Loneliness in Medicine and Relational Ethics: A Phenomenology of the Physician-Patient Relationship

Abstract
Loneliness in medicine is a serious problem not just for patients, for whom illness is intrinsically isolating, but also for physicians in the contemporary condition of medicine. We explore this problem by investigating the ideal physician-patient relationship, whose analogy with friendship has held enduring normative appeal. Drawing from Talbot Brewer and Nir Ben-Moshe, we argue that this appeal lies in a *dynamic* form of companionship incompatible with *static* models of friendship-like physician-patient relationships: a mutual refinement of embodied virtue that draws both persons together. The ideal physician-patient relationship has a dialectical character that fosters each member's improvement of phenomenologically recognizing and embodying moral virtues. A key component of this dynamic is a commitment to the common goal of the patient's health, realized through joint interactivities and conversations over time. The physician's presence to the patient's suffering—understood best as an alienating phenomenological condition for the patient—orients and discloses possibilities for virtuous caregiving by structuring the meanings of the goals, conversations, and joint narrative constitutive of their relationship. Presence to suffering, paradoxically, is perhaps an important prerequisite for this dynamic partnership. These activities dialectically build an interpretive horizon of understanding through which moral goods and character refinement—in and for the other—may become revealed for both persons in their shared being-in-the-world. This analysis of suffering, mood, and revealing of (possible) moral goods has implications for addressing the modern problem of loneliness for patients and physicians, who are increasingly inhibited from building flourishing relationships with each other.

Keywords: physician-patient relationship, loneliness, suffering, friendship, phenomenology, virtue

I. Introduction: Physician loneliness and the role of suffering

The deleterious health effects of loneliness have received newfound interest in recent years. This focus on loneliness in medicine has taken place against the broader cultural backdrop of the so-called "Loneliness Epidemic" of the 2010s brought on by increased social media use, fewer personal interactions, heightened political and ideological polarization, and decreased investment in social infrastructure, which includes the physical assets of a community, programs, and local policies that support the development of social connection. The social infrastructure of these communities is in turn influenced by broader social policies, cultural norms, the technology environment, the political environment, and macroeconomic factors. Moreover, individuals are simultaneously influenced by societal-level conditions such as cooperation, discrimination, inequality, and the collective social connectedness or disconnectedness of the community.[1] Recently, the public health impact of loneliness has been amplified by the social distancing and isolation effects of the COVID-19 pandemic, and many people continue struggling to re-integrate into pre-pandemic communities. This attention to the pernicious effects of cultural loneliness is not merely theoretical. Important empirical work has emerged in the COVID era demonstrating loneliness' powerful (and adverse) mediating effects on cardiovascular disease,[2, 3, 4] COPD,[5] adverse mental health outcomes,[6] and overall mortality.[7, 8]

While such attention to the impact of loneliness upon patients is important, there is a relative paucity of investigation into how loneliness manifests for healthcare practitioners themselves. Given their constant day-to-day communications with fellow practitioners and patients, it may seem odd to consider that healthcare workers might experience such loneliness in the course of their work. But narratives and data about clinician burnout suggest a paradoxical phenomenon: in an era of increasing communication among clinicians and patients, clinicians have reported a decline in the quality of such interactions and relationships, and the meaning and satisfaction they derive from them.[9] Burdened by ever-increasing digital documentation, administrative duties, and steadily compressed face-to-face time with patients, physicians report increased professional dissatisfaction, emotional fatigue, and reduced empathy to the

extent that they may even feel unable to care for their patients' social and emotional needs.[10] This constellation of symptoms suggests an increasing sense of loneliness among healthcare practitioners.

Much of the existing literature attempts to explain this phenomenon by finding discrete, historical causes inimical to meaningful face-to-face caregiving and discussions of care: excessive charting and paperwork duties, a decline in a collegial culture of care, "RVU medicine" that incentivizes less time in conversation per patient, and more.[9] While these are important considerations, the analysis of such external factors to the physician-patient relationship neglects consideration of the extent to which this relationship has been misunderstood by contemporary practitioners and patients alike, which may contribute to such loneliness. The patient-physician relationship is increasingly misconstrued and understood solely as one that is primarily transactional—and in many cases, economic—in nature: a social construal that renders physicians as "providers" and patients as "consumers" in the so-called "provider of services model" as articulated by Farr Curlin and Christopher Tollefsen.[11] This assumption motivates the trend of an ever-increasing separation of physicians from their patients—including, crucially and ironically, from the presence to patients' suffering, which we contend is foundational to a normatively ideal physician-patient relationship.[12]

Recognizing the problem of separation from patient suffering is our starting point for theorizing why physicians experience loneliness and alienation in medicine today. We understand suffering as a phenomenological (and, for the patient, alienating) mood that structures and reveals features meaningful to the patient's being-in-the-world, and argue that presence to suffering is uniquely important for physicians because it grounds a normatively ideal, friendship-like physician-patient relationship through which both parties build a shared interpretive understanding and encounter moral goods in the world. The physician's presence to her patient's suffering—a mood distressing for the patient—does not only remind her of a shared human mortality in the moment, of which she already has at least a primordial understanding; it also orients the kinds of *future goals* and interactivities between the patient and physician that constitute a jointly authored narrative. Our argument retrieves and expands the longstanding ideal of the patient-physician relationship as a moral partnership between two agents, contingent upon the virtue of trust to dictate that both act unconditionally in accord with the good of the other in light of the patient's suffering—an ideal becoming lost in today's financialized, radically individualizing worldview of medical care.

This paper proceeds as follows: We first describe the patient-physician relationship as one that is fundamentally moral in nature and that shares constitutive components of friendship, particularly its foundation in dialectical, narrative-forming activities, but one that is also necessarily constrained by factors not shared by friendship *simpliciter*. We then claim that this friendship-like relationship, which requires longitudinal sets of morally relevant conversations and doings (as they relate to the patient's affliction), is normatively ideal because it forms a dynamic, shared, and continuously reworked horizon of understanding through which both parties refine their moral sensibilities to appreciate moral goods relevant to the patient's medical care, general health, and wellbeing. Presence to suffering is a unique and necessary component of this kind of relationship because it draws the physician to her (common) human mortality and affectively orients the shared goals and decision-making that constitute the interactivities within this relationship. We conclude by addressing potential counterarguments and limitations.

II. How is the ideal physician-patient relationship friendship-like?

The analogy between the physician-patient relationship and character friendship has an enduring history in the Western bioethical and medical tradition not just as a descriptive picture, but often also as a prescriptive model of how two persons in a longstanding relationship ought to act towards each other.[13, 14, 15] In the *Nicomachean Ethics*, Aristotle describes friendship as a state of affairs involving mutual goodwill among equals that leads to their pursuing shared, virtuous actions for the sake of the beloved other's benefit.[16] Recently renewed debate in bioethics also focuses on this comparison: the physician

devotes her clinical skills and judgment, informed by her intimate knowledge of the patient, for the sake of the latter's wellbeing, and the ill patient must trust and confide in the physician-as-friend, often revealing his most personal problems.[17]

In so doing, the two persons are not merely bound by impersonal moral and legal norms regarding medical care but engage in a unique partnership that fosters a *eudaimonistic*, virtuous way of living specifically drawn from their particular, shared set of experiences. This constitutes the normatively ideal, friendship-like physician-patient relationship through which both parties build a shared interpretive understanding and encounter moral goods in the world (relevant to the care of the patient's health). For friendship consists at least in part by how each friend recognizes—and improves—an embodiment of virtue in the other. Sherman's interpretation of Aristotle, in fact, aligns with this view: character friends find belonging in each other by sharing the same ways of deliberation and action that are informed by a shared conception of virtuous living towards which the friends collectively strive.[18] This shared project leads to a *concomitant* flourishing and virtue-improvement of each friend, even though such flourishing is not the intentional object of their pursuits, as this perspective would render their relationship instrumentally valuable for the sake of attaining it.

In medicine, the good which the patient and physician collectively deliberate about and pursue is the patient's health, broadly speaking. Relatedly, Ben-Moshe supplies a theory of a *constructivist* and *internal*, teleological morality of medicine: given that medicine aims to benefit patients *pro tempore* in need of medical treatment and care, and given that this end is partially constitutive of relevant normative judgments (i.e., set the standard for their correctness in promoting it) and what it means to practice of medicine, then this end can serve as an internal, independent basis for a morality of medicine not reducible to general or external obligations *qua* personhood.[19] An approximation of Aristotelian character friendship becomes possible as the physician and patient collectively recognize and agree upon the pursuit of the good of the patient's health as constitutive of their relationship. In such a context the two may come to respect and care for each other through sustained dialogues over time—and in so doing embody core virtues of friendship, moving towards flourishing through shared action. In contrast to what Brewer describes as imperfect, transactional friendships of utility, in which partners cannot cultivate shared virtues because their relationship is primarily a means towards a nongeneralizable, personal benefit (and in which goodwill is merely incidental), we often view the flourishing physician-patient relationship to be valuable for its own sake insofar as its constitutive interactions may be universally recognizable as for the good of both persons in any instantiation of the physician-patient relationship.[20]

Indeed, many practitioners and medical curricula emphasize the image of the physician as nothing less than character friendship. Ideally, the physician uses intimate knowledge of the patient to make clinical judgments for the sake of the trusting patient, whom the former values intrinsically and not as a mere consumer.[21] Conversely, the patient ideally recognizes the physician and the pair's relationship as uniquely and intrinsically valuable, as constitutive of and not incidental to his health and well-being.

III. Some limitations of the friendship analogy

Yet the model of the physician-patient relationship as consisting in (or at least analogous to) friendship *simpliciter* also faces serious criticisms. Critics contend that friendship, strictly speaking, is not an apt component of or analogue to the physician-patient relationship for at least four distinct reasons. (1) Patients and clinicians often do not desire to share mutual experiences beyond professional, impersonal expectations[17, 22] or seek the intimate, disclosive, and often emotionally taxing conversations required for friendship.[13] That is, either person may desire not to act within the relationship with the partiality and interested, other-regarding motivation that makes *this* relationship intrinsically valuable such that one would feel a profound sense of loss if, say, the physician permanently moved to another hospital. A physician seeking such an intimate relationship against the patient's wishes for nothing beyond one with a committed but professionally disinterested caregiver—such as when treating sensitive, private issues like

prostate cancer—would thus violate the latter's autonomy.[23, 24] (2) This model is in tension with the value of impartiality and distributive justice in patient care. Even if excellent medical care is that which is personalized for each patient's illnesses and needs, it is unfair for the physician to grant extraordinary and special medical attention to her established patient. Yet friendship, and special moral obligations more broadly, often precisely demands general obligation-overriding partiality. This is problematic in cases like triage and access to scarce medical goods. (3) The institutional nature of several medical specialties sometimes renders the physician-patient relationship-as-friendship impossible. An emergency medicine physician, anesthesiologist, or specialty consult often encounters a particular patient only once or a few times over a brief period, and while the physician and patient may treat and view each other cordially, they would not have the opportunities to engage in the disclosive, world-sharing activities that constitute friendship. (4) The physician-patient relationship is an inherently inegalitarian fiduciary relationship that usually begins with a vulnerable patient seeking (and eventually paying for) the skills of a physician who has "socially conferred authority" and oft-invasive power over the patient's body.[23, 25] This means that the physician has additional and exclusive moral obligations—to beneficence, patient privacy, and so on—not mutually required from the patient. Hence, the relationship is not one of reciprocity, which generally defines friendship.[26]

These critiques, especially the fourth one, cast doubt on distinguishing the ideal physician-patient relationship strictly and perfectly as friendship *simpliciter*. That is because the patient-physician relationship is one that, at its core, is founded on the fiduciary commitment of the physician to the individual, ill patient who is often in a state of vulnerability and dependence on the former.[1] Nevertheless, this does not preclude that we can consider it to share *some* components with friendship or at least classify it as a friendship-like relationship which its members often can and ought to obtain. It is a moral enterprise that Ben-Moshe argues is characterized by (1) common goals of medical care (to benefit the recipient) between the physician and patient, (2) deliberative equality that draws on the epistemic authority of the patient (including values and life-goals) and physician, and (3) other-regarding compassion and concern for the patient.[23] In particular, Ben-Moshe notes that:

"…the physician ought to care about the patient like a friend… *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.*"[23]

The physician and patient *jointly* determine the goals of medical care given all the factors present in the patient's presentation, broadly understood to include the "feeling-at-home" functionality of the body and biosocial wellbeing, consistent with the values and desires of the patient.[15] They jointly deliberate about and execute these goals as equals who "respect each other's epistemic authority over the respective knowledge that each party possesses in furthering the common goal of their interactions," and these activities are motivated by compassion and governed by norms contributable by both persons.[23]

Thus, unlike the one-way relation between parent and child, the friendship-like physician-patient relationship is marked by equal standing in the modeling of the goals of patient care, and unlike the impersonal exchange between merchant and customer, the physician embodies warmth and fidelity towards this *particular* patient, whose state of illness is a matter of intrinsic concern for the physician. Further, the merchant-consumer relationship is marked by the expectation that each party will maximally pursue self-interest, while the ideal physician-patient relationship is marked by altruism and other-regard. We, therefore, find friendship models of the physician-patient relationship to be worthy of further

[1] For all the differences several authors in the literature note between friendship and the physician-patient relationship—especially because of the inherent inequality and lack of mutuality and reciprocity within the relationship—we stress that friendship *simpliciter* does not constitute the ideal physician-patient relationship and instead critically focus on shared components between the two kinds of relationships.

exploration for at least four reasons: (1) the friendship/partnership model has been referenced since antiquity and has gained relatively recent attention in bioethics,[27] (2) there is a level of (relatively) equal epistemic standing in domains of interaction, such as in deliberating goals of care, (3) there is mutual concern for the other, as we elaborate further, and (4) other important kinds of interactions (like conversations about ideal living outside the hospital) are not characterized by the epistemic inequality or one-sidedly fiduciary nature of the physician-patient relationship. As we soon discuss, these seem to be sufficient reasons to adopt Talbot Brewer's Aristotelian model of virtue development in friendship, which we aim to critically examine and apply to medicine.

As they pursue their common goal of working toward the patient's health through joint activities—the physician learning from the patient how to best pursue health in accord with the patient's wishes, the patient learning from the physician how to best work toward and facilitate restoration of health given the constraints of his or her current state—they develop over time a relationship, akin to friendship, in which they may become more affectively invested in each other's flourishing and may discover virtues.[2] In fact, as we explain in the following section, the joint process of determining and pursuing medical goals is not only a feature characteristic of a friendship-like physician-patient relationship; it is the way by which both members dialectically build an evaluative outlook that makes possible their attunement towards and attainment of such goods in their shared world. And importantly, what we mean by "virtuous" or "moral goods" has implications for the transformative potential of ideal physician-patient relationships.

IV. Why are friendship-like physician-patient relationships normatively ideal? Dialectical and dynamic development of both patients and physicians

Much work describing the ideal, friendship-like physician-patient relationship focuses on the required character traits or intentions of each member *prior* and *in order* to attain it, such as commensurate values,[17] reciprocal loving,[28] and concern for well-being.[26] Yet what is often elided in this discussion is attention to how these persons become changed in the course of their pursuing shared medical goals. For instance, as noted in the previous section, the friendship-like physician-patient relationship requires that the physician embodies a measure of goodwill, compassion, and concern toward the patient. As several authors have argued, the development of such a character disposition is extrinsic to the relation, ideally cultivated beforehand through training in medical school, residency, and non-medical life experiences.[21, 28, 29] We agree with this assessment. Nevertheless, these stances fail to account for how patients radically and continuously transform their moral sensibilities in the course of their illness experience, such as finding hope while facing a life-threatening illness in the ICU.[30] Ethical flourishing in this vignette is distinctly active and dialectical: it is found in conversations, interactions, and mutual observations through which participants "become more articulate about the best and most laudable patterns of human activity" and correct each other's blind spots towards this end.[20]

In contrast to a generally static picture of social relationships, we argue that the friendship-like physician-patient relationship is ideal in virtue of its dynamic, self-and-other-improving character. Thus, we find it more helpful to conceptualize the ideal relationship itself as a dialectical *process*, rather than a state of affairs, to explain how goods become attainable to the physician and patient in the course of their relationship. This is consistent with the view of friendship as a temporally extended joint *project* whose participants come to develop and find in each other a shared sense of flourishing in everyday living.[31] Drawing upon Talbot Brewer's interpretation of Aristotelian character friendship in *The Retrieval of Ethics*, we claim that the ideal physician-patient relationship is a dynamic process that brings about a constant refinement of their sensibilities towards an embodiment of substantive moral goods through

[2] The patient *qua* patient is not necessarily expected to be invested in the physician's flourishing, even if, arguably, the physician in her fiduciary role ought to be invested in the patient's flourishing.[15] However, this one-sided investment does not preclude the patient from contributing to the physician's flourishing.

experiences particular to their deliberations of and interactions in light of a common medical goal in an egalitarian and goodwill-oriented way (i.e., in a similar "physician-*qua*-friend model" described by Ben-Moshe and Emanuel and Emanuel).[17, 23] Insofar as one's improved sensitivity towards (and eventual embodiment of) these goods is normatively preferential, we claim the physician-patient relationship-as-dialectic holds intrinsic moral value.

According to Brewer, character friendship "both fosters, and requires for its flourishing, an uncodifiable evaluative outlook whose verdicts meet a stringent standard of affirmability from all relevant social perspectives" and whose prerequisite is some mutual appreciation for each other's goodwill.[20] This evaluative outlook is a horizon of understanding that contains the mutual, intimate commitments and concerns drawn from their shared experience, and it enables them to interpret their shared world in a way in which this array of meanings is phenomenologically illuminated only to those persons. The dialectic is therefore inaccessible to perversely or instrumentally motivated relationships because the right sort of outlook must be unreservedly affirmed by friends who understand their mutual doings as unconditionally valuable: the physician affirms not only her own outlook as capable of recognizing the good, but also implicitly recognizes that the patient's outlook maintains the same kind of virtue-appreciating perspective.[20] It must be affirmed by partners who understand their mutual doings as unconditionally valuable.

If an evaluative outlook enables its co-authors not only to apprehend human goods in the world (and in each other's character and activity in particular) but to become better at such recognition, then the refinement of an outlook is central to such a relationship. One's attunement towards a companion's personality, interests, and cares is the result of interactivities in which individuals help draw each other's distinct personalities and self-conceptions;[31] in this way, friends come to help develop and constitute one another. Their practical dealings together, whose experiential whole can be understood as a co-authored narrative, bring about a constant reshaping and improvement of their evaluative outlook to attain ethical virtues and human goods.[20] Unique patterns of interactions within a genuine friendship supply the background-structure of meanings enabling their further grasping and embodying of each person's sensibilities while simultaneously deepening the relationship. In other words, they form an *unfolding narrative* whose joint authors have concurrently built an intimate epistemic vantage point for subtly recognizing the value of one another, including the concomitant goods they embody in everyday practices.[20] As Cocking and Kennet argue, what really constitutes friendship isn't one's self-disclosure of static character traits within or to the other, but rather a regular, reciprocal, dynamic "drawing and interpretation" of one another, through which friends develop their interests and attitudes with regard to one another.[31]

But a jointly improved evaluative outlook is not just relevant to cataloging documentation of the other's praiseworthy and blameworthy acts—it also adds depth, meaning, and import to how each person considers shared conversations. Recognizing and experiencing distinctly moral problems with and through a genuine friend, in particular social encounters together, enlivens the sense and meaning of activities that would otherwise have felt qualitatively different to that individual. Specifically: these experiences phenomenologically "deepen rather than cheapen our understanding of what we care for" in the relationship by rendering intelligible core bioethical concerns about care, neglect, autonomy, justice, and so on.[32] They comprise a self-conscious history of shared activity, cumulatively enrichening further encounters and refining each person's evaluative outlook in virtue of a habituated world of shared sensibilities, understandings, and possibilities.

V. Why is presence to suffering a necessary component of the physician-patient relationship?

The physician's presence to her patient's suffering is a crucial component of the ideal physician-patient relationship (*qua* a friendship-like relation) yet also distinguishes it from friendship *simpliciter*. We note

that suffering extends from the patient's somatic pain owing to physiological dysfunction to psychic anguish and a broader, existential sense of loss of how one may have lived in a community.

Drawing on Dreyfus, we contend that suffering is best understood as a meaning-structuring life situation, or phenomenological *mood*: the way activities and options that we are always already involved in show up as mattering in a particular way (facticity), or a "where-you're-at-ness" that is the background for intentionality.[33] As Svenaeus argues, "suffering is a potentially alienating mood overcoming a person and engaging her in a struggle to remain at home in the face of the loss of meaning and purpose in life" and involves painful experiences of not-being-at-home at the levels of one's (1) embodiment, (2) engagements in the world and community, and (3) core life values.[34] For example, to the patient with COPD, breathing *feels* like a frustrating and emotionally taxing chore with which few other individuals can relate. The lived experience of labored breathing and violent productive coughs shows up as a limitation to the activities or plans towards one's possibilities in life. Such experiences are painful because they consist in one's inability to live up to one's identity and dignity, especially in the eyes of others (e.g., feeling like a burden on one's family).[34, 35] Indeed, we often take for granted how embodied health—wholeness, broadly speaking—is central to our ability to perform projects and potentialities of life we find ourselves engaged in.[35] This concept of suffering thus connects how "physical suffering is connected to the other types of suffering" of broken life plans and values embodied in a world shared with others.[35]

How are we to understand "presence" in this context? Here, the physician's *presence* to suffering does not imply an act of (1) privacy-invading voyeurism (a moral wrong) or (2) passive surveillance or (3) observing the patient *as* his diseases through the lens of the "clinical gaze."[36] Instead, we refer to the kinds of in-person, intimate, and generally conversational activities that healing doctors do—checking vital signs, taking a history and physical exam, and listening to and talking with the patient, which "allow patients to bring their experience of illness into words, to reach an understanding of what is going on, and to make decisions about their own care."[37] This kind of presence, therefore, is challenging for the beleaguered doctor separated from face-to-face time with her patients due to extremely brief clinical visit time-allotments, excessive charting and paperwork, insurance authorizations, and other phenomena endemic to contemporary, financialized "RVU medicine."[9]

It is important to note that this presence to suffering is not unidirectional. Indeed, the patient's visceral suffering calls for a response and moves the doctor, who also "suffers in the perceiving" in her awakening to her own mortality and the needs and values of her patient.[29] This realization of one's end of life, or what Heidegger calls being-towards-death, manifests in the physician's understanding that she, too, might have felt the same loss of meaning sickness brings.[38] An attending physician literally attends to her patients in no small part by becoming attuned to and "getting" the primordial background understanding that already has structured the intelligibility of her patient's everyday experience of illness. Even in cases where purely disinterested detachment is preferred by the patient, presence to suffering still provides the affective familiarity about the patient's life-situation, which may even make coherent to the physician the reasons why her patient prefers a more impersonal relation.

What, then, is the import of such presence? The importance of the physician's presence to suffering is not reducible to its ability to enhance high-quality biomedical care using the best information from the patient or moral responsibilities for understanding the hardships or perspective of the infirm. While these reasons are incredibly important, we stress that presence to suffering has unique value for the physician, too. We argue that this is because the physician who is drawn towards the patient's being-in-the-world may also access the stock and structure of meanings of this patient's suffering, which makes intelligible the means for the common, deliberative health goals that ground the kind of fulfilling physician-patient relationship we illustrate. The physician's attention to and subsequent discomfort with the suffering of her patients serves as a reminder of the physician's own finitude and mortality, as a starting point for the possibility of a shared patient-physician narrative.[12, 39] Moods like suffering matter for physicians (and caretakers in

general) too because they are *social* sensibilities about a world-situation; as Heidegger mentions, moods are "the sort of thing that determines being-with-one-another in advance… like an atmosphere, in which we are steeped and by which we are thoroughly determined."[40] They shape *prima facie* how the physician and patient may begin to deliberate about the good of the patient: the well-functioning of the body, values and needs, preferences, and so on.[15, 17, 23]

If suffering is a mood marked by an overwhelming sense of alienation for the patient, and if moods are *public* transcendentals that disclose the thrownness of one's (bio-psycho-social) condition, then the (caring, empathetic) physician's access to the sensibilities and meaning-disclosive concerns of her suffering patient privileges the physician to the phenomenological content, or "commonsensicality," that governs how she and her patient may possibly explore their world and form a fulfilling, friendship-like relationship by "getting" each other. In other words, in addition to health goal-informing cognitive contents (by which moods are not exhausted), presence to suffering grants shared access to the phenomenological ways by which these values are made important and ultimately attainable—for instance, the normative boundaries of the patient and physician's conversations about end-of-life care.[35] The physician, often exhausted by juggling multiple duties on a tight schedule, on top of empathetically understanding the patient's sense of suffering, must make active ontological distinctions about what the best care might be for this particular patient. The physician makes intelligible the sense of commitment (i.e., care for what ends?) and maps of meaning one needs to "get" the other's concerns. This is especially important because it shapes the course of their future shared dialogues and activity, and thus how the patient and physician come to view each other. Thus, while presence to suffering can be morally taxing and uncomfortable, we contend that it is this presence that serves as the background social context that provides the inroads to the friendship-like relationship between patient and physician which mitigates the loneliness patients and physicians alike may feel when their relationship is interrupted by the structural and bureaucratic obstacles we mentioned earlier. Suffering, as a phenomenological public mood, structures the intelligibility of the patient's values, preferences, and needs within illness—precisely illuminating the specific contents in such values and preferences which Ben-Moshe finds internal to and crucial for the deliberative, constructivist procedure of "determining the norms and standards of excellence that govern the craft" of medicine, for its end of *prima facie* medical care.[19] The physician's presence to suffering is a starting point for mutual trust because the physician becomes attuned to the meaningful content of *this* patient's *particular* needs, values, and preferences, which then govern the norms of their relationship.

Thus, presence to the patient's suffering allows for a deepening of the physician-patient relationship not available when such presence is systematically precluded. The intrinsic vulnerability wrought by illness renders the patient dependent on the physician to act in accord with her own good—the individualizing experience of illness is not reducible to the sufferer's experience alone. The empathetic physician likewise experiences vulnerability in the significantly limited ability they possess to heal and relieve suffering in its entirety, due to the intractable nature of much illness and suffering patients experience.[41] Such bidirectional vulnerability warrants a mutual trust that complicates the ability of physician or patient to view the illness experience as isolated and contained.

Admittedly, the idea that presence to suffering might enhance, rather than detract from, feelings of embeddedness and friendship may seem surprising. However, we stress that while emotionally taxing, witnessing patient illness is not the main cause of physicians' loneliness in medicine. Rather, the presence to suffering wrought by illness is constitutive of the role of the physician, and we argue that, insofar as the physician understands the fundamental nature of her role correctly as one who offers presence in the midst of suffering,[39] such presence (which sometimes includes offering ameliorative therapies and other times involves acknowledgment of one's own limits), actually allows one to fulfill their vocational commitment more fully and can, in fact, prove a source of satisfaction and renewal. Even in instances when curative measures are not possible, physician presence to suffering works toward achieving health

through crucial mental and emotional support, thus fulfilling the patient-physician joint vocational pursuit of the good of health which constitutes their relationship as friendship-like.[3]

Indeed, this bidirectional vulnerability (overt on the part of the patient; implicit but still present for the physician) engenders a bi-directional trust and dialogue between patient and physician, which when done well, allows for something of a "moral friendship" to take root, whereby the physician makes the good of the patient her own good.[12, 42] Beyond this, the physician bears witness to suffering and serves as the "bridge" between illness and the broader community for patients.[12] Thus, the patient-physician relationship is grounded in a unique, shared understanding of vulnerability, finitude, and mortality that guides both persons' mutual cultivation and exhibition of shared moral virtues. While suffering is painful even for the physician bearing witness, it is nevertheless formative for them to spend adequate time in the (difficult to manage) presence of patient illness.

VI. Care is the unity of presence to suffering and moral refinement

Drawing from Svenaeus, we can therefore consider (presence to) the patient's suffering as a past-informed *mood* that colors the sensibility of a socio-cultural situation, like clinical encounters, and "throws" the patient (and physician) into a world in which certain concepts are *affectively* salient as mattering: the unhomeliness of one's body, the sudden isolation from one's life-projects and community, mortality, and frailty.[34] Suffering reveals the world as alienating for the patient, and the physician present to it "gets" (is concerned with) the meaning-structure of her patient's medical goals beyond its propositional bare facts. On the other hand, we can also understand the evaluative outlook described by Brewer as a future-projecting, commonsensical "*room for maneuver*" for the patient and physician to interpretively *understand* and render intelligible current and future ways of acting (the for-sake-of-which in local ways of coping).[33, 38] Furthermore, as Dreyfus notes, mood delimits the ways things already show up in the world as mattering, understood at another level as "*pressing into possibilities"* for the two persons' possible being.[33] So, if suffering structures how the patient makes sense of his (originally alienating) world, once the physician is attendant to this mood, the evaluative outlook the patient and physician interpretively hammer out over time makes certain embodied character virtues commonsensical as they relate to what's salient in their world.

Affectedness and understanding are thus "two correlative aspects of Dasein's disclosing of its current world—two aspects of Dasein's openness," the unity of which is care, or how things make themselves as existential issues for persons, who are constantly wrapped up in self-interpreting ways of being.[33] It is fortunate here that care in its phenomenological use is not simply pragmatic concern or worry but, as most probably assume, has more to do with *philia* and "getting" someone.[33, 38] The physician and patient thus ontologically care (better yet, are verbally caring) for their world. In either the theoretical, present-at-hand stance or the practical, ready-at-hand attitude, how physicians relate to themselves, the other, and the things around them are issues revealed *for* them, which are structures in time: the illness one is *already in*, the bedside procedure one is *amidst*, and the prescribed "lifestyle modifications" *ahead of* oneself.

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[3] Although suffering may be an important characteristic of friendships—intuitively, for instance, friendships can be improved through shared hardship—we do not make any claims about its necessity or its characterizing friendships. The point we make, rather, is that *attendance* or *presence* to suffering (or the other's hardships) is crucial for the flourishing physician-patient relationship, given that the patient's disposition is usually one of suffering and that the physician ought to be attuned to it. Attendance to suffering may well be important for character friendships as well, since, for instance, one counts on friends to listen to one's potential distress and give counsel. In fact, one's attendance to suffering might plausibly be understood as a modal quality: even if in the present world B (e.g., a friend or a relatively healthy primary-care patient) is not suffering, if B were to (possibly) suffer in illness, then A (another friend or the physician) would be predisposed to attend to and concern herself with B's suffering.

Illness and injury themselves disrupt the patient's moral-existential situation, effecting one's concept of self and the activities that would have constituted the good life.[43] The patient finds himself thrown into a world in which he becomes distanced from his prior everyday embodiment, engagements with others, and life-values.[35, 44] This *sense of distancing* or alienation is a public mood that structures the background for how actions and options appear relevant to the patient and empathetic, goodwill-oriented physician. Certain activities are meaningful, or seem commonsensically important in their clinical encounters, in light of the patient's suffering. The negotiation of medical goals of care, for example, is paradigmatic here: a goal of care in itself can be studied as a simple, typed proposition, but for the physician and patient bound up in their world, a goal of care is intelligible as relevant to the patient, for instance, wishing to go home to see his young children as soon as possible. Such deliberation also phenomenologically illustrates how, as Ben-Moshe argues, patients and their values engage in the "constructivist procedure that determines the internal morality of medicine" given that there is "no *a priori* reason to limit what constitutes patient benefit" (which ought to include the patient's medical needs and perception of the good) and given that the relationship between physician and patient is constitutive of the practice of medicine itself.[19] Mood then sets the stage and illuminates how the physician finds certain treatment options "best" for the patient's situation (about whom she is concerned) and why she prescribes and explains it as optimal over other options. Peritoneal at-home dialysis is not as hands-free as clinic-based hemodialysis appointments; however, it allows the patient to stay closer to his young children made distant by his illness, and that is why this prescription may be judged as preferable by the physician who has understood the meaning-structure of her patient's goals.

We contend it is this commitment to presence in the face of suffering that sets the stage for and interacts with the subsequent "moral refinement" process to take place and constitute morally sound care for the patient. The possible "for-sake-of-which" actions mentioned above often articulate moral matters from this situation. The evaluative outlook from the ideal physician-patient relationship is distinctly moral because the two, in their mutual interactions, are concerned about unique obligations to one another and evaluate critical interests about what is required for recognizing and embodying certain virtues of the good life within the context of medicine.[4] Longitudinal encounters in clinical care—explaining consent for a procedure, discussing one's immobility, listening to the sounds of the ailing body, sharing one's medical values—gradually bring the two into greater attunement toward each other's particular concerns. As they cultivate a sense of admiration and ownership for each other, they may come to grasp and articulate those goods meaningful to their shared goals and ways-of-being, such so-called "moral refinement." In doing so, they notice a wide range of praiseworthy human goods embodied in each other's

[4] The ideal physician-patient relationship is distinctly moral (or at least ethical)—and not only value-laden or prudential—for at least two reasons. First, this is because the relationship contains (and is partially constituted by) unique special obligations between the two agents; for example, Pellegrino argues that physicians, in virtue of their professional oath of patient fidelity, take on special obligations to use their expertise for the good of the sick, who are in a dependent and exploitable state, even if the physician would not prefer to enter a relationship with her patient.[47] As Ben-Moshe argues, these special obligations and norms bind physicians *qua* physicians (and not persons generally) because they are developed in promoting an end of medicine ("benefitting patients in need of *prima facie* medical treatment and care") that constitutes an internal morality with normative authority over the relevant agents.[19] Second, we note that, when experienced rightly, an evaluative outlook between the physician and patient renders intelligible unique virtues that are moral in nature (and that the two eventually embody). Such virtues include compassion, empathy/regard for the other, and (at least a predisposition for) supererogatory acts like advocating for patients. The content of these virtues is often moral precisely because the kinds of interactions and conversations between the physician and patient are often informed (or explicitly structured) by such special obligations—for instance, special patient rights to privacy and confidentiality.

activity. When the physician notices the patient's pain, speaks with him, and acknowledges the undignifying and alienating nature of pain, the patient does not merely notice a distinct observation within this sequence of actions. Their mutual cultivation of virtue draws them closer to one another, bringing about a special sense of ownership and responsibility they have towards each other—friends trust and take confidence in each other's outlooks precisely because they are collaboratively built from the stock of shared contingent experiences.[20] The patient is also drawn to this physician's care, which she actively embodies towards his goals, and he is awakened to the virtues she embodies such that he may aim to emulate them in future practical dealings. Although neither is necessarily aware *a priori* of the sense of what it is like to grasp these goods, much less a set of principles for human excellence, the two become better attuned towards certain virtues, recognizable and meaningful in light of the care of the sick patient, over multiple interactions together. Their evaluative outlook thus makes relevant in their shared experiences fine, unique moral goods—solidarity, fidelity, respect—that further bridge the two persons amid the isolating experience of suffering. In fact, realizing such virtues *requires* their shared development of an evaluative outlook precisely because its intersubjectively self-affirming nature enables its members, by constant character reformation, to recognize certain content in the world as morally good.[20]

In addition to personal character virtue, the physician's and patient's interpretive understanding of their world—including the norms of their relationship and *ec-static* anticipation of their future—may become transformed.[38] This recursively interpretive model of the relationship is consistent with Ben-Moshe's constructivist theory of medicine as an *evolving* practice whose normative content (in light of the end of medicine) is supplied by patients' authoritative knowledge of their view of the good, which calls for joint deliberations of the patient's needs between physician and patient.[19] Medicine thus is a craft in which the physician-patient "relationship is a constitutive component" for attaining its end by bridging the physician's expertise and judgment with the patient's values (which govern the norms of practice).[5 19] What it means to be a kind of (caring, trustworthy) physician and be in a particular relationship with unique ways of being is paradigmatically disclosed in light of how one can become, including grasping radically authentic possibilities.[38] The physician refines her understanding of her patient's life-world and begins to advocate for her patients' interests while the patient, despite the individualizing moods of his own illnesses, feels more comfortable opening up about his lived socio-political experiences. Hence the background meaning-structure composing how the patient and physician perceive their relationship and world becomes enriched in a two-way unfolding. Their encounters comprise a coherent story of how they attain a (moral) sense of solidarity through self-disclosure and care, motivating them to interpret clinical conversations as merely about healing ailments of the patient's body to addressing the socio-political body public. The physician thus plays a vital role in overcoming the alienating nature of her patient's suffering—not being at home in one's body and in one's community—in their exploration of the ethical.[12, 34, 39]

VII. Counterarguments and limits

Our portrait of the ideal physician-patient relationship as sharing key features of friendship is best understood as a normative ideal towards which many—but not all—physicians should aspire. For instance, this model is not congruent with how healthcare professionals in certain specialties make sense of their relationships with their patients. Still, this does not invalidate our claims but instead encourages investigating non-ideal theories of how such friendship-like relationships are brought about. For example, considering the institutional nature of surgical specialties, in which much care is performed when the

[5] The constitutive and constructivist components of Ben-Moshe's view are thus the source of the normative force for the unique, internal morality of medicine. As Ben-Moshe stresses, deliberations about these norms (under the right conditions) take place in actual, inclusive processes (and not just hypothetical deliberations, as in Rawlsian veil-of-ignorance arguments, for instance) and deliberation with the relevant stakeholders and knowledge, especially patients themselves.[19]

patient is anesthetized, we can still say that presence to suffering has great importance for the surgeon who must perform an invasive, risky, and permanently disfiguring amputation for her patient. And the surgeon still spends significant time listening to and conversing with her patient as they discuss the patient's painful loss of mobility in surgery clinic, gain consent for procedures, and explore possible ways of moving and flourishing post-operatively—helping the patient authentically grasp his being-in-the-world *as* a person with a mobility limitation. In psychiatry and pediatrics, in which the patient may not have capacity to enter a relation of friendship, the physician may engage in a similar parallel relationship in which she recognizes and becomes concerned with the goals of the patient's parents or guardians. Our model is most consistent with longitudinal outpatient or inpatient hospital care, and emergency medicine and specialty consultation present challenges that show the limits of our argument.

Another counterargument is that presence to suffering is not required for a normatively ideal relationship—for example, in cases of minor illness or in an outpatient family practice where a patient is consistently well.[45] Intuitively, the lack of suffering does not seem to be relevant for the physician and patient developing a fulfilling relationship. We have three responses: (1) first, for most of their lives, many patients are never truly unwell, and a patient likely visits his family practitioner precisely in order to discuss illness or the potentiality of illness—vaccinations, colorectal cancer screening, or tobacco cessation. The physician plays a crucial role in engendering trust in the patient, aligning the medical care with his life-projects and values, and, not unlike what we argue, gains an appreciation for the trust and radical openness of her patient (and vice versa). Although the illness-defining alienating mood of suffering is not present, it still lurks in the background as a potentiality. (2) Especially for older patients, the pair are always already oriented towards the *possibility* of suffering (and how the physician can attend to it) regarding diseases of old age and eventual mortality—and, over time, these concerns will eventually radically reshape the narrative content of the relationship. (3) If (1) and (2) are discounted, this "perfect patient" scenario may lead one to consider the relationship a conceptual mismatch, so it would be more apt to consider the physician *qua* health advisor, which while no less important to human health, makes radically different the nature of their relationship.

Furthermore, presence to a patient's suffering itself is arguably an act of virtue even if such presence would not impact the status of a physician's particular relationship with one of her patients. One's presence to suffering as a caregiver provokes an affective orientation that, as Rasmus Dyring elaborates, is no less than realizing, in the moment of provocation, one's freedom to possibly act morally.[46] This affective orientation at least cultivates a more global attitude in the physician that impacts her other patients—yes, she may never interact with patient B. But her attendance to the suffering of patient A made her a better doctor for patient B by developing the virtues attendant to presence to A's suffering. And this is in addition to (and not mutually exclusive with) the physician's professional oath to accept special obligations to act for the good of the ill, who often are dependent on them.[47] Even for emergency physicians and surgeons who take care of patients briefly, without forming longitudinal relationships, or who care for unconscious patients, with whom no bidirectional relationship is possible, their presence to suffering at least contributes to a change in how they approach and care for their other patients.

One also may counter that the narrative and horizon of understanding brought about by this relationship need not include moral goods, such that both can have a "value-free" orientation towards the medical world. We argue that an evaluative outlook has an intrinsically moral character to it because, first, the friendship-like physician-patient relationship is characterized as such because it arises from morally salient dialectical activities, like conversing about advanced care directives. Second, everyday discussions about goals of care are not value-free because they include concepts with intrinsic value judgments. When a caregiver explains a pre-procedure questionnaire or asks prior to discharge if their patient has somewhere safe to go home, which are routine and required discussions, the ensuing conversations have everything to do with balancing core matters in biomedical ethics.

VIII. Conclusion

Our aim has been to illustrate the normative appeal of and some requirements for the physician's and patient's engagement in an idealized, non-instrumental, friendship-like relationship. Specifically, our paper is diagnostic and aims to provide a normative model or picture of an ideal physician-patient relationship that is becoming more difficult to attain, which may explain increasing physician loneliness and alienation. We argue that the friendship-like features of the ideal physician-patient relationship provide normative value to the role of attention to patient suffering, and loneliness is a negative symptom of systemic deviations from or the increasing inability to achieve this kind of relationship (and its concomitant goods) as it relates to the *telos* of medicine. The ideal physician-patient relationship we have described is antithetical to the lonely, alienating, and individualizing nature of illness and is best understood as a dialectical process. Its friendship-like features bring the patient and physician together to jointly encounter virtues in a world oriented by mutual concern (as mooded by the patient's suffering) regarding possible actions relating to goals of care. The commitment to presence on the part of the physician (and the patient, whose willingness to avail themselves instead of turning inward), leads to a narrative whose joint authors find particular value in each other and build a joint horizon of meaning for recognizing and embodying a manifold of virtues. Care, in the phenomenological sense, bridges the significant emotional toll of witnessing and treating patients who suffer with the moral fulfillment afforded by right relationship with the patient.

As evident in numerous physicians' testimonies, depriving the time and space for physicians' attention to suffering, the starting point for this dialectic, leads to mutual alienation, mistrust, and, ultimately, loneliness. Something lost in modern medicine is to be retrieved. This seeming paradox of enhanced loneliness, despite ample and in many cases increasing social interactions, makes sense once we understand the attunement and care required in a flourishing patient-physician relationship and the encounters that take place in its context. When this non-alienating relationship is experienced rightly, it allows the physician to flourish in her role and to experience the goods of solidarity, friendship, and fulfillment.

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