29). Indeed, not only does the physician have general medical

knowledge and skills, but she also has specific knowledge about her patients' bodies and lives. Moreover, the physician has legal power to invade patients' bodies, prescribe poisons, and use procedures that would otherwise be rendered aggravated assaults (Loewy 1994: 57). Finally, and perhaps most importantly, the imbalance of power in the physician–patient relationship grounds, as Davis (2000: 29) notes, various de facto moral obligations and responsibilities on the part of the physician toward the patient that the patient does not have toward the physician; this is not the case in friendship, which is generally characterized by *mutuality* and *reciprocity*: while mutuality and reciprocity may not always define friendship between any two individuals, they are generally crucial to the sustenance of friendship and their persistent absence often warrants its dissolution.

The differences between friendship and the physician–patient relationship, especially the lack of mutuality and reciprocity, suggest that this relationship cannot be one of "friendship," at least not as we usually understand this term. Nevertheless, I want to examine the more one-sided idea, expressed in Bleuler's words above, that the *physician* could, and perhaps should, be a friend to the patient. In other words, instead of a friendship model of the physician–patient relationship, I want to examine a "physician-qua-friend model" of this relationship. The importance of this idea should be understood, I believe, against the backdrop of shifts in our understanding of the physician–patient relationship in recent decades. When paternalistic models of this relationship fell out of favor several decades ago, fact-provider models – according to which physicians merely provide patients with non-value-laden medical information and patients then choose their preferred intervention based on their own values – seemed like a promising alternative. However, it was soon realized that the assumption underlying these models, according to which there is a clear distinction between facts and values, is untenable: physicians cannot really avoid making value judgments (Emanuel and Emanuel 1992; Savulescu 1995; Veatch 1972). Given such problems and

growing recognition that medical decision-making should be shared by patient *and* physician, deliberative models, which prize joint physician–patient deliberation, emerged. According to Emanuel and Emanuel's (1992) version of this model, physicians deliberate together with patients regarding the best health-related values that could, and ultimately should, be pursued in the clinical situation.[1] Accordingly, the physician serves, among other things, as a "*friend*, engaging the patient in dialogue on what course of action would be best" (ibid.: 2222; emphasis added). If one subscribes to Childress and Siegler's (1984: 20–1) observation, according to which friendship in the physician–patient relationship incorporates both "love or care" and "equality and respect" – their thought is presumably that the combination of these components, care expressed within the context of an egalitarian relationship, allows one to speak of "friendship" between physician and patient – then there is a prima facie case to be made that the physician could, and perhaps should, be considered a friend to the patient in the deliberative model. First, the model can embody an ideal of a caring physician who engages patients in evaluative discussions (Emanuel and Emanuel 1992: 2225). Second, the model can embody an ideal of equality and respect in the sense that the physician and the patient are fellow deliberators. Therefore, insofar as there is a prima facie case for (a) construing the physician–patient relationship along the lines of a deliberative model, and (b) construing the deliberative model as one in which the physician could, and perhaps should, be a friend to the patient, then there is also a prima facie case for construing the physician–patient relationship as one in which the physician could, and perhaps should, be a friend to the patient.

[1] There are variations of these models in the literature. For example, Savulescu (1995) argues that physicians should make all things considered value judgments: physicians form a conception of what is best for their patients and rationally argue with them (without coercing patients). He calls this "rational non-interventional paternalism."

2. The Physician-qua-Friend Model as a Normative Ideal

In this section, I wish to develop what I take to be the most plausible conception of the physician-qua-friend model, according to which the physician could, and perhaps should, be a friend to the patient. I will then demonstrate, in the next section, that this model can have great value in certain contexts. Let me commence by following MacIntyre's (2007: 156) lead, who argues that one can understand friendship in two ways: According to a modern perspective, "affection is often the central issue […].'Friendship' has become for the most part the name of a type of emotional state rather than of a type of social and political relationship." According to an ancient Greek view, attributed to Aristotle, while friendship involves affection, "that affection arises within a relationship defined in terms of a common allegiance to and a common pursuit of goods." While I cannot delve into Aristotle's views about friendship, there is a case to be made that Aristotle understood friendship as a "shared activity" that involves a shared and mutually known commitment to a goal, a mutual understanding of participants' roles in their pursuit of this goal, and an agreement on the part of participants to do their respective shares in the common effort (Cooper 1980: 326).[2] Accordingly, one could understand friendship as a complex social relationship that is constituted in part by a commitment to a common goal, in light of which parties jointly pursue certain goods. If we also include Childress and Siegler's focus on equality and care, we get the following model of the physician–patient relationship, which, so I shall argue, can

[2] Cooper's analysis of the characteristics of "shared activity" builds on this passage from Aristotle (1984): "[Men] think that the happy man ought to live pleasantly. Now if he were a solitary, life would be hard for him; for by oneself it is not easy to be continuously active; but with others and towards others it is easier. With others therefore his activity will be more continuous, being in itself pleasant, as it ought to be for the man who is blessed" (*Nicomachean Ethics*: 1170a4-9). While any friendship between physician and patient will presumably be, following a distinction in Book VIII of the *Nicomachean Ethics*, a friendship of "utility" rather than one of "excellence," this does not entail that there is no genuine other-regarding or disinterested concern in such friendships, per Aristotle's own views about friendships of utility (Gartner 2017). This means that physicians can genuinely care for their patients, even in a friendship of utility.

incorporate the idea that the physician could, and perhaps should, be a friend to the patient: (a) a common goal to the physician–patient relationship, that is, one that physician and patient share; (b) certain forms of equality between physician and patient; and (c) an ideal of a caring physician. The phrase "could, and perhaps should" suggests that this model should not be understood, in the first instance, as an *explanatory* model that aims to makes sense of current medical practices. Indeed, this cannot be the case, since, as noted, the institutional structure of the health-care system often dictates that the physician is a stranger. Rather, it is more plausible to understand this model as a *normative* ideal, toward which (many) actual physician–patient interactions may aspire. As James (1989: 144) put the point in connection with the friendship model of the physician–patient relationship: the model "points towards and helps to organize important moral goods and ideals which physicians and patients may strive to attain" and "is most plausibly seen as aspirational, helping bioethics to focus on the distinctive goods possible within medical relationships."[3]

If we understand friendship as involving, among other things, a commitment to a common goal, in light of which parties jointly pursue certain goods, we first need to inquire regarding the identity of this common goal in the physician–patient relationship. Some authors have argued that physicians and patients do not necessarily share the same goals (Engelhardt 1996: 298; Veatch 1972: 7). In Emanuel and Emanuel's "deliberative model," there seems to be an implicit assumption that the goal in question is health, for they argue that physicians deliberate together with patients regarding the best health-related values. However, "health" is problematic as a

[3] Illingworth (1998: 34) argues that because models prescribe for a wide range of cases, they are limited in what desires they can assume to exist. In particular, she argues that, on the one hand, models might assume uncontroversial desires that will be true of everyone – e.g., a desire that physicians treat one with respect and benevolence – but will not generate a very interesting model; on the other hand, models can posit desires that have some substance to them – e.g., a desire for friendships with physicians – but are not necessarily shared by all and are problematic with respect to patient autonomy. However, if we understand the proposed model as a normative ideal, then it can abstract away (in part) from the specifics of individuals' psychology and current practices. This is so because we are not primarily interested in what specific patients and physicians desire or in how physician–patient interactions currently play out.

common goal, since physicians and patients do not necessarily share the same concept of health. Consider, for example, a patient who comes to a surgeon requesting that her left leg be amputated above the knee. She says that her left leg has always felt "alien" to her and that her life would be much better without it. Indeed, she compares herself to a person who feels he or she has been born in a body of the wrong gender and wants an operation to put things right, to be "whole."[4] The surgeon might stipulate health as pertaining primarily to bodily integrity, while the patient might stipulate health as also incorporating the patient's psychology in general and her happiness in particular. I have argued elsewhere that a good candidate for the constitutive end of medicine is "benefiting patients in need of prima facie medical treatment and care."[5] As I argue, this is not an arbitrary choice. First, the constitutive end of medicine, without which the practice would not exist, needs to make mention of the fact that this practice advances *medical* treatment and care. Second, the constitutive end needs to mention the fact that the relevant treatment and care *benefits* its recipients because this is how physicians have understood their craft ever since the introduction of the Hippocratic Oath (Ben-Moshe 2019: 4457–8).[6] This end could manifest itself, in turn, as the goal of individual physician–patient interactions. Of course, even with the goal of benefiting patients in need of prima facie medical treatment and care, physicians and patients might disagree about definitions and actions, for example, about what counts as a healthy limb or about whether a healthy limb should be removed. But if there is agreement about the goal of their activity, then disagreements about what benefits patients in need of prima facie medical treatment are to be

[4] I am indebted to Daniel Brudney for this example, which I discuss in Ben-Moshe (2019: 4450).

[5] Brody and Miller (1998: 386–7) suggest that medicine has multiple goals, such as diagnosing, preventing, curing, and lessening the pain caused by disease or injury, which are unified by the fact that the physician is dedicated to "benefiting patients in need of medical treatment and care"; but they do not postulate this as the end of medicine.

[6] As I also note in this earlier paper, "benefiting patients in need of prima facie medical treatment and care" is different from "medicine" (the latter would have the unwanted result of making "medicine" the end of medicine): the end of medicine does not focus on medicine *simpliciter*, but also on benefiting patients. Moreover, the focus is on "prima facie" medical treatment and care: what is considered "medical treatment and care" is not an unchanging fact of the matter; rather, its nature will be transmuted in the course of the history and development of medical practice.

resolved, insofar as they can be resolved, in deliberation between the two parties, in light of this shared goal.

If the goal of physician–patient interactions is benefiting patients in need of prima facie medical treatment and care, then there is an even stronger case to be made than the one afforded by Emanuel and Emanuel's deliberative model that physicians and patients can deliberate *as equals*. This is so because, contrary to their model, the focus of deliberations need not be solely health-related values, about which the physician has epistemic authority, but can include values more generally, including patients' values, about which the patient has epistemic authority. The idea that patients' values should be incorporated into medicine has become all the more pressing given the prevalence of patient rights movements in recent decades. It has also been recognized in the literature. For example, Pellegrino (2001: 569) has argued that "the good of the patient" includes both the patient's medical good, which aims at the restoration of the well-functioning of the body, and the patient's perception of the good, which concerns his values and preferences. More recently, I have argued that since the end of medicine can be construed as "benefiting patients in need of prima facie medical treatment and care" and since there is no a priori reason to limit what constitutes patient benefit, it should include both patients' medical good and their perception of the good. While the physician might be the expert when it comes to the patient's medical good, it is the patient who has intimate knowledge of his perception of the good. Hence, patient values are an integral part of the physician–patient relationship in the following sense: what will benefit the patient in need of prima facie medical treatment and care should be jointly determined by physician and patient, who, together, have the knowledge needed to attain this goal. I further argued that this makes medical practice a *relational* enterprise: rather than being an enterprise in which the craftsman produces a product that is independent of the relationship between craftsman

and consumer, medicine is an enterprise in which the relationship is a constitutive component of the craft itself. Accordingly, the interactions between physicians and patients constitute in part the norms that govern the craft (Ben-Moshe 2019: 4462–3). Therefore, while some of the structural asymmetries between physician and patient that were noted in section 1 will no doubt remain, the ideal of equality in the physician–patient relationship can be understood as follows: (a) deliberation as equals, that is, as two parties who respect each other's epistemic authority over the respective knowledge that each party possesses in furthering the common goal of their interactions; (b) equal contribution to the norms that govern the craft in which their relationship is embedded. Hence, like friends, both parties could, and perhaps should, have an equal say not only within the interactions between them, but also about the boundaries of the framework in which those interactions occur.

Now, a common goal and equality may also characterize relationships that are not ones of friendship. For example, colleagues might share a common goal and interact as equals in all the relevant respects, but they might not be characterized as friends. And although my aim was merely to present a model of the physician–patient relationship that incorporates the idea that one could (and should) characterize the physician as a friend to the patient, a common goal and equality does not even get us to this idea. This is where the third component, an ideal of a caring physician, comes in. (Colleagues do not need to exhibit care in any interesting sense!) In this regard, some authors have noted that a good physician is compassionate like a friend (Pellegrino and Thomasma 1993: 82–3).[7] One can understand the justification for physician care as follows: the ideal of care is part and parcel of how the medical profession has understood itself and, to some extent, still

[7] Other authors have argued against the friendship model of the physician–patient relationship by arguing that this relationship is not generally characterized by "compassion, kindness, sympathy, warmth, and fidelity," which "stand in contrast to the character traits stereotypically attributed to the modern, more specialized, businesslike physician: efficiency, technical competence, impartiality, coldness, and distance" (Veatch 1983: 188). However, I am arguing for a certain *ideal* of the physician–patient relationship and not for what happens currently (or recently) to be the case.

understands itself. Seneca (2011), for example, associates the physician qua friend with his "kind and friendly disposition" and provides an account of a compassionate physician for whom the patient is "always his prime concern" (*On Benefits*: 6, 16.1 and 16.4–5). Consider also the oaths that the medical profession has endorsed, and continues to endorse: in addition to the classical Hippocratic Oath, which requires the physician to benefit patients and keep them from harm and injustice, the modern version of the oath asks physicians to exhibit "warmth, sympathy, and understanding" (Hajar 2017: 157) – or "compassion," per the American Medical Association's "Principles of Medical Ethics" (Kass 1985: 231) – in their dealings with patients. Indeed, physicians should presumably exhibit these attitudes in greater degree to patients than to persons in general. This differential level of concern seems crucial to friendship. Note that physician care does not entail that physicians should forsake the type of detachment that is professionally required of them: a physician can, for example, be compassionate *and* dispassionately analyze the situation, provide competent medical care, and so on. Moreover, if physician care, understood primarily in terms of compassion, should be an integral part of the physician–patient relationship, then, as Rhodes (1995) rightly argues, the physician must, as a matter of professional obligation, be equipped with a compassionate character; this would need to be cultivated, for example, as part of physicians' training in medical school. So while my proposed model does not get us the mutuality and reciprocity that characterizes friendship, since patients need not care for physicians in the manner in which physicians should care for their patients, it can incorporate the idea of a physician who is a friend to the patient. In particular, and to expand on a thought noted earlier, the physician ought to care about the patient like a friend – rather than, for example, like a parent – *because* this caring attitude occurs in the context of a social relationship that is constituted in part by a commitment to a *common* goal, in light of which physician and patient jointly pursue certain goods *as equals*.

3. The Physician-qua-Friend Model and Physician-Assisted Dying

In the previous section, I presented what I took to be the most plausible version of the ideal that the physician could, and perhaps should, be a friend to the patient. I now wish to show how this ideal can be instantiated in a certain type of physician–patient interaction. In these interactions, the caring attitude of the physician could (and should) also include characteristics such as "closeness" and "emotional as well as intellectual investment" in the sense that "one has staked some of one's own happiness, feeling, and being in the happiness, not just in the success, of another" (Loewy 1994: 54).[8] The type of interaction that I will discuss concerns physician-assisted dying (PAD). I will take PAD to cover cases of physician-assisted suicide *and* active voluntary euthanasia and assume that there is no significant moral difference between the two; I will further assume, for argument's sake, that PAD is both morally permissible and a sound public policy.[9] The discussion of the relations between PAD and the friendship model of the physician–patient relationship has primarily focused on the physician and the good of the physician. Clark and Kimsma (2004), for example, argue that PAD is the kind of activity where physicians should be more personally involved, including in a "loving act" toward patients. The patient, they argue, must respect the vulnerabilities a physician faces in agreeing to assist in ending a life. Accordingly, the physician and patient should enter a personal relationship or a "medical friendship." In order to make their case, the authors point to, among others things, the fact that (a) some physicians, who are impeded

[8] Loewy discusses these characteristics as counterexamples to the claim that physicians and patients are friends. I am making the case that, under certain circumstances, the physician, at least, could (and should) exhibit them.

[9] See Brock 1992 and Buchanan 1996 for excellent discussions of these issues. Regarding the first issue, as Brock (1992: 10) observes, the factual difference between physician-assisted suicide and active voluntary euthanasia amounts to the identity of the person who actually administers the lethal dose, the patient (physician-assisted suicide) or the physician (active voluntary euthanasia). In both cases, the physician plays an active and necessary causal role, and the choice rests fully with the patient. Therefore, according to Brock, there is no substantial moral difference between the two.

from participating in PAD for their patients, do nevertheless participate in PAD, qua "loving act," for family members and friends, even at the risk of prosecution (Vaux 1988: 2141); (b) some physicians who participate in PAD claim they need a personal relationship with the patient so as to be able to live with themselves and not experience guilt (Clark and Kimsma 2004: 63).[10] My focus will be on the physician-qua-friend model and on the claim that this model of the physician–patient relationship can allay worries pertaining to questions of trust and the ends of medicine, which tend to arise in connection with PAD. However, I first wish to contrast two well-known cases in order to motivate the importance of the physician-qua-friend model in the context of PAD.

First, consider the following case, reported by a gynecology resident at a large hospital, who was called in the middle of the night to see a 20-year-old girl named Debbie dying of ovarian cancer:

> I entered [the room] and saw an emaciated, dark-haired woman who appeared much older than 20. She […] was sitting in bed suffering from what was obviously severe air hunger. The chart noted her weight at 80 pounds. A second woman, also dark-haired but of middle age, stood at her right, holding her hand. […] The room seemed filled with the patient's desperate effort to survive. […] She had not eaten or slept in two days. She had not responded to chemotherapy and was being given supportive care only. […] Her only words to me were, "Let's get this over with." I retreated with my thoughts to the nurses' station. The patient was tired and needed rest. I could not give her health, but I could give her rest. I asked the nurse to draw 20 mg of morphine sulfate into a syringe. Enough, I thought, to do the job. […] [I] told the two women I was going to give Debbie something that would let her rest and to say good-bye. Debbie looked at the syringe, then laid her head on the pillow with her eyes open, watching what was left of the world. I injected the morphine intravenously and […] waited for the inevitable […] effect of depressing the respiratory drive. With clocklike certainty, within four minutes, the breathing […] ceased. The dark-haired woman stood erect and seemed relieved. ["It's Over, Debbie" (1988): 272]

[10] For example, the authors quote a Dutch physician, who, when asked why he felt the need for a personal relationship when participating in PAD, said, "because I have to go on for the next 20 or 30 years myself. […] The next morning I want to look into the mirror right into my eyes without feeling any guilt" (Clark and Kimsma 2004: 63). Satisfying the need for a personal relationship might outweigh the risk, noted above, that friendship with patients would be emotionally exhausting for physicians.

Setting aside worries pertaining both to the legality of this case and to patient-informed consent, it seems obvious that some of the troubling aspects of this case pertain to the physician not being a friend to the patient: the two parties had just met for the first time; there was no shared deliberation as equals regarding the decision to kill the patient; the physician did not exhibit a caring attitude of, for example, warmth and sympathy, let alone closeness and emotional and intellectual investment.

A very different case was documented by Timothy Quill (1991) regarding a leukemia patient named Diane. Despite having a 25 percent chance of survival, Diane declined treatment. Quill, who had been Diane's physician for several years before the cancer diagnosis, knew her well, including the details of her life story. When she was diagnosed with cancer, not only did he provide her with all of the requisite medical information, but they also "together […] lamented her tragedy and the unfairness of life" (ibid.: 692). Quill and Diane met several times to discuss her decision to forego treatment, especially since Quill had previously seen Diane fight and use her considerable inner resources to overcome alcoholism and depression and so he half expected her to change her mind. However, he "gradually understood the decision from her perspective and became convinced that it was the right decision for her" (ibid.: 692). She then raised the option of PAD:

> It was extraordinarily important to Diane to maintain control of herself and her own dignity during the time remaining to her. […] When the time came, she wanted to take her life […]. I acknowledged and explored this wish […]. In our discussion, it became clear that preoccupation with her fear of a lingering death would interfere with Diane's getting the most out of the time she had left […]. I feared the effects of […] [suicide] on her family […] [but] [t]hey believed that they should respect her choice. With this in mind, I told Diane that information was available from the Hemlock Society that might be helpful to her. A week later she phoned me with a request for barbiturates for sleep. […] [I]t was important to me […] to be sure that she was not in despair or overwhelmed in a way that might color her judgment. In our discussion, […] it was […] evident that the security of having enough barbiturates available to commit suicide when and if the time came would leave her secure enough to live fully and concentrate on the present. It was clear that she was not despondent and that in fact she was making deep, personal

> connections with her family and close friends. I made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide. We agreed to meet regularly, and she promised to meet with me before taking her life, to ensure that all other avenues had been exhausted. […] [When] it was clear that the end was approaching […], she let me know […]. [I]t was clear that she knew what she was doing, that she was sad and frightened to be leaving, but that she would be even more terrified to stay and suffer. […] Two days later her husband called to say that Diane had died. […] They called me for advice about how to proceed. When I arrived at their house, […] [w]e talked about what a remarkable person she had been. [Quill 1991: 693]

If we are more approving of this case than the previous one, it is presumably because, among other things, Quill was a friend to Diane: he knew the patient well, cared deeply about her, and treated her as an equal in sustained deliberation, paying close attention to her values and preferences. Indeed, he also learned important lessons from her: "Diane taught me about the range of help I can provide if I know people well and if I allow them to say what they really want. She taught me about life, death, and honesty and about taking charge and facing tragedy squarely when it strikes. She taught me that I can take small risks for people that I really know and care about" (ibid.: 694).

The contrast between the two examples demonstrates that we tend to look more favorably on PAD if it is performed in the context of a relationship in which the physician is a friend to the patient. There are also a couple of specific benefits to the position according to which, insofar as PAD is performed by physicians, they should be doing so *qua friend* of the patient. Consider the following two worries. First, it has been argued that PAD might lead to a loss of trust by patients in their physicians: "if physicians become killers or are even merely licensed to kill, the profession – and, therewith, each physician – will never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty" (Gaylin et al. 1988: 2140). Second, it has been questioned whether *physicians* in particular should assist patients in dying, since doing so might not further the end(s) of medicine. Kass (1989: 29–30), for example, has taken this position, since

he argues that the end of medicine is "health," understood as the "wholeness" and "well-working" of "the living body." Accordingly, he argues that "for the physician, at least, human life in living bodies commands respect and reverence – *by its very nature*" and that "the deepest ethical principle restraining the physician's power […] is the dignity and mysterious power of human life itself" (ibid.: 38). Now, one might attempt to allay these worries by arguing that if (a) PAD is restricted to cases in which it is truly voluntary, and (b) X has not voluntarily requested it, then X should not fear getting it. Moreover, one could argue that it is physicians' commitment to the values of respecting patients' self-determination and promoting their well-being that should be at the "moral center" of medicine, and these values support PAD when patients make competent requests for it (Brock 1992: 16–17). Nevertheless, merely insisting that patients have nothing to fear, if PAD is truly voluntary, would probably do little to reassure patients for whom this practice causes doubt about the medical profession in general and individual physicians' intentions in particular. Moreover, while it is true that PAD usually respects the patient's self-determination – and, insofar as the patient's life is not worth living, promotes their well-being – if the end of medicine is construed as "health" or "healing," PAD would be outside the realm of permitted medical interventions. And even if "health" or "healing" is a too-narrow conception of the end of medicine, similar worries could also arise on a wider conception of this end, such as "benefiting patients in need of prima facie medical treatment and care," for it is not conclusive that PAD falls under the category of "prima facie medical treatment and care" and thus that is furthers this end.

If PAD is (legally) performed only when the physician is a friend to the patient – that is, only if the physician and the patient have a common goal, they deliberate as equals, and the physician exhibits a caring attitude (in the expansive sense discussed above) – patient trust in physicians could be enhanced. In particular, those patients who opt for PAD could rest assured that the

physician is a friend to them and has a duty to be loyal to them qua friend, and thus that they can place trust in her as one does in a friend. And those who are not interested in PAD would at least know that physicians would perform PAD only in the context of an intimate and caring relationship, which is also characterized by a common goal and shared deliberation, of the type that Dr. Quill had with Diane. The proposed model can also allow for physicians, who are obligated to act in accordance with the ends of medicine, to nevertheless assist patients in dying. More specifically, physicians who participate in PAD would be justified in doing so primarily *qua friends*. The thought here is that the role of the physician qua physician and the role of the physician qua friend can come apart; this allows for the possibility that the physician qua friend can perform, and even be obligated to perform, actions that are at the very least controversial, and are at most supererogatory, for her to perform qua physician. Thus, PAD might very well be obligatory for the physician qua friend, but at most supererogatory for the physician qua physician. Of course, I do not mean to suggest that the physician qua friend is not availing herself of the prerogatives, rights, and powers that she has qua physician; nor am I suggesting that she is unconstrained by professional norms and obligations. Indeed, the physician would still need to justify her actions qua physician, that is, in terms of some of the specific goals of medicine that fall under the more general and constitutive end of "benefiting patients in need of prima facie medical treatment and care." In the case of PAD, the physician can justify herself by arguing that, for example, she is relieving suffering, even if she is not prolonging life. In doing so, she can at least argue that PAD is not inconsistent with the constitutive end of medicine, even if it cannot be shown to conclusively further it. So while Kevorkian (1991: 202–3) has argued that PAD should be performed in the context of a unique *subspecialty* of medicine – "obitiatry," in which obitiatrists would practice "medicide" – I am suggesting that PAD should be performed in the context of a unique form of

relationship, namely, one in which the physician is a friend to the patient. Therefore, while disagreement might continue regarding whether physicians should be involved in suicide and euthanasia, my proposal allows for the possibility of physicians justifying their participation in PAD, while also enhancing patient trust in them and in the medical profession.

4. Conclusion

In this chapter, I have tried to make the case for what I take to be the most plausible conception of the physician-qua-friend model of the physician–patient relationship and explained its potential importance against the backdrop of recent developments in our understanding of this relationship. I also argued that it is most plausible to understand this model as a normative ideal, toward which (many) actual physician–patient interactions may aspire, but showed how it can be implemented in one type of medical scenario. I should emphasize, in conclusion, two important limitations of my argument. First, even as an ideal, the physician-qua-friend model can better guide certain types of physician–patient interactions, but less so others. For example, while this model might be able to guide a patient's long-term relationship with his primary care physician, it might not be able to guide the type of interactions that patients have with specialists in one-time referral consultations, in emergency care situations, or, for very different reasons, with mental healthcare providers. Second, and more importantly, I have not conclusively shown that the physician-qua-friend model is the only model for conceptualizing the physician–patient relationship, or that it is, all things considered, the most plausible one for doing so. For all I have said, perhaps other models of the physician–patient relationship would, for different reasons, fare just as well, or, indeed, better. Nevertheless, I hope that I have shown that there is much more to this type of model than, as one

author puts it in connection with the friendship model of the physician–patient relationship, a mere recent "compensatory rhetorical turn" (Montgomery 2006: 180).[11]

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