# What Does 'Respect' Mean? Exploring the Moral Obligation of Health Professionals to Respect Patients

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Respect is frequently invoked as an integral aspect of ethics and professionalism in medicine, yet it is often unclear what respect means in this setting. While we recognize that there are many reasonable ways to think about and use the term 'respect', in this paper, we develop a conception of respect that imposes a distinct moral duty on physicians. We are concerned mainly with the idea of respect for persons, or more specifically, respect for patients as persons. We develop an account of respect as *recognition of the unconditional value of patients as persons*. Such respect involves respecting the autonomy of patients, but we challenge the idea that respect for autonomy is a complete or self-sufficient expression of respect for persons. Furthermore, we suggest that the type of respect that physicians owe to patients is independent of a patient's personal characteristics, and therefore, ought to be accorded equally to all. Finally, the respect that we promote has both a cognitive dimension (believing that patients have value) and a behavioral dimension (acting in accordance with this belief).

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## INTRODUCTION

Respect is frequently invoked as an integral aspect of ethics and professionalism in medicine—an essential feature of how good physicians ought to conduct themselves. Many things are said to warrant our respect, including, but not limited to, people, ideas, and institutions. Some advocate *respect for human life and dignity*.[1] Many regard *respect for autonomy* as the preeminent principle of contemporary bioethics.[2–4] Health care professionals are frequently reminded to have *respect for cultural differences*.[5,6] Disclosure of sensitive medical information to third parties is proscribed on account of *respect for patient privacy and confidentiality*.[7] References to respect, it seems, are ubiquitous in the medical literature.

It is not always clear what (if anything) it means to respect those things we are supposed to respect. Is the respect one has (or at least ought to have) for one's patients the same as the respect one has for one's colleagues? For individual privacy? For autonomy? For the profession of medicine? Most professional organizations use the term 'respect' in their descriptions of professionalism,[1,8–10] but nowhere is it defined. There are benefits and drawbacks to such an approach. Nearly everyone can agree about the importance of respect when it is not defined, perhaps because everyone naturally reads into it his or her favored connotation. Unfortunately, this version of respect is devoid of content: it tells us nothing about what we should believe or how we ought to act. It forces us to ask whether respect has any particular meaning, or whether it is merely used rhetorically in defense of what one happens to believe or support.

In this paper, we develop a conception of respect that we believe imposes a genuine moral duty on physicians. This duty cannot be reduced to other concepts, like politeness, honesty, deference to patients' wishes, and so forth. While many things may merit our respect, in this paper, we focus on the idea of respect for *persons*, or more specifically, respect for patients *as persons*. We develop an account of respect as *recognition of the unconditional value of patients as persons*. Such respect includes respect for the autonomy of patients, but we challenge the prevailing idea that respect for autonomy is a complete or self-sufficient expression of respect for persons. We suggest that the duty to give this sort of respect is independent of its consequences, and therefore, different from duties of beneficence and nonmaleficence. Furthermore, we suggest that the type of respect that physicians owe to patients is independent of patients' personal characteristics, and therefore, ought to be accorded equally to all. Finally, the respect that we promote has both a cognitive dimension (believing that patients have value) and a behavioral dimension (acting in accordance with this belief). While we recognize that there are many other reasonable ways to think about and use the term 'respect,' our account is meant to clarify the type of respect that we believe physicians ought to have for all patients.

At the outset, it is important to distinguish between respect for persons in the broad sense and respect for persons in the context of clinical medicine. The former, we regard as a universal obligation that people have toward other people in general. The latter sense of respect is a further specification of

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this duty. It is *because* physicians have a special kind of relationship with their patients that the nature of this obligation to respect them has special features. The same might be said of respect, for example, between children and parents or between teachers and students.

## WHAT IS THE APPROPRIATE OBJECT OF RESPECT?

Because the nature of respect we ought to have is obviously related to the object of respect, we must first specify what or who it is that we ought to have respect for. Contemporary bioethics often speaks of the importance of *respect for autonomy*, which is defined concisely by Beauchamp and Childress as "acknowledgment of a person's right to hold views, make choices, and take action based on personal values and beliefs."[2] Acknowledging the values and choices of individuals is a way of treating them with respect, and hence, respect for autonomy is an important expression of respecting the persons who possess it. But the shift in language, away from respect for *persons* and toward respect for *autonomy*, suggests another possibility that concerns us, namely, that "autonomy" has effectively supplanted "persons" as the object of respect.[11]

We suspect this change is more than just semantic: it perhaps marks a substantive shift in bioethical thought, suggesting that we ought to regard autonomy as more important than the persons who supposedly possess it. Health professionals may come to view patients on the basis of their goals and preferences, rather than on any deeper, more meaningful characteristics they have. In essence, an exclusive or nearly exclusive focus on personal autonomy *distorts* our view of what persons are and may actually undermine the larger goal of respecting persons.[12,13] It may lead us to disrespect persons. For example, when we view individuals through the lens of autonomy in this way, those with unacceptable goals (e.g., relapsing drug addicts) and those who seem to have few or no goals at all (e.g., infants and those with severe cognitive impairment) may not merit respect. We may be perfectly willing to respect those who are (or are at least working to become) what we believe they ought to be; we may be far less willing to respect those who are not what we would like them to be, or for various reasons, lack the capacity to act autonomously. A broader focus on respect for persons, in our view, requires that we respect people who lack autonomy or who have abused their autonomy by making decisions that are objectively bad. Furthermore, even when a person is given respect based on their autonomy, the nature of that respect is too limited.[12–14] For example, some may assume that honoring patients' preferences and obtaining informed consent for any nonroutine treatments or procedures is the essence of respect. We certainly agree that such behaviors are compatible with respect, but there are many other important behaviors that may result from a broader view of respect.[14,15]

For these reasons, we suggest that the language of *respect for persons* is better suited to describing how physicians should think about and act toward their patients. "Respect for persons" is already a well-established term in the bioethics discourse. It was identified as one of three ethical principles guiding human subjects research in the Belmont Report[16] and has been invoked frequently ever since.[12] However, it is often described in a way that is essentially indistinguishable from the principle of "respect for autonomy," and we believe this has contributed to substantial misunderstanding. While respect for autonomy requires an assessment of a patient's capacity to think and act autonomously, respect for persons requires only an acknowledgment of the patient as a person. We grant that some philosophical accounts of "personhood" view autonomy as a necessary (and perhaps sufficient) criterion for counting as a person. However, we disagree with the notion that individuals must be autonomous to qualify as persons. In our account of respect for persons, we remain attached to a pre-philosophical (but no less valid) notion of personhood. To a first approximation, and certainly for the purposes of clinical practice, we hold that all living human beings are persons, and consequently, deserving of respect. Thus, all patients are persons, in our view. There may be some loss of philosophical sophistication and precision in adopting this view, but we believe that an enriched understanding of respect in clinical practice is worth this risk.

## DOES RESPECT REQUIRE ADMIRATION?

Having established that persons are the appropriate object of respect, we turn our attention to describing what the nature of that respect entails. In doing so, we suggest drawing a distinction between *respect* and related concepts such as *admiration* or "*liking*." It is to be expected that physicians will have a natural or instinctive preference for some patients over others. Such feelings are often couched in the language of respect. Physicians may remark that they have particular respect for patients who are able to persist in spite of serious illness. So-called "VIPs" may receive special treatment because they are thought to command a high degree of respect. On the other hand, intravenous drug addicts and alcoholics may be viewed quite differently because they are regarded by some as undeserving of respect. In moments of frustration, the rhetorical question is often posed: "How can you respect someone who doesn't respect himself?"

What all of these examples have in common is that they employ the notion of "respect" to justify differential value judgments and treatment for certain people or types of people. Whatever else we might say about respecting people in this sense, it is clear that admiration is not something we could owe to everyone *equally*. We might aspire to find something admirable in everyone, something to relate to, but our ability to respect them cannot be dependent on the success of that enterprise. We will invariably find some people to be admirable or pleasant to be around, and others not. If indeed there is a moral or professional duty of physicians to respect every patient (which we believe there is), it cannot be founded on this conception of differential respect.[17]

On the face of it, there is nothing wrong with admiring or liking particular patients or even with seeing others as "difficult." Medicine would be a boring venture if we insisted on seeing all patients as identical, as if there were nothing unique about individuals that could give rise to the special feelings that are the essence of caring for and about other people: admiration, empathy, and joy, and anger, discouragement, and frustration. The problem arises when our appraisals of patients serve as the basis for believing that some are "worth more" than others or for providing some patients with decidedly less adequate care that we otherwise would provide

them. To do so is to set a troubling precedent, namely, to imply that patients "deserve" a certain level of attention, according to who they are or what they have or have not accomplished in their lives.

uals that make them unique. Although we are not opposed to the idea that physicians ought *also* to value the individuality of particular patients (in fact, we endorse it), in promoting the duty to respect, we seek to acknowledge something else about persons, something that everyone has in equal measure. Thus, we base our conception of respect on the belief that all persons have unconditional intrinsic value as human beings.

## ARE RESPECTFUL BEHAVIORS SUFFICIENT?

Finally, we wish to emphasize that our conception of respect involves valuing patients, or at the very least, acknowledging their value. This attitude of valuing will typically express itself in certain behaviors—extending common courtesies, expressing concern for others and their well-being, taking their feelings and experiences seriously. Indeed, many accounts of respect in medicine and in the professional education of physicians rightly emphasize behaviors.[18] For example, the Accreditation Council for Graduate Medical Education requires that residents "demonstrate respect"[10] and the Association of American Medical Colleges stresses that students must "act with respect."[9] A complete account of the sorts of behaviors that constitute respect is beyond the scope of this paper, especially as many "respectful" behaviors are culturally bound and contextually dependent. These behaviors therefore must be responsive to each individual patient. Thus, in our account of respect, we wish to emphasize the attitude, which may be more universal than any given set of behaviors.

Actions and behaviors are certainly important, but are not a sufficient substitute for having a genuine attitude of respect. If respect for a person entails *recognizing the value* of a person, as we have suggested, it will come in two forms: *believing* the person has value and *acting* in light of that belief. The two should not be confused. It may be possible to act in a way that is interpreted as respectful without having the corresponding attitude of respect. One may simply behave that way because someone else is watching or because one wants to avoid the consequences of not being courteous. Conversely, it may be possible to have an attitude of respect and still behave in a way that is inappropriate (e.g., expressing excessive anger with a noncompliant patient, while still valuing him or her as a person). However, it is only when respectful behaviors are a genuine expression of one's belief about the value of persons that the duty to respect one's patients is fulfilled. Behaving respectfully and courteously to patients is clearly important, and we do not mean to suggest that such behaviors ought to be ignored or discounted. Our point is that physicians do not fulfill their moral responsibility unless they also engage in the internal work of appreciating the value of the people they treat.

An unreflective emphasis on behaviors (with a corresponding de-emphasis on the essential attitudes) may have undesirable effects. We do not doubt that, at first, it feels unnatural to respect *everyone*. There are some patients of whom it will be difficult to appreciate the value. Most would argue that, even when such respect does not come instinctively, we still ought to act respectfully, and we agree. But simply because a feeling does not come instinctively or naturally does not mean that it can never come. It may take time and effort on the physician's part, and hence, we emphasize the internal work of feeling respect, in addition to the external work of demonstrating it. By focusing solely on a set of behaviors, there is the theoretical concern that clinicians and especially students may take away the idea that it is acceptable to *think* whatever one wants about a patient, as long as one *acts* in an appropriate manner in the patient's presence. This logical disconnect cannot survive for long. Practitioners may stop acting respectfully altogether (perceiving those actions were "fake" to begin with), or they may cease to appreciate the inherent value of their patients (believing actions alone to be sufficient). Either alternative is undesirable. Actions and attitudes are so closely intertwined that having one without the other simply cannot suffice. We need both, or we end up leading a sort of moral double life—never quite succeeding at connecting who we are on the inside with what we do on the outside.[14]

## CONCLUSION

Typical ways of speaking about respect, doubtless, take us in many conflicting directions. For example, it is often said that respecting people essentially requires that we not interfere with them, leaving them free to do as they please. It is commonly thought that people *deserve* respect based on their status or their accomplishments, and by the same token, that they can sometimes *lose* our respect, or, it is suggested that respect is solely a matter of following norms and rules of social engagement—something we can do by rote.

Because these common ways of thinking about respect do not capture what, in our view, ought to be the moral obligation of physicians to respect patients, we have developed a conception of respect that calls for *recognition of the unconditional value of patients as persons*. We expect that our view of respect is controversial, and we hope that debate on the topic will occur. It is only through reflection and discussion about the meaning of respect, and about what sort of moral obligation it imposes on physicians, that we can make any sort of sincere commitment to respect patients.

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