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Reimagining Medicine as a Practice of Solidarity: A Corrective to Spaceship Ethics

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Abstract

The culture of medical training and contemporary medicine is largely influenced by “spaceship ethics,” where healthcare professionals are taught to take “refuge in principles that place them outside, or above, the complicated, ambiguous, contradictory lives of those others who sicken and die” (Irvine and Charon 2016). Is there a better way that medicine can care for individuals immersed in ambiguous, contradictory lives of sickness and death? In this paper, we argue that one corrective to spaceship ethics is reimagining medicine as a practice of solidarity. At its conceptual core, solidarity is a cooperative relationship that transcends self-interest and respects each person’s dignity and sense of belonging—a collective human need that does not distinguish caregivers from patients. We build a theory of solidarity in the context of medical training by describing the life and legacy of Father Damien as well as the ongoing HIV-focused work of *Shalom Delhi*. We then discuss three practical ways in which contemporary medical training can encourage solidarity: (1) proximity to patients and communities; (2) choosing careers based on a community’s needs; and (3) an openness to transformation by patients. We conclude that solidarity can be a corrective to spaceship ethics by enabling healthcare professionals to engage in complicated social realities of sickness, death, and provider–patient dynamics. A practice of medicine that is animated by a commitment to this type of solidarity reorients clinicians’ lives and professional priorities around the experiences of the patients they care for. In a medical culture that trains healthcare practitioners to distance themselves from patients as whole persons, practicing solidarity encourages sustained proximity, advocacy, and dignity.

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Introduction

Prior to medical school, there were times I (KH) considered becoming a chaplain instead of a physician. There was something I found rewarding and inspiring about helping people find hope and meaning in the face of stigma and uncertain death, particularly in resource-limited settings. Although I ultimately pursued medicine so that I could meet patients' physical needs, I also hoped to perhaps practice in a way a chaplain would—caring for patients' psychosocial and spiritual needs as well. With this in mind, I began my third year of medical school with an almost a ministerial-like zeal to holistically care for my patients' needs. "I finally get to participate in the care of patients," I thought to myself. It was going to be the pinnacle of all of my years of preparation.

Dozens of evaluation forms later (in addition to thousands of USMLE practice questions), I found that my passion for patient care began to wane. Somewhere in the middle of my third-year clerkships, I realized I was operating out of a desire for the approval of and recognition by attendings and upper-level residents. "Honors" was the badge I coveted.

There was no specific moment I could point to; instead, it was a gradual change wrought by the imperceptible accretion of criticism, feedback, and praise, typified by subtle comments like, "If you want to go to x residency, you need y (i.e., Honors, good evaluations, a better USMLE score, Honors Society membership, etc.)." What exactly had gone wrong? More importantly, how could I become more human again and bring holistic care back to the forefront of my work in medicine?

The Problem of Spaceship Ethics: Medical Education Trains Us to Distance Ourselves from Patients

Sociologist Arthur Frank has argued that contemporary medicine is steeped in what he calls "spaceship ethics": "When you get up in the morning, pretend your car is a spaceship. Tell yourself you are going to visit another planet... On that planet, terrible things happen, but they don't happen on my planet. They only happen on that planet I take my spaceship to each morning" (Frank 2013). The culture of medical training is largely influenced by spaceship ethics, where healthcare professionals are taught to take "refuge in principles that place them outside, or above, the complicated, ambiguous, contradictory lives of those others who sicken and die" (Irvine and Charon 2016). Is there a better way that medicine can care for the souls of individuals immersed in ambiguous, contradictory lives of sickness and death?

Medical Education Trains Us to Crave Achievement and Success

The 2018 commencement speaker at the Mt. Sinai Icahn School of Medicine, Debrework Zewdie, reminded graduates: "The poor and sick are human and not only deserve your empathy; they deserve your respect" (Zewdie 2018). Yet in our world of medical training, respectfully caring for patients—particularly those who are poor and sick—is often less important than being competent and successful. Without respect for our patients, they become a means to an end, not individuals with inherent dignity.

We propose that in medical training, this drive to become competent and successful

physicians can hinder us from treating people who are “poor and sick” with dignity and respect. For instance, we are shaped by visions of success propagated by online forums and career panels in ways that shift our focus away from our patients. We mitigate fears of inadequacy through regimented test preparation, resume-building, and creating strategies to obtain the best letters of recommendation. Through the process, many trainees come to see the purpose of medical education as self-improvement—a step in the direction of a higher-status career—which shields us from having to think about the realities of pain and suffering that we see in our patients. There is also an element of power that comes with being a physician, which further distances trainees from the world of many patients. The irony is that while the decision to study medicine is rooted in the desire to help others, medical training’s career-driven culture focuses on “us.” Narratives of success are embedded in our systems, language, and culture at large.

Defining Solidarity

One corrective to “spaceship ethics” is reimagining medicine as a practice of solidarity. The notion of solidarity in Western thought can be traced to various European political movements as early as the eighteenth century, the writing of philosophers Auguste Comte and Emile Durkheim, and various Catholic theologians drawing on the work of Thomas Aquinas (Prainsack and Buyx 2017). At its conceptual core, solidarity is a cooperative relationship that transcends self-interest and respects each person’s dignity and sense of belonging—a collective human need that does not distinguish caregivers from patients (Jaeggi 2001; ter Meulen 2011; Kolers 2021). Solidarity is a deliberate enactment of a value-laden commitment that is motivated and *enlivened* by an “enduring orientation” to act when confronted with a situation in which those to whom one is committed are in jeopardy, and a desire to *seek out* such encounters (Kolers 2021, 123). It is not a program of compulsory

benevolence, nor is it an abstract platform from which to mount a moral critique of contemporary individualism. Instead, solidarity is a constitutive expression of shared humanity manifested in personal relationships (Margalit 2010).

In a world riven by profound health and socioeconomic inequalities, solidarity necessitates a deep sense of recognition and treatment of people who are vulnerable and suffering. Solidarity is an act of mercy, which can be defined as “the willingness to enter the chaos of another” (Keenan 2017). In his *We Drink from Our Own Wells*, Theologian Gustavo Gutierrez speaks of spirituality as a way of life grounded in solidarity with people who are poor and based on giving them what he calls a “preferential option.” He argues that “the need is not simply to recognize that the experience of people [who are poor] raises questions and challenges for [our] spirituality;” instead, the need is “[to make the experience of the poor] our own” (Gutierrez 2013). Solidarity must go beyond what we can learn from people in poverty to a way of life—an orientation to the world based on the experiences of those who are suffering. Duncan MacLaren further argues that solidarity can be understood as “our co-responsibility to one another and our world; on a bias towards the oppressed neighbour; and on a recognition of the ‘other’, overcoming self and egoism to commit oneself to the transformation of, not just the symptoms of social injustice but, above all, the causes” (MacLaren 1991).

How could the practice of medicine be reimagined as a practice of solidarity? In the space below, we build on a theory of solidarity by using two examples that challenge the paradigm of spaceship ethics. First, we examine the life and legacy of Father Damien, a Catholic priest from Belgium, who lived among, cared for, and died alongside people affected by Hansen’s disease in Kalaupapa, Hawaii. Second, we describe the ongoing work of *Shalom Delhi*, a clinic staffed by Indian health professionals that provides medical and supportive services to socioeconomically disadvantaged individuals affected

by HIV in a resource-limited area of Delhi. We end with a discussion of how these examples of proximity, advocacy, and care of souls could suggest a reorientation of medical professionals calling toward suffering and solidarity with patients.

Building a Theory of Solidarity

Father Damien

By the year 1884 on the island of Molokai, Father Damien—a Catholic priest from Belgium—had been faithfully caring for people living with Hansen’s disease for more than a decade. In line with a form of spaceship ethics, Father Damien’s colleagues admonished him to “not get too close to the patients,” who feared Father Damien would contract or be morally contaminated by Hansen’s disease. Father Damien did not heed their advice. He learned the Hawaiian language, ate with patients, and cleaned wounds. Yet one day, Father Damien noticed that he was losing peripheral sensation after accidentally spilling boiling water on his feet, and he realized: he too was infected with *Mycobacterium leprae*.

Contemporary medical practice looks much different than it did more than a century ago, and we now have a cure for Hansen’s disease. While Father Damien cared deeply for the community, some argue that his work contributed to colonial legacies and narratives in Hawaii and the Pacific. Nevertheless, former Native Hawaiian University of Hawaii John A. Burns School of Medicine faculty member Dr. Kalani Brady believes that there are key lessons that medical trainees can glean from Father Damien regarding “the doctor-patient relationship.” “He treated the patients suffering from Hansen’s disease as if they were on the same level as him” (Brady 2017).

In an era where people with Hansen’s disease faced devaluation and distance from the rest of society, Father Damien countered a spirit of spaceship ethics by seeing himself on the same level of those he served, and he

advocated for social services and sought to counter the sentiment that the residents of Kalaupapa were inferior (Char 2009). In 1889, Father Damien died of Hansen’s disease, and he was buried in Kalaupapa (National Park Service, n.d.).

Shalom Delhi

A project of the *Emmanuel Hospital Association*, Shalom Delhi¹ was started in 2001 to respond to the start of the HIV epidemic in Northern India. Shalom currently operates out of a small building and small budget in Northern Delhi. “Staffed by a team of Indian physicians, nurses, and community outreach workers, Shalom provides in- and outpatient medical services to persons with acute HIV-related illness at their 10-bed Health Centre located in North Delhi. The majority of patients are referred to Shalom by word of mouth and from government Antiretroviral Therapy Centers and other non-government organizations. In 2018, there were 249 inpatient admissions and 1,284 outpatient visits” (Kang et al. 2019). Shalom also provides “ancillary services that focus on the specific needs of children and adolescents (HIV Disclosure Support, Character Development, and Life Skills Education), women (Income Generating Livelihood Program),” and the community of *hijras* and *kotis* (i.e., transgender women) through home-based care services.

The clinic is surrounded by dust and loud truck horns a few minutes off a heavily trafficked truck driver route; slum and informal housing settlements surround the clinic on all sides. In the Hebrew language, *shalom* means peace, wholeness, welfare, and justice. At first glance, it could seem that “Shalom” is not the most appropriate name to give to an organization that works among individuals contending with both poverty and HIV. The everyday lives of many of *Shalom Delhi’s* patients are marked by fear, brokenness, injustice, and oppression. Further, many have lost loved ones to

AIDS-related conditions, and most have faced discrimination due to HIV.

Shalom Delhi has cultivated an “institutional climate of proximity and embrace” of people living with HIV, aligned with its organizational mission to “preferentially treat members of society who are vulnerable to marginalization with dignity, as exemplified by the life of Jesus” (Kang et al. 2019). In contrast to a form of spaceship ethics that maintains distance between the world of providers and patients, seeing all people as “divinely created beings,” *Shalom* has cultivated “deep relational engagement,” which “not only reified the centrality of their beliefs to preferentially engage the poor and dispossessed, but it challenged and deconstructed negative perceptions staff may have held toward” transgender patients.

Shalom’s former medical director (and co-author), Dr. Savita Duomai, once poignantly shared that over the years, she has “seen a lot of suffering and brokenness.” But in the midst of this suffering, she has “seen God.” “We have had a glimpse of the heart of God and of His deep love for those . . . who are marginalized and for those who are the least in society. We—the staff of *Shalom Delhi*—we ourselves . . . are experiencing shalom.” She further explained that as she cared for her patients, “I have been transformed. I have been changed.” She shared: “When someone comes with HIV first to our clinic [with AIDS], they come in the depth of brokenness . . . I have learned not just to stop at that. I have learned to look at what they can become.” For Dr. Duomai and the staff at *Shalom*, solidarity is marked by an openness to transformation by the patients they serve.

The examples above build a notion of solidarity marked by sustained and intentional proximity. We argue that this type of proximity can provide a framework for reimagining medicine as a practice of solidarity—one that could encourage healthcare trainees and practitioners to engage in ambiguous and complicated social realities of sickness and death more fully. Yet, what could solidarity practically look like in contemporary medical

training? For many, sustained and intentional proximity may seem unrealistic. And, for physicians who feel they are not called to caring for people in resource-limited settings, is solidarity even relevant? There are many complex structural factors that distance trainees from the lived experiences of patients and limit practices of solidarity. Nonetheless, we argue that there are specific ways that medical trainees can discover and embody practices of solidarity within the constraints of modern medicine. In the remaining space below, we outline three practical areas of solidarity for medical trainees: (1) proximity to patients and communities; (2) choosing careers based on communities’ needs; and (3) advocacy and openness to transformation.

Pragmatic Solidarity for Contemporary Medical Trainees

1. Structured Practices of Proximity

Proper professional boundaries and a healthy degree of distance from patients are important for medical trainees’ self-preservation and well-being. Yet, how can trainees orient professional priorities around the lived experiences of patients and engage with their social realities? In our experience, structured curricular opportunities to engage with community-based organizations are key to forming practices of proximity and solidarity. For example, meeting with and volunteering alongside indigenous health leaders as part of community-based Native Hawaiian health elective in medical school taught me (KH) to understand the health of land as an integral part of the health of people (Hosaka 2019). KH’s residency program gives trainees longitudinal opportunities to learn from a gang-rehabilitation nonprofit organization and a local social service agency that utilizes a multipronged approach to address homelessness and domestic violence. There are several noteworthy potential pitfalls with medical trainees working with community organizations in resource-limited settings—including

medical tourism, cultural insensitivity, and unintended harm—and it is important to maintain a posture of cultural humility and mutual respect. Nevertheless, opportunities to longitudinally learn from community leaders can not only help trainees understand the lived experiences of groups of people that influence health decisions but also shift the focus from trainees' careers to patient-centered needs.

There are also individual ways that trainees can engage in sustained proximity with their local community. Simple practices such as choosing to use public transportation or to purposefully live in communities alongside patients can cultivate proximity. For others (including KH and WR), participation in local churches and other community organizations during residency allows trainees to build and engage in relationships with members of the populations they serve outside of the hospital setting.

2. Prioritizing the Needs of People and Communities When Deciding on a Career

When choosing a specialty, medical students in the United States are commonly advised to choose career pathways that factor in fulfillment, financial compensation, lifestyle, board scores, and relative ranking compared to peers (Association of American Medical Colleges 2024). There are many calculators and questionnaires that medical students can complete to find a “perfect match” for one's career. While basing career decisions on preference and personality is important, what would it look like if these tools also incorporated geographic calling and specific needs of patients and communities? In the United States and in many other parts of the world, there are significant clinician shortage areas in resource-limited settings (Ahmed and Carmody 2020). Despite advances in medicine, health outcomes are often based on geography and intersect with race and socioeconomic status.

Trainees can practice solidarity by prioritizing the needs of communities (in addition to

their own) when deciding on career. As MacLaren argues, for trainees who have a calling toward the “oppressed neighbor,” solidarity involves “overcoming self and egoism”—a movement toward communities suffering from health inequity and injustice. Yet what could it practically look like for trainees to shift their career focus to communities' needs? While this invariably depends on trainees' local and geographic context, this might mean choosing a specialty that is less “prestigious” (e.g., primary care) but more needed in resource-limited settings. For others, it may also involve choosing to work and live in a geographic area that may be less “desirable” culturally but that may offer different rewards, namely, the opportunity to have a significant impact on the health of a particular community. A commitment to specific communities may involve not only clinical work but also advocacy, research, and addressing systemic inequity.

3. An Openness to Transformation by Patients

Medical care is usually envisioned as a unidirectional enterprise; patients come to a healthcare institution to receive care, and healthcare professionals give knowledge, expertise, treatment, and guidance to patients. In this model, healthcare professionals impact patients' lives (most of the time for the better), while healthcare providers are largely left unaffected. Yet considering the theory and examples of solidarity above, perhaps our goal in medicine is not merely to “help” patients, many of whom are poor. Instead, perhaps it is to *orient* our lives and professional priorities around their experiences, allowing ourselves as medical practitioners to be transformed and changed.

For trainees, the process of seeking to embody solidarity that is marked by an openness to transformation can practically look like intentionally learning from patients at the bedside, asking about their lives and how the health system can better meet their needs. For other trainees—particularly those who

routinely take care of patients in poverty—this may look like choosing to live simply, avoid opulence, and advocate against systems of oppression. Medical schools and residency programs can also create spaces to form bidirectional relationships with patients by structuring opportunities for trainees to learn from patients' lived experiences. For example, I (KH) was particularly impacted by a panel discussion that my residency organized with parents whose children passed away for trainees to learn about grief, loss, and hope. Intentionally remaining present with the patients that we care for can cultivate humility and a genuine openness to their experiences and knowledge.

Discussion

In this paper, we argue that reimagining medicine as a practice of solidarity can be a corrective to spaceship ethics. Based on theoretical and practical examples of solidarity above, we argue that solidarity requires sustained and intentional proximity (physical, spiritual, and emotional) and a willingness to grapple with complex and fluid provider–patient dynamics, navigating the juxtaposition of shared humanity and divergent life narratives. In the process, we argue for solidarity's potential to shape medicine's "moral imagination," or "the capacity to take a critical distance from the given, to think reality otherwise" (Jennings and Dawson 2015). Solidarity is often messy, costly, and liberating.

In highlighting three practical areas of solidarity for contemporary medical trainees—(1) proximity to patients and communities; (2) choosing careers based on communities' needs; and (3) an openness to transformation—we wonder: could solidarity have implications for how we collectively might choose to practice medicine? Perhaps the ideal medical career is not one of upward achievement, awards, and external success; instead, what if medicine is about life lived in proximity to our patients? What if it involves advocacy and truly working toward a world where our patients' social needs are met? A

practice of medicine that is animated by a commitment to this type of solidarity reorients clinicians' lives and professional priorities around experiences of the patients they care for—being connected to them with a deep sense of shared life. Solidarity may not be for everyone. A practice of solidarity offers more than a mere ethical program to implement. Lives like Father Damien's and organizations like *Shalom Delhi* confront us with both a demand and a promise: here is an opportunity to become more truly human.

Thus, solidarity is not only principally and ethically right but also unavoidably changes healthcare professionals' personhood. As such, while it is not a simplistic solution to the ills and inequalities that characterize modern healthcare, it is a place to begin. This fact is typified by Dr. Paul Farmer, whose life and writing testify to the transformational power of solidarity and how it inevitably leads to a lifelong accompaniment of the vulnerable. Paul Farmer writes:

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. The process is humbling, since there is always an element of temporal and experiential mystery, of openness, in accompaniment. Grand theories and well-laid plans often come to naught; clear objectives and "deliverables" and metrics are all too rare in such endeavors. Even good intentions and long experience sometimes fail us ... If an effort is not laden with anxiety, it's probably not accompaniment, or it's just the beginning of the effort. (Farmer and Gutierrez 2013)

In a medical culture that trains practitioners to distance themselves from patients as whole persons and their social realities, practicing solidarity encourages proximity, advocacy, dignity, and care of souls—both those of our patients and our own.

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