The Power of PROXIMITY

Toward an Ethic of Accompaniment in Surgical Care

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Surgical training often encourages emotional distance. An ethic of accompaniment, by contrast, asks surgeons to become proximate to their patients—both in the operating room and outside the hospital's walls—to address health disparities and structural drivers of injustice. The ethic can also help interrogate how these problems are reinforced by the relational and epistemic distance between surgeons and patients.

A twenty-six-year-old man named Samuel[1] with a history of gunshot wounds presented to the trauma bay after sustaining multiple new gunshot wounds. Samuel underwent emergent lifesaving surgery requiring placement of a chest tube for hemodynamic instability and repair of injuries to the small bowel, rectum, femur, and bladder. More than one hundred days later, one of us (Phifer Nicholson), a White man of upper-class background, met Samuel, who is Black and lives in an impoverished part of the city served by the hospital, while on an inpatient surgery rotation as a medical student.

The sequalae of Samuel's injuries were staggering. He had multiple enterocutaneous fistulae and was completely bedridden, with an external fixation for the repair of his fractured femur. Week by week, the team had altered the care plan, desperately trying to overcome his severe malnutrition, deconditioning, and significant medical and surgical illness. Years later, Samuel continues to grapple with very serious disability that significantly limits his ability to function in work and social settings.

Being a surgeon involves laying hands on those who, like Samuel, have been wrested from the world of the healthy into the company of the ill.[2] Clinicians frequently confront people and stories that are rarely encountered by other people who have as privileged a social standing as clinicians—especially doctors and medical students—enjoy.[3] Self-reflective practitioners may recognize a vast gulf of socioeconomic, experiential, educational, and geographic difference between themselves and the patients they serve—and how this gulf impacts patient care. This often troubles those pursuing the practices of medicine

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and surgery and invites clinicians to reconsider their ethics of care.

In this article, we posit that an ethic of accompaniment in surgical care offers a framework to address the problem of health disparities and structural drivers of injustice and can be used to interrogate the way these are reinforced by the relational and epistemic distance between surgeons and patients. The ethic of accompaniment was born out of liberation theology, a practical theology developed in response to inequities and injustices in Latin America and brought to bear explicitly on the practice of medicine through the work of the late physician-anthropologist Paul Farmer and Partners in Health, a nonprofit focused on global health and social justice that he cofounded.[4] Accompaniment invites the surgeon to become *proximate* to her patients—both in the operating room and outside the hospital's walls—in solidarity, advocacy, and even community and friendship. It also invites the surgeon to consider moral issues generally neglected in medical and surgical ethics, such as how surgeons spend their money and their time and where they choose to live and practice. At face value, this may seem a laudable invitation reserved for "moral heroes," but we hope to show how accompaniment betters our communities, patients, and the practice of surgery, as well as the broader profession of medicine.

For pedagogical and personal reasons, we limit the scope of this article to the practice of surgery. Surgery is distinguished by its invasiveness, emphasis on technical training, and privileged position in medical hierarchies. Surgery crosses intimate boundaries, giving "comfort or cure by piercing the integrity of another's body."[5] Most surgical patients are anesthetized and placed on a ventilator, stripped of their clothes, and, while sedated, touched, manipulated, and monitored—and all of that before the first incision, at which point the surgeon traverses the boundary that separates a patient's innermost being from the outside world, exposing and manipulating the patient, who is utterly vulnerable to the surgeon's ministrations. To cross such intimate boundaries, in direct relationship with those who otherwise exist on the other side of a large social gulf, is necessary for the healing that surgery can bring but is also ethically fraught. Yet—in our experience and the experiences of mentors and colleagues—surgical training often prioritizes technical training and encourages emotional distance, ostensibly to sustain poise and effectiveness in the crucible of the operating room and postoperative period.[6] Additionally, surgery occupies a relatively privileged position in the field of medicine due to a number of factors, including both historical narratives and billing patterns. These characteristics together make surgery seem perhaps least well suited for the values that comprise an ethic of accompaniment. If, as we will argue, accompaniment offers much to surgery, it follows that accompaniment offers much to other domains of medicine.

We focus on surgery also because a few of us (Nicholson, Monica Bodd, and Ellery Sarosi) are aspiring or current surgical trainees, and our clinical experiences have evoked a desire to consider what difference accompaniment might make in surgical disciplines. We hope that this article will inspire others also to imagine the difference an ethic of accompaniment might make for other clinical specialties.

Returning to the central case, how would surgical ethics as a discipline approach the encounter with Samuel? It might clarify how the doctrine and practices of informed consent were or were not honored in Samuel's case. It might examine how acting to preserve his life was justified by the principle of beneficence or ask whether the surgical team ever violated the principle of nonmaleficence—the principle to do no harm. It might challenge the team toward transparency in reporting any mistakes, should they occur.

We propose that surgical ethics should expand on these approaches by prioritizing questions about the social realities that disproportionally affect poor, marginalized, and minoritized patients.[7] Recent changes in the field of surgery include a deepening interest in social justice and bringing new tools to bear on surgical health disparities.[8] These tools most often focus on diversity, equity, and inclusion (DEI) within the ranks of academic surgery,[9] but they largely fail to attend to actions surgeons might take to ameliorate injustice and improve patient outcomes. To that end, in what follows, we give a brief history of the current model of surgical ethics, describe recent approaches to health inequity through DEI, introduce the concept of accompaniment, and illustrate the difference an ethic of accompaniment might make in the care of Samuel and other surgical patients.

After attending to Samuel in the acute setting, a surgical team devoted to the accompaniment of patients would ask the question, how did Samuel get here in the first place?

Contemporary Surgical Ethics and Its Limitations

Recent years have brought to new light how the history of medicine and surgery is tarnished by stark racism and checkered with exploitation of marginalized and impoverished communities.[10] Partially in response to this history, as well as the infamous Tuskegee Syphilis Study and other research scandals, the field of bioethics emerged to protect vulnerable people from unethical conduct

by physicians and other health professionals.[11] Although several normative frameworks, such as the impartial rule theory,[12] casuistry,[13] and virtue ethics,[14] have been employed in the field of bioethics, Tom Beauchamp and James Childress's framework of principlism[15] has become a pervasive way of evaluating bioethical questions. Despite principlism's popularity, a number of prominent ethicists have critiqued it as inadequate to meaningfully inform ethical decision-making. Some also have critiqued the way principlism tends in practice to elevate patient autonomy above all other concerns, prioritizing Western, affluent ideas of individualism at the expense of robust consideration of the social drivers of disease.[16]

Regarding the field of surgical ethics, endocrine surgeon Peter Angelos has drawn attention to the unique moral challenges that surgeons face. He argues there are three aspects of surgical care that merit special attention. First, consider the nature of informed consent in surgery. "The fact that a patient is willing to lie down and be in a completely vulnerable position (in my case, to allow me to cut their throat)," he observes, "suggests the high level of trust that our patients place in us."[17] Second, surgeons have a distinctive culture of taking personal responsibility in the case of a bad outcome. Instead of asking, "What happened?," surgeons ask, "What did I do wrong?"[18] Third, Angelos notes that surgeons are granted unusual power and authority to innovate procedures with limited oversight.[19] Angelos's considerations are apt and important, but they also focus on the actions of the surgeon set apart from broader social realities that powerfully influence the prevalence of surgical disease and poor surgical outcomes in patients like Samuel.[20]

Social Justice in Surgical Care: Is DEI Sufficient?

In recent years, the field of surgery has attempted to reckon with the social realities that impact patients' health. Considering the Covid-19 pandemic and the "second crisis related to social injustice stemming from deep-rooted systemic racism," journals such as *Annals of Surgery* have started featuring pieces that promote "equality and social justice in our workforce and in surgical care."[21] These changes have spurred research that largely focuses on systemic racism and the racist past and present of surgery, generally culminating in calls for greater diversity, equity, and inclusion (DEI) in the ranks of academic surgery.[22]

While these are welcome endeavors that can lead to important changes in patient care,[23] DEI initiatives often stem from those already working in the health care hierarchy, too easily ignoring the voices of those most harmed by the unjust structuring of society. As put in a recent *Hastings Center Report* Perspective essay, "DEI is only the beginning,"[24] for such initiatives also largely fail to account for structural drivers of injustice as well as the privileged positionality—namely, the relatively high economic, educational, and social status—of the surgeon and many other clinicians. The so-called private sphere, including how one uses one's money and personal time and where one lives, has traditionally been neglected in bioethics and social justice movements. Surgeons and patients often are separated by a social and economic gulf, one made even wider in the care of minoritized racial and ethnic groups, refugees, and disabled people.[25]

This gulf invites surgeons to reflect on their private life and their own social position and character, especially in light of their discipline's deeply engrained, intrinsic motivation to offer care that is humanistic, technically excellent, and just. An ethic of accompaniment offers a framework to interrogate this gulf and respond meaningfully to the pressing social issues of our time.

Accompaniment in Health Care

The Latin origin of the word "accompaniment" is "*cum pane*," literally meaning "with bread."[26] The word is used in common speech to mean "going with or alongside someone." Beyond its use in common speech, accompaniment is a concept and praxis that has specific implications for work toward health equity. The values that accompaniment comprises—drawing near to, walking alongside, and breaking bread with the sick and others at the margins[27]—have a long history rooted in various religious traditions, but accompaniment was first explicitly advanced as a response to injustice in Oscar Romero's final pastoral letter.[28] Romero was a Salvadoran Roman Catholic archbishop who was assassinated in 1980 for his advocacy for the oppressed and his nonviolent resistance against an oppressive political regime. Chilean priest-theologian Gustavo Gutiérrez, known as the "father of liberation theology," uses accompaniment to frame the praxis of a "preferential option" for the poor.[29] Theologian Roberto Goizueta further expands accompaniment into an ethic of solidarity, shared resources, proximity, advocacy, and friendship with particular poor persons.[30] One cannot simply help the impoverished and otherwise marginalized and then retreat to what he calls a "safe enclosure" at a "controllable, geographical distance."[31] Accompaniment is not the same as traditional charity or as mere "presence," which, for a surgeon, may mean doing morning rounds or discussing a treatment plan with a patient. For Goizueta, the key difference accompaniment makes is that the person with power is challenged to become geographically and physically *proximate* to the person or community they seek to accompany.[32]

Accompaniment as a means of engaging with disease and disparity can be traced to Farmer's work. Gutiérrez and other liberation theologians significantly influenced Farmer's ap-

proach to clinical care and research throughout his career. In an essay on the insights liberation theology offers to health care, Farmer asserts, "To those concerned with health, a preferential option for the poor offers both a challenge and an insight. It challenges doctors and other health providers to make an option—a choice—for the poor, to work on their behalf . . . [because] diseases themselves make a preferential option for the poor. Every careful survey, across boundaries of time and space, shows us that the poor are sicker than the nonpoor . . . . Given this indisputable association, medicine has a clear—if not always observed—mandate to devote itself to populations struggling against poverty."[33]

Farmer then moves to critique traditional global health ethics that tends to neglect the profound influence of poverty on health outcomes and blame those who are impoverished for their illness and destitution. Farmer suggests an alternative approach of "pragmatic solidarity," through which one "makes common cause with those in need," adding to that sentiment "the goods and services that might diminish unjust hardship."[34] This alternative approach leads to the ethic of "accompaniment," which is invoked time and time again to frame Partners in Health's[35] mission to bring the best possible care to impoverished and marginalized patients across the world. In an address titled "Accompaniment as Policy," delivered at a Harvard Kennedy School of Government commencement, Farmer explains, "'Accompaniment' is an elastic term. It has a basic, everyday meaning. To accompany someone is to go somewhere with him or her, to break bread together, to be present on a journey with a beginning and an end. There's an element of mystery, of openness, of trust, in accompaniment. The companion, the *accompagnateur*, says, 'I'll go with you and support you on your journey wherever it leads. I'll share your fate for a while'—and by 'a while,' I don't mean a little while. Accompaniment is about sticking with a task until it's deemed completed—not by the *accompagnateur*, but by the person being accompanied."[36]

There is cooperation, mutual respect, and even risk involved in accompaniment. In it, the *accompagnateur* proceeds in step with the one being accompanied. They are on the road together; there is skin in the game, so to speak, for both parties. The *accompagnateur* puts herself at the service and under the direction of the accompanied, finishing when the accompanied person or community says the work is done. There is friendship—a familiar proximity and care—as well as solidarity and undermining of traditional power dynamics at the heart of this approach.

Accompaniment also includes an epistemological shift[37] that moves our ethical locus or starting point to those who are impoverished or otherwise marginalized or minoritized.[38] Such a shift entails more than simply inviting people to the table; rather, it moves the table to them or means going to their tables to listen.[39] Drawing near to and choosing to privilege and trust the voices of those who are oppressed is a way of undermining power differentials at the root of oppression, a prerequisite for working together toward a truly liberating justice.[40] Work guided by an ethic of accompaniment not only improves outcomes[41] but also challenges clinicians to forgo power, prestige, and wealth to create space for the marginalized and minoritized to flourish.[42] This challenging but fulfilling and ethical way of life blurs the boundaries that are often drawn between the professional and personal lives of clinicians.

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Accompaniment in Surgery: A Case-Based Review

Although an ethic of accompaniment has implications for how surgeons and other practitioners care for patients and engage with systemic ethical challenges, it has generally been applied in health care to chronic and communicable disease management, neglecting other dimensions of clinical medicine, including surgical care. There are resonances of accompaniment in the *Lancet* Commission on Global Surgery's 2015 report, "Global Surgery 2030: Evidence and Solutions for Achieving Health, Welfare, and Economic Development."[43] The authors (Farmer among them) analyze global surgical disease morbidity and mortality in low- and middle-income countries (LMICs), explore the economic implications of expanding surgical care, and speak clearly to the worldwide inequities in access to safe and affordable surgical care. The commission calls for deep and lasting collaboration between LMICs and high-income countries, with the goal of measurable improvements by 2030 in access to essential surgery and specialist care, in surgical volume, in perioperative mortality rates, and in protection from impoverishing or catastrophic medical expenditures. Other echoes of accompaniment are found in initiatives like Harvard's Program for Global Surgery and Social Change or the Pan-African Academy of Christian Surgeons.[44]

These echoes and resonances suggest that the principles of accompaniment are well suited to the mission of building surgical capacity in LMICs and other resource-limited settings. Yet an ethic of accompaniment has

not been applied to clinical medicine in the United States more broadly, nor brought to bear more specifically on the clinical care of surgical patients.

As one such patient, Samuel represents devastating experiences and circumstances that are too familiar in a United States that has become well acquainted with gun violence, especially in schools and among minoritized communities. Although the surgical team by all accounts offered good medical and surgical care, this case invites reflection on the difference an accompaniment approach might have made. After attending to Samuel in the acute setting, a surgical team devoted to the accompaniment of patients would ask the question, how did Samuel get here in the first place? Asking this requires a posture that first seeks to listen. As it turns out, Samuel had presented years before with two non-life-threatening gunshot wounds. He was discharged in stable condition after those wounds were repaired, only to return with these multiple new injuries. An *accompagnateur* seeks to meaningfully understand the world of the patients that most often present under their care. Gaining such understanding will look different based on geographic location and population demographics.

Relevant to Samuel's case, a recent *JAMA Surgery* piece on surgical innovation, "The Bullet Related Injury Clinic—Healing the Deep Wounds of Gun Violence," describes a surgical team listening to and accompanying their community.[45] Jayne Hayes, Indigo Hann, and L. J. Punch describe a clinic that focuses on creating "a new system of care . . . by providing low-barrier, timely, and culturally competent support of survivors of BRI [bullet-related injury]"—a clinic that was born out of extensive community involvement through the Stop the Bleed Campaign.[46] Upon discharge from the emergency department and referral to the Bullet-Related Injury Clinic, patients receive a "BRIC Box," which contains wound-care supplies and over-the-counter pain medications. Within seventy-two hours of discharge, they receive a call inviting them to the free clinic. At the BRIC, clinicians address patients' pain and wounds along with "whatever physical, psychological, or social need is most concerning to them at the time of care."[47] The authors hope that this integration of timely clinical and self-care support with existing hospital and community-based programs might decrease rates of future BRI and associated adverse psychological and social outcomes, as has been the case with similar hospital-based intervention programs.[48] This example demonstrates the art of listening to the needs of the community and responding in meaningful collaboration with those being accompanied. Perhaps a similar program would have prevented Samuel's reinjury and permanent disability.

A member of Samuel's surgical team seeking to accompany him would contend with the various structural realities that rendered him at greater risk for violent injury. He is a young Black man from a lower socioeconomic background. Black men are at disproportionately high risk for bullet-related injury and firearm homicide,[49] and firearm violent crime has been linked to poverty and lack of social capital.[50] Considering these realities might, for example, determine the research one chooses to pursue, lead one to join community initiatives like the BRIC, or motivate curricula that engage with structural drivers of inequity. Accompaniment does not require all surgeons to become activists in the conventional sense, but it does encourage activism and advocacy.[51] Surgeons are not multitool entrepreneurs who are morally obligated to become experts in social policy just because they care for patients within spheres of structural injustice. Nor is accompaniment a guise for extended paternalism, though roots of the latter provide "many of the ingredients necessary for a healthy patient-clinician relationship[, including] . . . trust, fiduciary responsibility and a commitment to resist self-serving, economic abuse and exploitation of the sick."[52] Rather, accompaniment makes room for encountering a patient's lived reality, being caught up in patients' lives. Such encounters are full of fear and surprise, of discovering creative and meaningful ways to leverage privilege to make a difference in the lives of the sick, especially those disproportionately affected by injustice.

Finally, an ethic of accompaniment is perhaps most challenging and most distinctive when it interrogates aspects of the practitioner's life that often have been deemed private and thereby outside the bounds of traditional bioethics and surgical ethics discourse. An accompaniment approach to surgical care pushes the surgeon to interrogate the totality of her life when considering how to ethically engage with her patients and community. This is because an essential aspect of accompaniment is its radical implication to live "in *proximity* with those one serves."[53] This good of proximity invites the surgeon (and all members of the care team) to consider how to mitigate the distance between clinician and patient, to resist retreating to "safe enclosures"—guised as "protective"—that are geographically and economically distant from zip codes where the most vulnerable patients reside. Accompaniment's whole-life ethic can be costly and entail risk, but according to the religious traditions from which it came, it also offers transcendent encounters and communion with the accompanied individual or community—encounters some have described as being like encountering the divine, although an *accompagnateur* need not be at all religious.[54] Further, as demonstrated in the work of Partners in Health and others, accompaniment improves health outcomes for those most affected by disease and disability—namely, those who are impoverished and otherwise marginalized.[55]

Within modern American health care, an ethic of accompaniment may also offer an antidote to the burnout caused by discontinuity: clinicians increasingly see themselves as instrumentalized, organized, and made efficient at great relational cost. In the recent *Hastings Center Report* article "Love Your Patient as Yourself," Tyler Tate and Joseph Clair argue that the technocracy of medicine has reoriented the aim of a clinician to one much like a mechanic's. To revive and renew both personal and structural tools of healing, medicine must, as the authors argue, be governed by its core virtue of *humanitas*. *Humanitas* relies on "the recognition of another person's shared likeness" and consequential awareness of "the duty to actually care about people."[56] Recognition of a patient in their humanity requires deliberate "looking" at a patient in their particularity (location, story, support system, and so forth) and disabusing oneself of a "spiderweb of self-serving fantasies encapsulated by the phrases 'doctors know best' and 'doctor's orders.'"[57] These actions require humility to become accountable to the story of a patient that breaks down the boundaries of a hospital, moving a clinician closer to her patients, their lives, and the suffering that has driven the clinician into a lifetime of healing work.

In the case of a patient like Samuel who has been affected by violence, one seeking to practice accompaniment would consider how to become proximate to the patient and to others from the communities served by the hospital. This approach "makes it clear that the essential knowledge needed to understand this issue can be found only by immersing oneself in communities,"[58] where one can learn the history of the communities, discern how to prevent cases like Samuel's, engage patients' family members across cultural barriers, and advocate effectively for reform. Surgeons, of course, do not bear this responsibility alone. Accompaniment calls for bioethicists and other clinicians to "alter their social locations, to locate themselves not only within the confines of the hospital but to sit in the midst of communities that have experienced gun violence in order to delve deeper into the lived realities of patients who have suffered a gunshot wound."[59]

Gaining proximity to patients who are poor or otherwise marginalized might stir clinicians or ethicists to support community health workers or other forms of social and medical support that mitigate drivers of structural injustice. It might prompt hiring people from the neighborhood to ensure representation that reflects the demographics of the populations a hospital serves—a strategy followed by St. Bernard's Hospital in the Englewood neighborhood on the South Side of Chicago.[60] It might inspire surgeons to allocate some of their personal wealth toward community organizations that serve those in need. It might even call some surgeons to move into the neighborhood where they work, placing themselves and their families in true proximity to their patients' community and allowing these surgeons to make connections and develop friendships with people there. Together with these neighbors, some surgeons may cultivate a community characterized by mutual care and commitment.[61] Insofar as these and similar actions multiply, the surgical ethos of cure becomes more anchored in caring relationships. The surgeon's ethical lens takes in not only the operating room and hospital but also the community, bringing congruence between the proximity inherent in surgical care and the experiences of patients outside the four walls of the hospital.

Toward an Ethic of Accompaniment in Surgical Care

Some might find the ethic of accompaniment in surgical care that we are advocating for unrealistic or even counterproductive. Students, trainees, and surgeons already are stretched thin given the vast body of knowledge and skills needed to become excellent clinicians. We nevertheless propose that accompaniment is possible for everyone from trainees to attendings, as, rather than adding to a surgeon's work, accompaniment reorders and focuses that work with respect to the surgeon's posture and priorities. It also invites clinicians and health care administrators to question the harried pace of modern medicine and consider what it would take to create time and space for true accompaniment of patients and communities.[62]

Accompaniment might help sustain busy surgeons and even make their work more fulfilling because of (not despite) the ways that it brings them close to the individuals and communities they are caring for.

Some might contend that accompaniment's interrogation of the private sphere could hinder a field that necessitates extreme focus and even compartmentalization. It is true that clinicians at times must compartmentalize to perform their job well. In the case of trauma surgery, for example, one might have to treat as many as thirty patients on a busy night of call. Excellent surgeons direct their full attention to the patient or operation at hand and then orient that same attention to the individuals and families that come next—all the while working cohesively with a diverse medical team. In an exacting discipline, many might believe it best to leave each practitioner to decide how to spend time in her self-defined "own world" to protect from exhaustion. Instead of another unfunded

mandate for those who are already terribly busy to "do more" or rest less, accompaniment offers social relocation, relationship, and proximity that are potential sources of renewal for busy clinicians suffering from the well-documented depersonalization that plagues modern medicine.[63] Accompaniment might help sustain busy surgeons and even make their work more fulfilling because of (not despite) the ways that it brings them close to the individuals and communities they are caring for.

Some also might see accompaniment as better relegated to nonsurgical fields and chronic disease management or worry that it might direct surgeons' focus away from operating on the many patients who need them working at the highest level of their training.[64] We believe that the examples cited in this article demonstrate accompaniment's relevance for surgical conditions. An ethic of accompaniment has already motivated violence-intervention programs, initiatives to mitigate racial disparities in maternal health outcomes,[65] expanding disciplines like surgical palliative care,[66] and the building of surgical capacity in and practice within resource-limited settings. These achievements give good reason to expect that an ethic of accompaniment can help surgeons discover ways to meaningfully work toward health equity and improve the care of patients like Samuel.

Despite the rich theoretical and practical history of accompaniment, some may see accompaniment as a utopian ideal, overextending the responsibilities of surgeons, and potentially endangering them and their families. Accompaniment *is* costly indeed, a "long defeat," in Farmer's words.[67] For that reason, society generally esteems people and communities that embrace such values. We do not expect that the average reader, in response to this article, will relocate to an underfunded part of the nearest city or to a rural community in need of a practitioner. Nor is the average surgeon necessarily able to add community engagement on top of already extensive responsibilities. Accompaniment is broad enough, however, to invite intermediary goods between "I need to sell everything and move" and "I will keep my patients at arm's length, offering them technically proficient care within the boundaries of my institutional role." Accompaniment will not look the same for every practitioner. Nor does it require everyone to relocate to impoverished communities—which could even cause harm through gentrification or perpetuate harmful White saviorism.[68] Rather, accompaniment is a *posture* of opening ourselves to the ways our patients' lives call out to us. It holds us accountable for the health of our patients and makes us open to their invitation to become geographically and physically proximate, often bringing discomfort because accompaniment entails surrendering or sharing power. Our argument is cautiously idealistic, knowing that if change happens in even a small minority of surgeons, entire communities will be better for it.

In step with this cautious idealism, outside the world of surgery, accompaniment can inform other medical specialties and clinical disciplines, as well as societal responses to inequities in health care and beyond.[69] To fundamentally address the structural drivers of health inequities, there needs to be change at a societal level. Such change necessitates high-level advocacy and collective work toward a new system oriented around health care for all who need it, particularly the vulnerable. Far from being limited to individuals, accompaniment, if adopted by surgeons and by medicine as a whole, could be a driver toward a new social reality. It would represent a collective of people with social power who interface with these inequities on a daily and bodily basis, who choose to embrace an alternative imaginary to the one that supports our for-profit, inequitable system. And, as noted by many who research civil resistance, it takes only about 3.5 percent of a population to affect lasting social change.[70] Accompaniment is not the sole answer to every health inequity or ethical quandary we face. Yet what broad social changes might take place if a small proportion of clinicians more broadly took up the values that comprise accompaniment, inculcating them in individuals and institutions across the United States and the world?

All in all, accompaniment is dynamic, as it takes its bearings from the particular individuals and communities that are accompanied. Those shaped by it root themselves in the lived experiences of marginalized communities that suffer most from injustice and thereby bear disproportionate burdens of disease. An ethic of accompaniment invites surgeons to reconsider their relationship to patients and the communities they serve, to reduce the gulf between surgeon and patient, and to create space for breaking bread together in a mutual pursuit of health, justice, and equity.

Notes

1. The name and other identifying information have been changed to protect the anonymity of the patient.

2. S. Hauerwas, "Salvation and Health: Why Medicine Needs the Church," in *The Hauerwas Reader*, ed. J. Berkman and M. Cartwright (Durham, NC: Duke University Press, 2001), 539-55.

3. We acknowledge that there are varying levels of privilege and diversity (racial, ethic, or economic, among others) among medical students in the United States and that not all of them hail from privileged backgrounds. Yet it is clear that the majority of medical students in this country come from relatively rich family backgrounds. According to the American Association of Medical Colleges' *Matriculating Student Questionnaire: 2021 All Schools Summary Report* (at https://www.aamc.org/data-reports/students-residents/report/matriculating-student-questionnaire-msq), the median income of matriculating students' parents was $140,000.

4. M. Griffin and J. W. Block, eds., *In the Company of the Poor: Conversations between Dr. Paul Farmer and Fr. Gustavo Gutierrez* (Maryknoll, NY: Orbis Books, 2013).

5. D. E. Hall, "Altar and Table: A Phenomenology of the Surgeon-Priest," *Yale Journal of Biology and Medicine* 81, no. 4 (2008): 193-98, at 194.

6. A helpful engagement with these themes can be found in J. L. Han and T. N. Pappas, "A Review of Empathy, Its Importance, and Its Teaching in Surgical Training," *Journal of Surgical Education* 75, no. 1 (2018): 88-94.

7. There is rich literature arguing for prioritizing the health of the poor and otherwise marginalized. The present article contributes to this literature. For a powerful, nuanced primer on the ways outcomes are positively affected by prioritizing problems that affect the poor, see P. Farmer, *Pathologies of Power* (Berkeley, CA: University of California Press, 2003).

8. A. Diaz et al., "County-Level Social Vulnerability Is Associated with Worse Surgical Outcomes Especially among Minority Patients," *Annals of Surgery* 274, no. 6 (2021): 881-91.

9. F. Nwariaku, "*Semper Prorsus*: Antiracism and American Surgery," *Annals of Surgery* 273, no. 5 (2021): E162-63; M. A. West et al., "Ensuring Equity, Diversity, and Inclusion in Academic Surgery: An American Surgical Association White Paper," *Annals of Surgery* 268, no. 3 (2018): 403-7; D. Blitzer, N. Coleman, and S. Amory, "A Complex History: Reckoning with Prejudice in Surgery's Past," *Annals of Surgery* 273, no. 3 (2021): e81-82; S. Massick, K. King, and T. M. Pawlik, "Practical Approaches to Foster Diversity in Surgical Faculty Recruitment," *JAMA Surgery* 157, no. 11 (2022): 981-82.

10. Blitzer at al., "A Complex History."

11. In this article, we understand a *profession* in a traditional sense, namely, as a self-regulating community with special expertise and (potentially dangerous) powers that professes to use that expertise and those powers only for the common good—in the case of medicine, to preserve and restore the health of those who face injury and illness. A profession involves more than a social contract or the exchange of goods. It includes a relationship between the professional and the general community that depends on the professional's pursuit of technical excellence along with other virtues necessary for ethical practice. We believe that accompaniment fits this conception of a profession, potentially providing a framework to make the practice of medicine more fulfilling and just.

12. K. D. Clouser, "Common Morality as an Alternative to Principlism," *Kennedy Institute of Ethics Journal* 5 (1995): 219-36; K. D. Clouser and B. Gert, "A Critique of Principlism," *Journal of Medicine and Philosophy* 5 (1990): 219-36.

13. A. Jonsen, "Casuistry and Clinical Ethics," *Theoretical Medicine* 7 (1986): 67-71.

14. E. D. Pellegrino, "Toward a Virtue-Based Normative Ethics for the Health Professions," *Kennedy Institute of Ethics Journal* 5 (1995): 253-77; S. Hauerwas, "On Medicine and Virtue," in *Virtues and Health Care*, ed. E. Shelp (Dordrecht, Netherlands: D. Reidel, 1984), 347-55.

15. T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001).

16. J. Azétsop and S. Rennie, "Principlism, Medical Individualism, and Health Promotion in Resource-Poor Countries: Can Autonomy-Based Bioethics Promote Social Justice and Population Health?," *Philosophy, Ethics, and Humanities in Medicine* 5, no. 1 (2010): 1-10.

17. P. Angelos, "Surgical Ethics and the Challenge of Surgical Innovation," *American Journal of Surgery* 208, no. 6 (2014): 881-85, at 882.

18. Ibid., 882. This is elucidated in C. L. Bosk, *Forgive and Remember: Managing Medical Failure*, 2nd ed. (Chicago: University of Chicago Press, 2003).

19. Angelos, "Surgical Ethics and the Challenge of Surgical Innovation."

20. Diaz et al., "County-Level Social Vulnerability Is Associated with Worse Surgical Outcomes Especially among Minority Patients."

21. See K. D. Lillemoe et al., "Promoting Equality and Social Justice in our Workforce and in Surgical Care," a letter from editors of *Annals of Surgery*, accessed January 12, 2024, https://journals.lww.com/annalsofsurgery/Pages/Social-Justice.aspx.

22. Nwariaku, "*Semper Prorsus*"; West et al., "Ensuring Equity, Diversity, and Inclusion in Academic Surgery"; Blitzer et al., "A Complex History"; Massick et al., "Practical Approaches to Foster Diversity in Surgical Faculty Recruitment."

23. L. M. Marrast et al., "Minority Physicians' Role in the Care of Underserved Patients: Diversifying the Physician Workforce May Be Key in Addressing Health Disparities," *JAMA Internal Medicine* 174, no. 2 (2014): 289-91.

24. N. M. P. King, "DEI Is Not Enough," *Hastings Center Report* 52, no. 3 (2022): 3.

25. There is debate between using person-first (e.g., "people with disabilities") and identity-first (e.g., "disabled people") language when referencing disability. In our experiences and friendships with various members of the disabled community, we have found that most members of this community use and prefer identity-first language. Therefore, we have elected to use this convention here.

26. J. W. Block and M. Griffin, introduction to *In the Company of the Poor: Conversations with Dr. Paul Farmer and Fr. Gustavo Gutièrrez*, ed. M. Griffin and J. W. Block (Maryknoll, NY: Orbis Books, 2013), 1-14.

27. C. P. Nicholson Jr., "Made Known in the Breaking of the Bread: Accompaniment and the Practice of Medicine," *Linacre Quarterly* 88, no. 3 (2021): 281-90.

28. S. J. Pope, "Integral Human Development: From Paternalism to Accompaniment," *Theological Studies* 80, no. 1 (2019): 123-47.

29. G. Gutierrez, *A Theology of Liberation* (Maryknoll, NY: Orbis Books, 1971).

30. R. Goizueta, *Caminemos Con Jesus: Toward a Hispanic/Latino Theology of Accompaniment* (Maryknoll, NY: Orbis Books, 1995).

31. Ibid., 199.

32. Some of the values of accompaniment deeply resonate with surgeon-ethicist Miles Little's "The Fivefold Roots of an Ethic of Surgery." Little contends that there are five "categories of experiences and relationship which are especially important in surgery—*rescue*, *proximity*, *ordeal*, *aftermath*, and *presence*." He explores the ways these are at work in the surgical encounter through in-depth interviews with surgeons and patients. We believe that, in particular, Little's concepts of proximity and presence touch on the proximity, intimacy, and friendship that accompaniment invites surgeons (and other medical practitioners) to consider as constitutive of an ethical approach to caring for the sick. Accompaniment extends beyond the surgeon-patient dyad to include a social and geographical proximity or presence that we believe has profound implications for the practice of medicine and surgery. See: M. Little, "The Fivefold Roots of and Ethic of Surgery," *Bioethics* 16, no. 3 (2002): 183-201, at 183 (in the abstract).

33. P. Farmer, "Health, Healing, and Social Justice," in *Pathologies of Power* (Berkeley: University of California Press, 2003), 139-59, at 139-40.

34. Ibid., 146.

35. Partners in Health was founded by Farmer, Ophelia Dahl, Thomas J. White, Todd McCormick, and Jim Kim in 1987.

36. P. Farmer, *To Repair the World: Paul Farmer Speaks to the Next Generation*, ed. J. Weigel (Los Angeles: University of California Press, 2013), 234.

37. "Epistemological shift" refers to the efforts made to change where knowledge is obtained from due to a recognition that knowledge and theories are particular to specific circumstances and communities.

38. M. T. Lysaught and M. McCarthy, *Catholic Bioethics and Social Justice: The Praxis of US Health Care in a Globalized World* (Collegeville, MN: Liturgical Press, 2018), 16.

39. P. Freire, *Pedagogy of the Oppressed*, 30th ed. (New York, NY: Continuum International Publishing Group, 2005).

40. Farmer and Gutierrez, *In the Company of the Poor*.

41. This has been most clearly demonstrated in community health worker programs, see "Unit 7: Improving Outcomes

with Community Health Workers," Partners in Health, accessed September 24, 2021, https://www.pih.org/practitioner-resource/pih-program-management-guide/unit-7-improving-outcomes-with-community-health-workers; R. Crespo et al., "An Emerging Model for Community Health Worker-Based Chronic Care Management for Patients with High Health Care Costs in Rural Appalachia," *Preventing Chronic Disease* 17 (2020): doi:10.5888/pcd17.190316.

42. E. Reinhart, "Medicine for the People," *Boston Review* March 22, 2021, https://www.bostonreview.net/articles/eric-reinhart-accompaniment-and-medicine/; J. W. Block, *Paul Farmer: Servant to the Poor* (Collegeville, MN: Liturgical Press, 2018); Nicholson Jr., "Made Known in the Breaking of the Bread."

43. J. G. Meara et al., "Global Surgery 2030: Evidence and Solutions for Achieving Health, Welfare, and Economic Development," *Lancet* 386 (2015): 569-624.

44. B. Till, "God's Surgeons in Africa," *Atlantic*, December 28, 2012; "Our Objective," Harvard Medical School, Program Global Surgery and Social Change, accessed January 14, 2024, at https://www.pgssc.org/.

45. J. M. Hayes, I. Hann, and L. J. Punch, "The Bullet Related Injury Clinic—Healing the Deep Wounds of Gun Violence," *JAMA Surgery* 157, no. 2 (2022): 167-68.

46. Ibid., 167.

47. Ibid., 167.

48. Similar initiatives include the San Francisco Wraparound Project at the University of California, San Francisco, which implements interventions that address "root causes of violence [that] can prevent future injury and incarceration," such as assisting patients in obtaining employment opportunities, mental health services, vocational training, driver's licenses, aid in other legal hurdles, and more through extensive community partnerships. See University of California, San Francisco, San Francisco Wraparound Project, accessed September 8, 2022, https://wraparound.ucsf.edu/. See also E. J. Kramer et al., "Violent Re-injury Risk Assessment Instrument for Hospital-Based Violence Intervention Programs," *Journal of Surgical Research* 217 (2017): 1-20; C. Juillard et al., "A Decade of Hospital-Based Violence Intervention: Benefits and Shortcomings," *Journal of Trauma and Acute Care Surgery* 81, no. 6 (2016): 1156-61. There has also been a recent collaboration between Duke University and the city of Durham, North Carolina, in seeking to support survivors of gun violence, address root causes, and prevent future injury through research and partnership with grassroots community organizations like the Religious Coalition for a Nonviolent Durham. See M. H. Moore, "Duke to Partner with City of Durham to Study the Needs of Gun Violence Survivors," *News & Observer*, August 18, 2022, https://www.newsobserver.com/news/local/crime/article264650234.html#storylink=cpy. See also S. Krueger, "Duke University Hospital's Violence Intervention Program Set to Begin in July," WRAL.com, June 3, 2022, https://www.wral.com/duke-university-hospital-s-violence-intervention-program-set-to-begin-in-july/20313671/. Regarding other research on hospital-based violence intervention programs, see C. Cooper, D. M. Eslinger, and P. D. Stolley, "Hospital-Based Violence Intervention Programs Work," *Journal of Trauma* 61, no. 3 (2006): 534-37.

49. C. A. Riddell et al., "Comparison of Rates of Firearm and Nonfirearm Homicide and Suicide in Black and White Non-Hispanic Men, by U.S. State," *Annals of Internal Medicine* 168, no. 10 (2018): 712-20.

50. B. P. Kennedy et al., "Social Capital, Income Inequality, and Firearm Violent Crime," *Social Science and Medicine* 47, no. 1 (1998): 7-17.

51. K. S. Chawla, A. Jayaram, and C. D. McClain, "The Missing Chapter: The Education of Surgery and Anesthesiology Trainees as Civic Advocates," *Annals of Surgery* 273, no. 4 (2021): e125-26.

52. T. Tate and J. Clair, "Love Your Patient as Yourself: On Reviving the Broken Heart of American Medical Ethics," *Hastings Center Report* 53, no. 2 (2023): 12-25, at 18.

53. Nicholson Jr., "Made Known in the Breaking of the Bread," 287.

54. Roberto Goizueta writes, in *Caminemos Con Jesus*, that accompaniment is "a fundamentally religious sacramental act" (p. 209). See also Farmer and Gutierrez, *In the Company of the Poor*. But we reiterate that a practitioner seeking to live an ethic of accompaniment does not need to be religious—the intrinsic reward that is central to this ethic's pursuits is accessible to all seeking to accompany the sick and otherwise marginalized.

55. Farmer and Gutierrez, *In the Company of the Poor*.

56. Tate and Clair, "Love Your Patient as Yourself," 16.

57. Ibid., 18.

58. M. Byrne et al., "Health Care Providers on the Frontline: Responding to the Gun Violence Epidemic," in *Catholic Bioethics & Social Justice*, ed. M. T. Lysaught and M. McCarthy (Collegeville, MN: Liturgical Press Academic, 2018), 31-45, at 38.

59. Ibid., 38.

60. R. J. Gordon, "Inviting the Neighborhood into the Hospital: Diversifying Our Health Care Organizations," in *Catholic Bioethics & Social Justice: The Praxis of US Health Care in a Globalized World*, ed. M. T. Lysaught and M. McCarthy (Collegeville, MN: Liturgical Press Academic, 2018), 179-97.

61. In the world of primary care interventions, Lawndale Christian Health Center is a Federally Qualified Health Center in the Lawndale neighborhood of Chicago—one of the areas of the city most plagued by health disparities and violence. It was founded initially by a community of faith that desired to respond meaningfully to these realities. Its stated values articulate principles of accompaniment. The health center writes of the value of "[r]elocation[, which] is a focus on 'living among' in order to clearly understand the issues that face a community." See "'Who We Are': Lawndale Christian Health Center," 2022.

62. It is well documented that our system is driven by a neoliberal economization of medicine and health care, to the detriment of patients and physicians. For a thoughtful engagement with this issue, see J. L. Havlik, M. R. Mercurio, and S. C. Hull, "The Case for Ethical Efficiency: A System That Has Run Out of Time," *Hastings Center Report* 52, no. 2 (2022): 14-20.

63. T. D. Shanafelt et al., "Burnout and Career Satisfaction among American Surgeons," *Annals of Surgery* 250, no. 3 (2009): 463-71; C. P. West, T. D. Shanafelt, and J. C. Kolars, "Quality of Life, Burnout, Educational Debt, and Medical Knowledge among Internal Medicine Residents," *Journal of the American Medical Association* 306, no. 9 (2011): 952-60.

64. This was a critique frequently levied against Paul Farmer, who throughout his career chose to literally, physically accompany his patients—be they in Boston, Haiti, Rwanda, or other underserved contexts. In a biography of Farmer, Tracy Kidder voices this concern that he had heard from scholars at Harvard, that "hiking [seven hours through the Haitian hills] to see just one patient or two is a dumb way for [someone like] Farmer to spend his time" (p. 294). He then offers Farmer's response. See T. Kidder, *Mountains beyond Mountains: The Quest of Dr. Paul Farmer, A Man Who Would Cure the World* (New York: Random House, 2003), 280-98. Farmer credits precisely this accompaniment not only for the critically important work of caring for each patient but also for the epistemological insights that enabled his pioneering initiatives in global health and infectious disease management. For a more extensive analysis of this critique, see B. Volck, "Wasting Time with the World's Poor: Theological and Scriptural Foundations for Paul Farmer's Praxis of Accompaniment," in *A Prophet to the Peoples: Paul Farmer's Witness and Theological Ethics*, ed. J. W. Block, M. T. Lysaught, and A. A. Martins (Eugene, OR: Pickwick Press, 2023), 200-223, which is

part of a larger section focusing on Farmer's practice of accompaniment.

65. J. Tang and R. Urrutia, "Comparing Four Ways to Reduce Pregnancy Complications among Black Mothers—the ACURE4Moms Study," Patient-Centered Outcomes Research Institute, 2021, accessed February 25, 2024, https://www.pcori.org/research-results/2021/comparing-four-ways-reduce-pregnancy-complications-among-black-mothers-acure4moms-study.

66. F. Greene, "Surgical Palliative Care: A Coming of Age," *BMJ Supportive and Palliative Care* 12, no. 1 (2022): 46-48.

67. Kidder, *Mountains beyond Mountains*, 288.

68. A. Banerjee et al., "Are We Training Our Students to Be White Saviours in Global Health?," *Lancet* 402 (2023): 520-21.

69. For a thoughtful account of the difference accompaniment might make in community-based care of formerly incarcerated individuals, as well as the movement toward "abolitional care," see E. Reinhart, "Reconstructive Justice—Public Health Policy to End Mass Incarceration," *New England Journal of Medicine* 388, no. 6 (2023): 559-64.

70. E. Chenoweth, *Civil Resistance: What Everyone Needs to Know*, 1st ed. (Oxford: Oxford University Press, 2021).